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Physiotherapy as a disciplinary institution in modern society – a Foucauldian perspective on physiotherapy in Danish private practice

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Abstract
In many Western countries, physiotherapy in a private context is practiced and managed within a neoliberal ideology. Little is known about how private physiotherapeutic practice functions, which is why this study aims to explore how physiotherapy is practiced from the perspective of physiotherapists in Danish private practice, within a Foucauldian perspective. This study consisted of 21 interviews with physiotherapists employed in private practice and observation notes of the clinic. Interviews and observation notes were analyzed through the lens of Foucault’s concepts of discipline, self-discipline, power and resistance. Three categories were constructed: (1) the tacit transition from person to patient; (2) the art of producing docile bodies; and (3) the inhibition of freedom of action by practicing in private homes. From a Foucauldian perspective, private physiotherapeutic practices have a disciplinary function in modern society as the physiotherapists produce docile bodies through disciplinary technologies, whereby their business becomes profitable. Most patients support the physiotherapists’ “regime of truth” but if they resist, they are either excluded or accepted as “abnormal” but as a necessary source of income. The physiotherapists appear to be unconscious of the bio-powers working “behind their backs” as they are subject to the Western medical logic, and the neoliberal framework that rules their businesses.

Introduction
Physiotherapy can be regarded as a historically and culturally constructed social practice where routines and practices occur and unfold both explicitly and implicitly for participants in the physiotherapeutic areas. Postmodern philosophies provide a set of tools and ways of thinking that challenge the implicit taken-for-granted obviousness of life; and in a continuation of postmodern ideas, this study aims to explore how physiotherapy is practiced from the perspective of physiotherapists in Danish private practice within a Foucauldian perspective.

Today, the Danish healthcare system, as in many other Western countries, is managed within a neoliberal ideology; a political philosophy whose fundamental idea is to minimize public costs, privatize as many welfare services as possible and to emphasize individual freedom, especially in acting and expressing oneself freely (Boas and Gans-Morse, 2009; Evers, 2003; Hamann, 2009; Harvey, 2005; Pollitt and Buckaert, 2000; Rose, 2003).

Neoliberalism is an ideology that refers to normative ideas about the proper role of the individual in relation to the collective and a particular conception of freedom as an overarching social value (Boas and Gans-Morse, 2009; Harvey, 2005). Neoliberalism can be regarded as a web of practices that are spun over forms of productions, governmental policies and ways of administering values and norms, which form the individual human being’s identity and ways of being. It is a web of power techniques, which support and supply each other, as a capillary web spun through society and create a hegemony, which forms the world, from global structures to the individual human being. Accordingly, the neoliberal subject is an individual who is morally responsible for navigating the social realm using rational choice and cost-benefit calculations grounded on market-based principles (Hamann, 2009; Harvey, 2005).

Practicing healthcare within this ideological framework generates challenges both for professionals and for patients receiving healthcare services, as it is implicit that values such as effectiveness, self-responsibility, calculability and predictability become central (Boas and Gans-Morse, 2009; Dahl, 2005; Hamann, 2009; Harvey, 2005; Holen, 2011; Lehn-Christensen and Holen 2012; Magnussen, Vrangbæk, Saltman, and Martinussen, 2009; Mik-Mayer and Villadsen, 2007). It is also implied that political ideology determines how professionals see and meet patients. Ideology determines what can and what cannot be seen as diseases requiring treatment. Ideology therefore also determines the diseases for which specific frameworks and standards are set to guide behaviors of professionals and informs patients to take on an active role in regards to their own healthcare. They are expected to be well-informed and to be able to choose relevant healthcare services in the consumer market place (Holen, 2011; Lehn-Christensen and Holen 2012; Magnussen, Vrangbæk, Saltman, and Martinussen, 2009; Mik-Mayer and Villadsen, 2007). The ideal patient is thus a person who is responsible, strong, self-determined, controlled and acknowledges and accepts the responsibility of playing a leading part in solving his or her healthcare-related problems (Holen, 2011; Mik-Mayer and Villadsen, 2007).
Like physicians, dentists and psychologists in private practice, physiotherapists become self-employed practitioners. In Denmark, private physiotherapeutic clinics are controlled by collective bargaining (Association of Danish Physiotherapists, 2013a) and laws (Association of Danish Physiotherapists, 2013a,b; Danish Ministry of Health, 2010), which primarily frame economic aspects (e.g., people receiving physiotherapy in private practices pay half of the cost and the state covers the rest). Otherwise, there is plenty of scope for practitioners to define the content of their practices. As a result, power and knowledge, interventions and professional logic are closely interwoven in the meeting between physiotherapist and patient. In these meetings, physiotherapy in private practice is revealed both as a business in which economy is the primary driver but also as a healthcare practice partly defined by the state.

Since the first published study on professionalism in physiotherapy (Perry, 1964), there has been a focus on giving normative directions for how physiotherapy ought to be which have been published in various comments (Bitchell, 2005; Helders, Engelberg, van DerNet, and Gulmans, 1999; Richardson, 1999; Rothstein and Scalzitti, 1999) and textbooks (Gabard and Martin, 2003; Jones, Jensen, and Edwards, 2008; Partilto and Doherty, 2011; Partilto and Haddad, 2002; Partilto, Jensen, and Royeen, 2005; Raja, Davies, and Sivakumar 2007; Swisher and Page, 2005). Clinical guidelines that offer physiotherapists directions for treatment of several diagnoses (Association of Danish Physiotherapists, 2013c), ethical guidelines (Association of Danish Physiotherapists, 2012) and codes of conduct (Association of Danish Physiotherapists, 2010) have been published.

From the turn of the millennium, a burgeoning focus on what physiotherapy practice is, has evolved and researchers from other fields have been looking to research in physiotherapy, this study aims to explore how physiotherapy practice partly defined by the state. Theoretical framework

The theoretical framework is inspired by Michel Foucault, French philosopher, historian of ideas, social theorist, philologist and literary critic. His theories address the relationship between power and knowledge and how they are used as a form of social control through societal institutions (Foucault, 1965, 1975, 1977, 2010; Hamann, 2009; Lindgren, 2005; Mik-Mayer and Villadsen, 2007; Rabinow, 1991; Rabinow and Rose, 2003; Rose, 1994, 1996, 2003).

A Foucauldian perspective has been chosen as it challenges faith in the seeming self-evidence of truths presently valued in thought and practice systems. The theoretical concepts of power, disciplining, self-disciplining and resistance have through many years provided an alternative view for clinical professionals such as physicians and nurses (Armstrong, 1994; Campbell, 2011; Fox, Ward, and O’Rourke, 2005; McCarthy, 2010; Nielsen and Glasdam, 2011; Patton, 1998; Rabinow and Rose, 2003; Riley and Manias, 2002; Roberts, 2005; Rose, 1990, 1994) and also physiotherapists (Eisenberg, 2012; Fadyl and Nicholls, 2013; Nicholls, 2009; Nicholls, 2012a, 2012b; Nicholls and Holmes, 2012).

Foucault has been influential in shaping understandings of power. Through his studies of the administrative systems and social services that were created in eighteenth century Europe, such as prisons, schools and mental hospitals, he showed how their systems of surveillance and assessment no longer required force or violence, as people learned to discipline themselves and to behave as expected. For instance, he showed how in the eighteenth century “madness” was used to categorize and stigmatize not only the mentally ill but also the poor, the sick, the homeless and, indeed, anyone whose expressions of individuality were unwelcome (Foucault, 1965; Stokes, 2004). Foucault had a particularly critical eye for what characterizes power in modern societies and he showed how actors in modern societies are caught in institutional structures, which pin down and form the actors’ actions (Mik-Mayer and Villadsen, 2007).

Foucault’s analysis of power relations led his work away from the analysis of actors who use power as an instrument of coercion, towards the idea that “power is everywhere”, diffused, invisible and tacitly embodied in discourse, knowledge and “regimes of truth” (Foucault, 1977; Lindgren, 2005; Patton, 1998; Rabinow 1991; Roberts, 2005; Rose, 1994). Foucault regarded power not as a thing but as a relationship; not simply as repressive but as productive. Power is not only localized in government and the State; power is also exercised throughout the social body, where it operates at micro levels of social relationships. Power is omnipresent at every level of the social body. Foucault showed that power is constituted through accepted forms of knowledge, scientific understanding and “truth”. These constructions of power in the form of “regimes of truth” are results of history, scientific discourses and institutions and are reinforced (and redefined) through the education system, the media and the flux of political and economic ideologies; they are never absolutes. From this, Foucault deduced that power is not just a negative, coercive or repressive thing that forces us to do things against our wishes, but it is also a necessary, productive and positive force in society (Foucault, 1975, 1977; Mik-Mayer and Villadsen, 2007; Patton, 1998; Rabinow, 1991; Rose, 1994). Power is understood as the ability to bring things into action; therefore, it has productive forces. As such, power will always generate some kind of resistance, and Foucault argues that resistance is co-extensive with power; as soon as there is a power relation, there is a possibility of resistance (Foucault, 1977).

Foucault regarded discipline as a mechanism of power, which regulates the behavior of individuals in the social body.
He emphasized that power is not discipline, but discipline is one way in which power can be exercised (Foucault, 1977). Disciplining takes place by regulating the organization of space (i.e. architecture), time (i.e. timetables) and people’s activity and behavior (i.e. drills, norms, posture and movement). The institutions, their systems and their roles as bodies of knowledge, even today, define norms of behavior and deviance, and Foucault showed how physical bodies are subjugated and made to behave in certain ways; Foucault calls this disciplining technology “bio-power”. Bio-power takes two main forms. First is the discipline of the body, where the human body is treated like a machine (e.g. productive and economically useful). This form of bio-power appears in the military, in education, in the workplace and in healthcare, and seeks to create a more disciplined, effective population. Second is the regulation of the population that focuses on the reproductive capacity of the human body. This form of bio-power appears in demography, wealth analysis and ideology and seeks to control the population on a statistical level, as a microcosm of social control of the wider population (Foucault, 2010; Hamann, 2009; Stokes, 2004). One of Foucault’s major influences was to point to the ways that norms can become so embedded that they are beyond perception, causing the individual to discipline themselves without any willful coercion from others (Rabinow, 1991).

Methods
This study consists of 21 individual semi-structured interviews, and observation notes recorded after each interview by the interviewer. Foucault never stipulated a defined set of methodological guidelines and was ambivalent about using interviews as data. He regarded the interview as a disciplinary technology while he aimed to locate the historical conditions that allow us to think, speak and act as we do now (Fadyl and Nicholls, 2013; Fadyl, Nicholls, and McPherson, 2013; Hook, 2001; Nicholls, 2009). Despite this, several Foucault-inspired studies in healthcare have used interviews as empirical materials (Fisher, 2010; Gilbert, 2003; Glasdam, Praetegaard, and Henriksen, 2013; Kokaliari and Berzoff, 2008). The argument for using interviews in this study is that interviews can be regarded as texts, and as discourses taking place from one view, at a specific time, in a specific context.

Two methods guided the gathering of texts for analysis. First, the study adopted an open approach to interviewing in which the interviewees were asked to speak about situations which they thought could give a picture of how physiotherapy in private practice is practiced. The physiotherapists were invited to express a discourse from their point of view, at a specific time and place. Second, the interviewer took observation notes of the arrangement of spaces, material objects and material practices. The idea was that the observation notes could help get behind the conscious constructive meanings and subjective level of the interviewee, and as a result decode and analyze the symbolism inherent in the construction of clinical practices.

Analytic strategy
The analysis is based on the dialectic between, on the one hand, the structural frame as the context, and on the other, possibilities for articulating the discourses on private practice from the perspective of the physiotherapists. The analytic strategy is to account for the construction of social reality in the structural context through concepts selected from Foucault’s work. This kind of analysis does not ask about what something is, but how something has become what it is, or how someone talks about something (i.e. noticing how others notice). The Foucauldian concepts of discipline, self-discipline, power and resistance (Foucault, 1965, 1975, 1977, 2010) have been chosen as the analyzing concepts. They form a perspective on a section of social reality, which leads to the construction of the physiotherapists’ reality. The concepts are not proved against reality, but manifest reality. The analytic strategy can be regarded as an analysis that tries to catch and decode the patterns of interactions in the specific context (Andersen, 2003). First, a naïve reading of the transcribed interviews and the observational notes was carried out to grasp the meaning of the texts from the speech position of physiotherapists in private practice.

Then the texts were read thoroughly, like a text analysis, through the lens of Foucault’s concepts of discipline, self-discipline, power and resistance, with the aim of getting behind the narrated stories of physiotherapists’ practices. To construct articulations about how the physiotherapists spoke about and formed their practices, the text was read through questions such as: what physical rooms is the clinic comprised; what do the rooms consist of; what do people do in the rooms; how do physiotherapists meet patients; and what do they do together? Through this procedure, three categories were constructed and within which the analyses were made. Quotes were selected from the empirical material to serve as illustration for the analysis. Quotes from observational notes are marked (observation note).

Recruitment
Denmark has some 12 000 physiotherapists serving a population of about 5.6 million. Approximately 40% of the physiotherapists are employed in private practice. In Denmark, a typical private clinic is owned by one physiotherapist, who sublets to two or more other physiotherapists at the clinic. Each physiotherapist operates as an independent practitioner. Some private clinics offer home treatment to people who are too ill or fragile to come to the clinic. The rest of the physiotherapists are employed within the public service, mainly in hospitals and municipal institutions (Association of Danish Physiotherapists, 2008).

An invitation letter introducing the subject of the study and asking for interested participants was sent out to 31 clinics in Denmark. The criteria were that selected physiotherapists should speak fluent Danish and work in private practice irrespective of gender, age, work position, experience or geographical region. Twenty-two participants, from 22 different clinics, willingly agreed to take part in an interview related to professional issues. All signed a written informed consent. One of the 22 was excluded due to forthcoming maternity leave. Nine clinics considered the study to be important but lacked time for participation. All interviewees were practicing physiotherapists in private practice with a range of experience from 2 to 28 years, geographically scattered throughout Denmark.

Interview procedure
Face-to-face, semi-structured, tape-recorded interviews were conducted with each participant by the first author. The majority of the interviews were carried out in the clinic, and four were carried out in private homes or in a neutral office according to the participant’s preference. An interview guide was constructed to help participants talk about their clinical practice in accordance with the themes; personal background, description of the organization of the clinic, description of a typical day, its contents and relationships. The interviewees were asked to talk about situations that they thought could give a picture of how physiotherapy in private practice is practiced. The interview lasted 45–60 min. After the interviews, field notes on the architecture, organization and décor of the clinic were made. Audiotapes of the interviews were transcribed verbatim by a secretary and were checked by the first author who read the transcripts while re-listening to the interviews.
Observation notes

Observations were made and notes were taken (e.g. simple overview drawings of the building of the clinic and the rooms inside and open memory boards of the architecture, structure and décor of the rooms in the clinic). The notes were semi-structured around what and who could be seen in each room; at the walls, ceiling and floor and what could be heard. The drawings and the notes were taken immediately after the interviews with each participant.

Ethical considerations

By law, this kind of study does not need approval by the Danish Research Ethics Committee (2005). The study followed the principles of the Code of Ethics of the Association of Danish Physiotherapists (2012) based on the Helsinki Declaration (World Medical Organization, 2000) and the World Confederation of Physical Therapy’s Code of Ethics (World Confederation of Physical Therapists, 2011a).

Findings

Three categories have been constructed: (1) the tacit transition from person to patient; (2) the art of producing docile bodies; and (3) the inhibition of freedom of action by practicing in private homes.

The tacit transition from person to patient

The architecture, organization and décor in the private physiotherapeutic clinics are similar. When a person enters a physiotherapeutic clinic, he/she is greeted by a secretary who sits behind a reception desk. She welcomes the person and offers to hang their coat in the wardrobe, registers the arrival, hands out relevant material and shows the person a seat in the waiting room together with other waiting patients. The walls are decorated with posters showing anatomic and physical expressions of bodily understanding and the pricing for the services. On the two small tables, magazines, which support the physiotherapeutic understanding of a healthy body, are placed for general use. The waiting person is offered water to drink:

‘‘Right in front of the entrance is the reception with a female secretary. Behind the secretary hangs a poster with the prices of the services the clinic offers. There are also shelves with folders and files and papers. The walls are coloured white. There are two posters on the one wall; one illustrating muscle stretching techniques; the other illustrating columna, its nerves and dermatomes. There are three chairs against one wall; all with armrests; and one against the other. Next to this chair is a small table where four different magazines are placed for general use. The waiting room leads to the clinic’s additional rooms’’ (Observation note).

These visual impressions form both the patient and the physiotherapist as they signal what physiotherapy is and is not about. They signal the physiotherapists’ medical understanding of the body as atomized parts (i.e. muscles and nerves), which are supposed to function in order for the whole body to function; showing a medical linear cause and effect understanding of the body. For example, a nerve is squeezed between two columna vertebrae (cause) and pain is experienced (effect), manual techniques are given (cause) and a relief is experienced (effect). Both the physiotherapist’s and the entering person’s mind-set and expectations to the physiotherapeutic process are shaped. The body is displayed as a thing that when broken or disturbed, can be fixed by the physiotherapists; for an in advance given price. In that way, physiotherapy can be regarded as a relation between physiotherapist and entering person, building on healthcare as being a business where both the therapists and the patients are subject to the underlying medical and neoliberal thinking for that business.

As the person waits for their appointment, the architecture and décor of the waiting room invisibly shape, prepare and tacitly discipline the transition of the person into a patient. In this way, the framework for the meeting is being established:

‘‘[…] We arrange the clinic professionally. People should not get the impression that they’ve entered a massage clinic or a fitness centre’’.

The waiting room functions as the physiotherapists’ tacit disciplinary tool, and at the same time, it frames what physiotherapy is about, what the physiotherapist has to do, what a patient has to do and what the agenda for the relation between a patient and the therapist is about. It becomes the link between the outer worlds, from which the person enters, to the clinical world, where the physiotherapist’s clinical practice unfolds. The time in which the person is in the waiting room depends partly on how early the person has arrived in relation to the agreed time and partly on the physiotherapist’s adherence to the schedule of the day; as a rule, the patient must wait until the physiotherapist is ready. The physiotherapeutic treatment is shaped around a time schedule that can provide for a rentable business.

The person’s explicit transition into a patient happens when the physiotherapist physically meets the patient in the waiting room and escorts the patient to the treatment room. The treatment room is understood as the real physiotherapeutic clinic:

‘‘Well, I pick up the patient in the waiting room and, yes, then, the physiotherapeutic practice begins’. And further: ‘‘For me, physiotherapy starts when I meet the patient and we sit in the cabin and talk about why he or she is here’’.

This suggests that the patient has been pre-disciplined in the waiting room and transforms into a real patient in the treatment room; it makes business running without wasting time, which means without wasting money. Visually, the physiotherapists at the same clinic dress alike; a uniform characterized by jogging shoes or sandals, jogging trousers and T-shirt. The patient is met with a visual sign of youth, fitness and awareness on body functions; a sign of the physiotherapists’ ‘‘regime of truth’’ about what physiotherapy is. It is also a sign of what implicitly is expected of the patients as this kind of uniform tacitly discipline that the patient has actively to take part in his or her treatment and that physiotherapeutic treatment entails bodily movement and training; to become fit and in shape like the physiotherapist. At the same time, it can be regarded as the physiotherapists’ self-discipline into the prevailing understanding of a healthy life where people have to be fit and take responsibility for their own life. Furthermore, the uniform signals a distinction. The physiotherapists are not the patients and the patients are not the physiotherapists; even though they might be in another setting.

Finally, the waiting room also functions as a room for transition between the clinic and the exterior world, as after the patient has finished treatment he or she is received by the secretary again, partly to make new appointments and partly to pay. The patient gets the coat from the wardrobe and steps outside the clinic; all in all, the waiting room appears as an ‘‘in-clinification’’ and ‘‘off-clinification’’. 
The art of producing docile bodies

Artifacts, which were décor in the waiting room, become active educational artifacts in the treatment room.

‘‘Often I use the posters, and especially I use the (plastic) joint components to visually represent my explanations […] I think that (name) both need words and visual knowledge to fully comply with my treatment’’.

The human body is displayed on walls and shelves as the atomized physical body through anatomic posters, plastic skeletal and plastic figures of a diversity of joint-components.

‘‘The room is painted white. There are posters on the walls where equipment offers space. The posters illustrate the human anatomy in general, specific joints, nervous system, stretching exercises, how to tape an ankle. At the wall on the left there is one big shelf with different balls, boxes with tapes in all colours, dumbbells, hula hoops. Mirrors at the back wall’’ (Observation note).

These are visible signs of a bodily understanding attached to functional treatment and training of muscles and joints; of the atomized body, not of the body formed as a whole and understood in a social context. Implicitly, this view conveys expectations to the patient which subject him/her to a medical understanding of the body.

The treatment rooms in the clinic generally consist of cubicles behind curtain walls, individual treatment rooms with wooden or stone walls and a gym.

‘‘The first treatment room consists of a small hallway to the left and six cubicles to the right; all surrounded by curtains’’ (Observation note) and ‘‘Right of the entrance is a reception desk. In front, two doors leading into two separate treatment rooms showing an examination couch, a washbasin, a mirror on wheels and a shelf with (maybe) massage cream and some paper in each room’’ (Observation note).

This means that the physiotherapists are in power to bring things in action as they can decide which patients are appointed their own soundproofed room and which are not. Everyone can hear what happens behind the curtains or see what happens in the gym. As a result, the visual and audible qualities of the room support the physiotherapists while they are disciplining the patient, and the patients are disciplining each other to become good patients, which due to the neoliberal ideology means taking responsibility for their own health and ways of living. The physiotherapists work within a neoliberal framework of making the patients docile and self-responsible due to the time schedule, while at the same time, the medical gaze and the understanding of the body and bodily symptoms implicitly rule the relationship between the physiotherapists and the patients. The contact and the treatment rule the patients and the physiotherapists in the defined right ways of practicing physiotherapy. The physiotherapists ask about the patient’s symptoms, examine the patient and seek to get an exhaustive survey of the patient by using a (standardized) plan.

‘‘Well we always have a plan […] a schema to follow when interviewing the patient. You know, as we were taught in school; anamnoses, examination, assessment, treatment […] It is good. It helps me to picture the patient’’.

The plan is often built on WHO’s International Classification of Functioning’s components ‘‘Participation and activity’’ and ‘‘Bodily function and anatomy’’. It is a classification formulated by the absent physicians; a classification of ‘‘truth’’.

‘‘Her treatment card is divided into fields describing name, personal data, diagnosis (Parkinson’s Disease is filled in), activity and bodily function and anatomy, goal, plan, a drawing of a human being (front, behind, sideways) and a calendar’’ (Observation note).

The idea is that this standardized classification of symptoms seems to be a way in which a chaotic amount of information about bodily systems can be commanded and managed in its components. At the same time, it can be seen as a medical technology within which the physiotherapists define and understand them and their practices; a tool for self-disciplining into the Western medical linear cause and effect understanding of body, health and disease and into a system of diagnostic and documentation practices decided and formed to control the physiotherapists, the patients and the expenses on healthcare.

The physiotherapists underpin the neoliberal ideal of being effective and self-responsible. From this, the physiotherapist sets his/her diagnosis of the patient in medical terminology and treatment is planned and effectuated; the success of treatment is valued through the concrete treatment techniques effects on the concrete muscle or joint dysfunction.

‘‘First I take anamnesis, and then I examine the patient. You know first his ability on activity level; walking, stairs, alignment. From these findings I carry on to more specific examinations; bodily function and anatomy. In this case I examined muscle strength, you know 0 – 5, range of motion of hip and knee, test of ACL, ligaments and so […]’’.

By this, the ring is closed; the physiotherapist knows what symptoms to look for and classifies the symptoms according to the classification.

Through the process of physiotherapy, the physiotherapists assume the right to see and know what is the matter with the other and what to do about it.

‘‘Well, in the initial meeting […] I ask the questions and the patient answers, it is as simple as that’’.

The physiotherapists seem aware of their power position in the physiotherapist–patient relationship and use it actively to treat and discipline the patients into the practice of physiotherapy. In that way, they educate and form the patient into the dominating physiotherapeutic framework of understanding health and disease. The physiotherapists bring things in action and transform the patients into docile bodies.

‘‘I see physiotherapy as my legal right, and duty, to have the authority over the other […] over the patient’’.

The physiotherapists have a space of possibilities for acting and thinking, implicitly defined by a combination of two discourses: (1) the medical gaze; and (2) the neoliberal framework. This space frames what physiotherapists can do and not; it frames the conditions for possibilities and impossibilities. All in all, it means that the space limits the possibilities for physiotherapeutic practice; they cannot do just as they please.

Despite this, standardized idea about physiotherapeutic practice it seems that sometimes patients can negotiate their treatment from personal preferences, some patients react with resistance when they meet the demands of the physiotherapists. This resistance is heard and accommodated by the physiotherapists, depending on the social position of the patient. When the patient’s
wishes for treatment correspond to the physiotherapist’s personal preferences, even though the patients wish may not be professionally substantiated, the physiotherapists respond positively to the wishes.

‘Well, yes, I can’t claim that I haven’t given a massage which I professionally can’t substantiate. And honestly, I don’t think that any physiotherapists can. It is cosy, too’.

In other words, the physiotherapist’s willingness to comply with a patient’s preferences in this case ranks higher than professional so-called evidence-based knowledge in the concrete practical reality. This can be seen as evidence of keeping the patient within one’s business. Running a business requires satisfied customers and thereby the physiotherapists have to accept a resistance from the patients due to the idea of evidence-based physiotherapeutic; an unsatisfied patient may result in no income. Another piece of evidence of satisfying the patient with a view to keeping the patient and thus ensuring a satisfied customer based in one’s business was:

‘To be a physio here gives me partly the right to decide and partly the right to earn money through my competences. It’s cool’.

Patients who look and live like the physiotherapists, carry to some extent the same understanding of body, treatment and training:

‘Good sessions in physiotherapy [...] are when things are smooth, such as when I told you about (name), she quickly understood my questions and directions [...] when she takes her problem as seriously as I do’ and ‘When a patient enters, one who seems uninterested in being physically active in participating, then I quickly realise that this will be all up hill. I tell you these patients are so difficult to handle [...] sometimes I think they are not suited for private practice’.

Some patients are regarded by the physiotherapists as good ‘normal’ patients: they seek what they get, and they get what they seek. They seem to be predisposed to conform to the dominant logic of the clinic about the purpose of the meetings, and the meetings are straightforward and unproblematic for both parties; their bodies are predisposed to become docile bodies:

‘The good physiotherapeutic treatment. Many of those I tell you [...] I feel that most of my treatments are good. They (the patients) turn up with their problem and I solve it. Well, that is the bright side of being a physio that one can actually get persons to function’.

It appears that some patients willingly and smoothly adopt the physiotherapists ‘regimes of truth’. However, it seems that the physiotherapists have difficulties including and disciplining two categories of patients into the order of the clinic: first patients to whom the physiotherapists ascribed a lower social status than themselves, the ‘underdogs’, which are described as patients from cultures other than Western modern societies, severe overweight, disorderly and mentally ill patients; the so-called ‘ab-normal’ human beings.

‘Some men [from other cultures than Danish] can be so difficult. They kind of make one feel worthless because I am a woman. They do not respect my professional skills. I endure them for a while, try to make them excercise, which never really works, and then I try to fix them a male physio. I feel so patronized’, and ‘Well, one woman comes to mind. She was severely overweight and had many complaints about everything, knee and ankle pain. Well, I found it rather obvious with all the weight she carried [...] actually I felt kind of nauseated, I mean how did she let herself become so fat [...] I could not grip around her knee with my hands. I told her to lose weight before I could treat her’.

These patients resist to the physiotherapists’ understandings and descriptions of body image, self-care and medicalization of the body. This means that the patients do not accept the premise for physiotherapeutic treatment, and even worse, they defy by not obeying. Accordingly, the physiotherapists meet these patients with judgmental and stigmatizing attitudes. Patients, who are not able to live in the political defined, normative ‘healthy’ way, are disapproved as they are not regarded as taking actively responsibility for their own life and in the end, of the societal economy. They are regarded as being out of control and self-careless. If the patient does not fall into line and accept the premises of the physiotherapists, it seems that the physiotherapists exclude the patients from their clinic; mainly justified as not being able to reach a positive outcome:

‘You just have to accept to give up on some patients. Some patients just don’t respond to one’s advice or treatments. It can be very difficult - one does one’s best - but they really need to comply, to do something themselves’.

Opposite, it seems difficult for the physiotherapists to include everyone in their practices due to the fact that their practices are ruled by a neoliberal framework where cost-benefit considerations rank higher than patient-related individual problems and challenges.

The second category of patients that seem difficult for some physiotherapists to handle is that of patients to whom they ascribe a higher social position than themselves.

‘I don’t really know what happens. I get all stiff and awkward, - almost afraid [...] If the patient turns out to be a physician, well, then I just stop thinking. She is supposed to have more sense than me’.

When the patient is a physician by profession, for instance, a displacement in the understanding of expert knowledge seems to occur, as physicians traditionally are seen as ranking higher in the knowledge and prestige hierarchy and as such have the right to refer patients to physiotherapy. Their position becomes blurred and the order within the clinic is disturbed. While being inscribed as a patient, the physician is outside the professional hierarchy, but as an object of treatment in the hierarchy. In that view, the physiotherapists are externally evaluated by the patients, and the success of their practice depends on this evaluation, predicted by persons who normally rank higher within the medical field than the physiotherapists, and who, formally refer other patients to the same practice.

Some physiotherapists manifest a certain form of professional self-assertion when physicians are in need, as a patient, of the physiotherapist's knowledge and treatment:

‘see, you don't know it all after all’.

This may be partly because some physiotherapists are invited to teach medical specialists in selected musculoskeletal examinations and treatment techniques. It can be seen as resistance by some physiotherapists towards physicians’ claim of knowledge dominance. In other words; physiotherapists can claim a limited topic of knowledge within the medical field where they have a higher ranking and can even teach medical specialists, but they continue to operate within the medical logic and field
of knowledge; a self-disciplining into the medical ‘‘regime of truth’’.

The inhibition of freedom of action by practicing in private homes

When a patient claims treatment outside the physiotherapeutic clinic in his/her private home, the patient is either a child with a severe handicap or an adult with chronic disease close to the end of life. Thus, physiotherapeutic practice in private homes primarily aims at patients who are at the outer edges of life continuum; the private practice in itself seems to exclude this category of patients as they are not able to transport themselves to the place of the private practice.

When a physiotherapist has to practice physiotherapy in the patient’s private home, this happens within physical frameworks other than the clinic. The physiotherapist steps into the treatment room in the private home of the patient as a guest with the purpose of uniting workplace, everyday life and the interior of the home, all the time on the premise of being a guest. Consequently, power positions change and need to be negotiated:

‘‘Well, I’m the guest. I can’t just enter a private home having a chrome-plated plan in my head. I mean what if the family isn’t used to see movement as playing, or if the living room isn’t seen as a place for doing active roll overs’’.

It means that the disciplining strategies of artifacts of the private practice dissolve and the tacit technologies of power of the physiotherapists also dissolve. When the physiotherapeutic practice is converted into a private home, it simultaneously implies a change of the physiotherapist’s understandings of the outcome of his/her treatments, as treatment and cure seems out of reach. The movement from clinic to home is also a sign of a movement from treat and cure to maintenance and caring.

‘‘Then it turns out that the patient has a severe cancer. And three weeks later I treat 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 into some of her territory of death and illness, … and this disregarding the fact that I usually help patients. Now I cannot do this. I can’t cure 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’’.

From this, it appears that the clinical gaze of the physiotherapist is not working as he/she is not used to take action on human suffering; their ‘‘regime of truth’’ does not work in the new context. The private home sets the physiotherapists in a work situation where they, through their therapy, cannot convert the ‘‘abnormal’’ (the fragile or chronically diseased) to the ‘‘normal’’ (the fit and healthy) and have to accept the premise that the ‘‘abnormal’’ remains the ‘‘abnormal’’; some even die, despite physiotherapeutic treatment. In other words, physiotherapeutic private practice complies with patients who can be characterized as potential well, able-bodied and engaged in active employment, contrary to physiotherapy in private homes, which complies with patients being ill, disabled and in the outer edge of life continuum.

The loss of freedom of actions when practicing in private homes seems to reveal an internal hierarchy in which physiotherapists practicing in private practice rank highest, second come physiotherapists who combine clinic and private homes as work places and lowest in the hierarchy rank the physiotherapists who practice exclusively in private homes. That is, physiotherapists who aim above all to cure rank highest and physiotherapists whose aim is to maintain and care rank lowest.

Discussion

Physiotherapy in private practice, practiced within a neoliberal frame, is a reality in modern Western society, as in other areas of healthcare, for example, dentist, medicine and psychology (Fries, 2008; Holen, 2011; Järvinen and Mik-Mayer, 2003, 2012; Shulamit, 2008; Walkerdine, 2003). In general, those involved, both physiotherapists and patients, support this form of practice in their way and for their own purpose. The physiotherapists are subject to the neoliberal ideology (Boas and Gant-Morse, 2009; Evers, 2003; Hamann, 2009; Harvey, 2005; Mik-Mayer and Villadsen, 2007; Mirowski and Plewe, 2009; Pollitt and Buchaert, 2000; Rose, 2003) and offer their knowledge and skills for payment: knowledge and skills, which they convert to treatment under certain frameworks and conditions. This means that physiotherapists underpin and adapt the neoliberal ideal in Western societies (Boas and Gans-Morse, 2009; Harvey, 2005), which also control physiotherapeutic private practice (Association of Danish Physiotherapists, 2013a,b; Danish Ministry of Health, 2010) and set values and norms for how to run a healthcare practice on market-based principles (Association of Danish Physiotherapists, 2013a,d; Hamann, 2009; Harvey, 2005).

Furthermore, there seems to be an understanding that physiotherapy in private practice ranks higher than physiotherapy in public managed practices; municipals and hospitals, which can be seen as an offshoot of the neoliberal ideal of minimizing public costs and privatizing most welfare services possible. The physiotherapists in private practice see their practice as something unique. They all have a conception of private practice as being ‘‘free’’. ‘‘Free’’ is understood in the wide sense of the word; free from tight sets of rules, long paths of bureaucratic decision making, top managed organizations; elements they find represent public management.

‘‘Private practice gives me total freedom to do as I please’’.

The right to freedom is described as the right to decide one’s working hours, one’s time schedule through the day, the amount of patients, the physiotherapeutic approach to the patient, the choice of treatment; the right to determine on behalf of the patient and the satisfactory right to earn money through this right.

‘‘I have consciously decided to be in private practice. I have known it since I was trained. Here we don’t have tight rules and regimes, no one decides except me. I can be my own master, decide working hours, the amount of patients per day [...] concurrently with having the right to do so’’.

Private practice seems to give the physiotherapists the understanding of professional autonomy but actually they tacitly and non-consciously approve the Western medical ‘‘regime of truth’’ and its direction in understanding health and disease; a binary cause-effect explanation is used in their examination and treatment practices. As a consequence, bio-powers work unnoticed behind their backs and produces the strategies for content and handling used in private physiotherapeutic practice. Bio-power occurs as a disciplinary and self-disciplinary technology of the actors in physiotherapeutic practice; the ideals of the neoliberal ideology lead the thoughts and actions of both patient, physiotherapist and practice conditions.
In theory, the patient can accept or deny the knowledge and skills of the physiotherapists, but the physiotherapists only meet the people in their practice who, as a starting point, have accepted to sign up to this treatment. The only patients met are those who have accepted the premises and frameworks for private practice physiotherapy and the way it is practiced in advance. From a Foucauldian perspective, the patients can be considered to be pre-disposed to be transformed into the kind of patient the physiotherapists wish to meet in their clinic; they let themselves be disciplined into the physiotherapists ‘regime of truth’ (Foucault, 1977). This phenomenon has been described as ‘becoming an intelligible patient’ or ‘creating a patient’ (Holen, 2011; Järvinen and Mik-Meyer, 2003; Lenn-Christensen and Holen, 2012; Magnussen, Vrangbæk, Saltman, and Martinussen, 2009; Mik-Mayer and Villadsen, 2007; Rostgaard, 2011). In a Foucauldian perspective, the patients discipline themselves into the physiotherapists ‘regime of truth’ (Foucault, 1965, 1975, 1977). This can be regarded as a part of the modern human being’s projectification of him or herself (Blædel and Borum, 2004; Brunila, 2011); every human being has created his or her own project, which seeks an expert for the part of the body, mind, spirit or economy that needs support. The physiotherapist is a helper for bodily salvation. This help can be given and achieved for payment if one follows the advice and treatment of the physiotherapist. This means that the patients who choose their healthcare treatment in private physiotherapeutic practices support the neoliberal project of achieving the greatest possible privatization of the public sector (Boas and Gans-Morse, 2009; Evers, 2003; Hamann, 2009; Harvey, 2005; Rose, 2003).

Physiotherapy in private practice can be regarded as the available treatment option for those who think and live like the physiotherapists themselves, for patients who make the order and flow of the clinic unproblematic. This order seems to be interrupted if disagreement arises about what physiotherapy is about. Sometimes, the physiotherapists meet patients who offer resistance to the physiotherapists’ concepts, frameworks and requirements for how to become a patient; these are not ‘good’ patients. These patients are categorized by some physiotherapists as ‘abnormal’, and the physiotherapists either exclude them from the clinic as quickly as possible or accept them as a necessary source of income while regarding them as supercilious, disorderly and/or ‘impervious to reason’. In this respect, physiotherapy in private practice can be seen as a continuation of the societal disciplining exclusion of the already so-called marginalized people in modern Western societies (Fallov and Nissen, 2010; Foucault, 1965, 1975, 1977; Frank and Jones, 2003; Järvinen and Mik-Mayer, 2003; Mik-Mayer and Villadsen, 2007; Praestegaard, Gard, and Glasdam, 2013; Roberts, 2005; Wright and Stickley, 2013). It can be discussed whether physiotherapists, through their use of rational choice and cost-benefit calculations ground on marked-based principles, support and consolidate themselves in priority over marginalized people in society.

The results show that the physical framework of the physiotherapeutic clinic seems to have symbolic value. The rooms have meaning for both how the physiotherapists understand and unfold their practice and for the physiotherapist’s experiences of the patients’ adaptation to their ‘regime of truth’. The physical frameworks of the clinic can in their design and expression be seen to socialize and discipline both patients and physiotherapists, making the daily routines of the clinic run effectively, reliably and profitably; referencing normative ideas about the proper role of individuals in the society (Boas and Gant-Morse, 2009; Hamann, 2009; Harvey, 2005). This understanding of the physical frameworks is also seen in many other contexts in modern society (i.e. hospitals have different rooms with their different possibilities for healthcare professionals, in relation to discipline, their internal hierarchy among professionals, patients and visitors) (Bayer, Henriksen, Larsen, and Ringsted, 2002; Fioretos, Hansson, and Nilsson, 2013; Foucault, 1965, 1975, 1977; Larsen, 2001, 2005; Thornquist, 2011). The rooms transform the social interaction and meetings between physiotherapist and patient (Jönsson, 1998; Schrinner, 2003). The room frames what can and must be done and not done within its four walls; they discipline (Foucault, 1965, 1975, 1977).

The rooms of the clinic tend to position patients under clinic employees in the hierarchy; the patient is assumed to be the one somebody can and must do something with and about. Concurrently, it seems that the rooms of the physiotherapeutic clinic function as place of surveillance of the patients and the secretary functions as the physiotherapist’s prolonged medical, clinical gaze from the moment the patient enters until they exit the clinic. The patients are controlled, regulated and treated by the physiotherapists within the sessions of treatment and are subject to a clinical ‘gaze’, whereby they are transformed into a medical object (Brady-Jones, Sambrook, and Irvine, 2007; Foucault 1975; Gilbert, 2001). In that way, physiotherapy in private practice accidentally supports the omnipresent power of medical surveillance and discipline in modern Western societies (Foucault, 1975, 1977; Nugus et al, 2010; Stokes, 2004; St-Pierre and Holmes, 2008).

Contrary to this, it seems that physiotherapy unfolded in patients’ homes loses some of its legitimate right and freedom of power. The means of the clinic to set the framework does not exist; only the physiotherapist in person and his/her knowledge and skills remain. The physiotherapist no longer has the right to define the rooms nor the possibility of ‘creating’ a patient by the means they have in the clinic; their technologies of discipline are dissolved. They simply meet a person with all his/her life and story of life in his/her own context. This is similar to other healthcare professionals, for instance homecare (Glasdam, Henriksen, Kjer, and Praestegaard, 2013; Glasdam, Praestegaard, and Henriksen, 2013), where the healthcare professional tries to convert the home to a workplace in which their practices can unfold. The physiotherapist’s movement from the clinic to the home of the patient seems to be a contemporary movement, which signals a change of clientele from the potential curable to the unavoidably incurable but also a movement from describing oneself as the expert with control over the situation to being a guest with treatment competences in a situational impotence. This can be seen in relation to the internal understanding of professional hierarchy within physiotherapy, where the possibility of curing people is ascribed higher prestige than having to deal with the incurable. In this study, physiotherapy seems to assign itself to the medical understanding of what is prestigious within a professional field, namely working closest to the acute and the possible curable is prestigiously above the chronic, incurable and terminal (Album, 1991; Pedersen, Bak, Dissing, and Petersson, 2011). Unlike the physicians, whose high prestigious areas of specialization are within the frames of the hospitals, the physiotherapists ascribe clinical practice high prestige when they have created a room which they, in their illusion, consider to be without medical dominance. It seems that the physiotherapists are not conscious of the strength of medical thinking and logic governing physiotherapeutic practice, even though it is evident in practice; in hospitals, the home of the patient and in private practice. They seem to be unconsciously accepting and approving of the medical ‘regime of truth’ and have tacitly adopted it into their clinical practice. The forces of bio-power are working ‘behind the backs’ of the physiotherapists.

The way in which the physiotherapists talk about the patients and their businesses reproduces the medical diagnostic, treatment
and atomized binary understanding of normality and body, which base itself in a cause and effect causality (World Health Organization, 2003); a contrast to physiotherapeutic textbooks, which recommend a bio-psycho-social approach (Higgs, Jones, Loftus, and Christensen, 2008; Lund, Bjørnlund, and Sjöberg, 2010). Furthermore, the physiotherapists reproduce the medical language and the Latin terminology. They reproduce the medical uniform which signals a perceptible distinction between who treats and who gets treated. Their use of design and decor within the clinic seems to be a copy of the physician’s clinic. Furthermore, it is evident that definition of the correct physiotherapeutic treatment for a concrete bodily dysfunction is not always exact, as some treatments are negotiated between physiotherapist and patient, dependent on the patient’s social status, his/her personal preferences of treatment and the physiotherapist’s need for income. Despite the physiotherapists’ efforts not to be seen to offer massage or fitness, also showed by others (Nicholls, 2012a; Snyder and Mitchell, 2003), it seems that these elements are actively included as potential treatment offers if it is preferred by the patient. This implies that the physiotherapeutic diagnostic and treatment approach to the patients cannot be considered an independent discipline but a continuation of and subjugation within the medical model, by which contemporary physiotherapists seem to support medical dominance. Through subjecting and underpinning medical thinking and logic, the physiotherapists unconsciously oppose their sense of professional autonomy as private practitioners and their own political intentions about physiotherapy as something special and also oppose their association’s rhetorical striving for achieving professional status (Association of Danish Physiotherapists 2013d; Carr, 2000; Dean, 1995; Laursen, 2004; Laursen, Moos, Olesen, and Weber, 2005; World Confederation of Physical Therapists, 2011a,b,2011c). Within professional theoretical research, five cited criteria of professionalism are commonly cited in the literature: (1) professions provide an important public service, which is client centered, not focused on the enrichment or aggrandizement of the professional; (2) they involve a theoretically and practically grounded expertise; (3) they have a distinct ethical dimension expressed in standards of practice, ethical and intellectual standards; (4) they require organization and regulation for purposes of recruitment and discipline; and (5) professional practitioners require a high degree of individual autonomy (i.e. the individual professional’s right and responsibility to practice and make decisions within the scope of the profession) (Carr, 2000; Dean, 1995; Fauske, 2008; Krejsjer, 2005; Larson, 1977; Laursen, Moos, Olesen, and Weber, 2005; Slagstad, 2008). From this understanding of a ‘profession’, physiotherapy, in the context of private practice physiotherapy in Denmark, must be regarded as only a semi-profession, since a profession must present at least an autonomous theoretical and practical grounded area of expertise (Carr 2000; Dean, 1995; Laursen, 2004; Laursen, Moos, Olesen, and Weber, 2005). The same picture is also shown in nursing (Glasdam, 2003), maternity care (Benoit et al, 2010) and in other semi-professions (Callewaert, 2003). Some authors go so far as to call this group the ‘wanna-be’-professions (Alvesson and Billing, 2009; Hjort, 2004). This excites reflections about the fruitfulness to think, discuss, elaborate and develop physiotherapy in the future as a specialist part of the medical profession rather than an autonomous profession.

Finally, the methodology of this study should be discussed. To choose a Foucauldian perspective as framework means to choose a perspective for the study, knowing that many other perspectives could have been chosen. The advantage of choosing an explicit theoretical perspective is to be able to work stringently and transparently through all the phases of the study and to obtain another abstract level over and above the immediate representations of the interviews. The disadvantage of this method is to be locked in a certain view and thereby see what one wants to see through the theoretic lens. An immediate weakness of the method is that it is based on how some physiotherapists articulate their practices and on observation notes of how physical clinics are constructed. The study says nothing about how clinical practice within practical reality is handled. Likewise, the study says nothing about the perspective of the patient, which means that it is not possible to describe all the relational understanding of the complex reality and meetings in this study.

Finally, the analytic strategy, using the lens of Foucault’s concepts of discipline, self-discipline, power and resistance, has an embedded risk in becoming self-affirmative and self-evident through closing the analytical gaze in the name of concepts rather than open the analysis. There is a risk of reproducing one’s theoretical pre-assumptions, which calls for critical reflection throughout the research process.

Conclusions

The study shows that physiotherapy in a private context, practiced within a neoliberal ideology as a self-employed business, is a reality in modern Western society. The physiotherapists offer for payment knowledge and skills which, under certain frameworks and conditions, they convert to treatment which the patients accept and take part in, just as expected of neoliberal subjects.

From a Foucauldian perspective, it has been shown how physical design and décor expressions are elements of disciplining and ‘creating’ a patient within a physiotherapeutic clinic. The waiting room functions as a place of transition from person to person when entering and from patient to person when exiting the clinic. It has also been shown how physical design and décor is a sign of the physiotherapists’ self-disciplining into the Western medical ’regimes of truth’.

Through the clinic’s disciplining design and décor, the physiotherapists produce docile bodies, as a result of which their business becomes effective, reliable and economically profitable. At the same time, the physiotherapists are subject to the medical gaze and the neoliberal ideology, which frame the possibilities and impossibilities in the practices. Sometimes, the physiotherapists meet patients who resist their ’regime of truth’ and practices; the physiotherapists try to exclude them from the clinic or to accept them as inevitable or ‘abnormal’ but as necessary income. When the physiotherapists practice outside the physical private practice, namely in the home of the patients, the physiotherapists’ disciplining technologies dissolve, and consequently some of the physiotherapists’ legitimate rights and freedom of actions also dissolve. Treatment in patients’ homes leads to redefinition of the clientele from potentially curable to incurable and terminal patients. This has importance for the internal understanding of prestigious positions within physiotherapy from the perspective of private practicing physiotherapists.

Physiotherapy in private practice seems to be mainly a reproduction of the Western medical diagnostic, treatment and atomized binary understanding of normality and body. This is based on a model of cause and effect, by which the physiotherapists assign their support to a medical dominance of their understanding and practice; an understanding about which they seem to be unconscious. In this way, they unconsciously oppose their own political intentions for physiotherapy to be an autonomous profession. All in all, physiotherapy in private practice inscribes itself as a ‘wanna-be’ profession.

The study has its limitations as it is built solely on a Foucauldian perspective as a framework and on the physiotherapists’ articulations of their practice, their understanding of this,
and observation notes. This means that the analysis only addresses how physiotherapists articulate their practices and does not address the issue of the handling of clinical practice within practical reality. Field studies may be developed to explore the relational reality where both the physiotherapists’ and the patients’ perspectives are taken into account.

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