

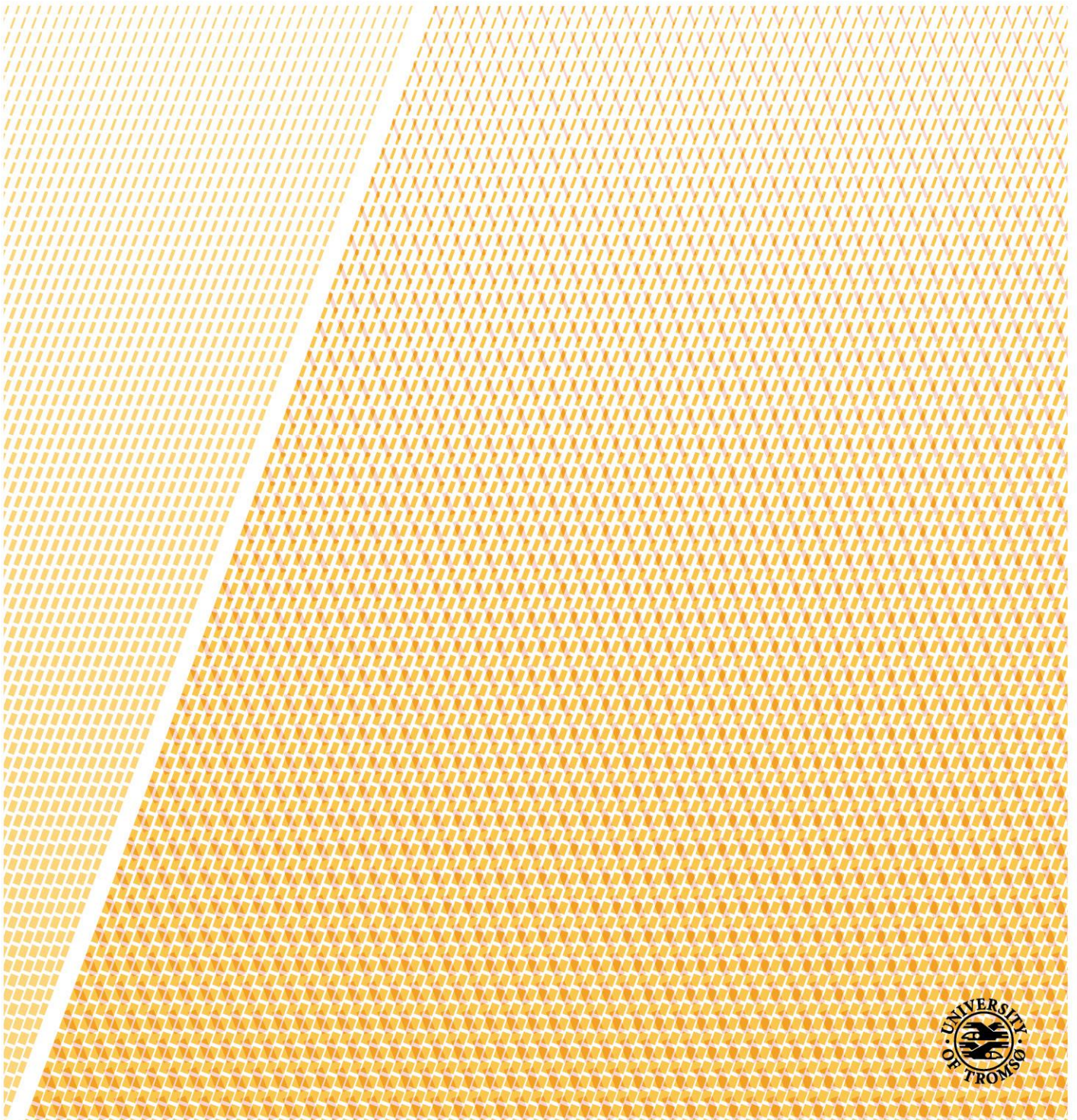
# Ambiguity and professional accountability in physiotherapy practice

*Acquired brain injury rehabilitation across health care levels*

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# Contents

Abstract .....	1
List of publications.....	2
Abbreviations .....	3
1 Introduction .....	4
2 Background .....	7
2.1 Acquired brain injury.....	7
2.2 Health care service developments and reformative work in Norway and Western countries .....	8
2.3 Rehabilitation and continuity of care.....	9
2.4 Physiotherapy practices and rehabilitation trajectories .....	12
3 Aims of the study .....	15
4 Theoretical framework .....	16
4.1 Social constructionist theories and interactionist perspectives.....	16
4.2 Professionalism and accountability .....	18
4.3 Practice knowledge and communities of practice .....	19
5 Methodology and methods .....	23
5.1 Recruitment and participants .....	23
5.2 Data collection.....	26
5.2.1 Interviews .....	27
5.2.2 Observations.....	28
5.2.3 Discharge summaries and reports .....	29
5.3 Data analysis.....	31
5.4 Ethical considerations.....	33
5.5 Methodological considerations.....	34
5.5.1 Reflexivity.....	34
5.5.2 Reliability and validity - Trustworthiness .....	35
6 Summary of the results.....	39
6.1 Article 1 .....	39
6.2 Article 2 .....	41
6.3 Article 3 .....	42
7 General discussion of the results.....	43
7.1 Rehabilitation policies and reformative work .....	43

7.2	Organization of health care services and continuity of care.....	48
7.3	Professional development and accountability in neurological physiotherapy.....	53
8	Concluding remarks and possible implications for practice .....	56
9	Future directions.....	58
	References .....	59

Article 1

Article 2

Article 3

Appendices

## **Abstract**

At the time of this study, the Norwegian health care system was in the middle of the implementation of the Coordination reform, initiated in 2012 due to insufficient coordination and an increase in health care service expenditure. Earlier hospital discharge and increased municipal responsibilities for rehabilitation following acquired brain injuries (ABI) challenge the traditional rehabilitation trajectories and the physiotherapists' efforts to enable ABI patients' recovery. The aim of the study "Ambiguity and professional accountability in physiotherapy practice – Acquired brain injury rehabilitation across health care levels" was to explore the physiotherapy practices in ABI rehabilitation trajectories by investigating how the involved physiotherapists experienced the process of transferring patients and coordinating physiotherapy services in the aftermath of the reform.

The research adopted a social constructionist approach with a qualitative design. The focus was the physiotherapists' perceptions, experiences and viewpoints regarding the redistribution of responsibilities following the coordination reform; potential practice variations in rehabilitation trajectories; and the communication of information and professional knowledge across health care levels. Interviews, field observations and collection of hospital discharge papers were conducted with specialist and primary health care physiotherapists involved in a total of 10 patients' rehabilitation trajectories following ABI. The study was conducted in northern Norway. The physiotherapists shared their experiences and opinions regarding neurological rehabilitation services in the aftermath of the Coordination reform introduced in 2012. The three articles in the thesis relate to different aspects of providing physiotherapy services for persons recovering from acquired brain injuries. The articles highlight the physiotherapists professional dilemmas related to service provision, perspectives on physiotherapy practice variations, and physiotherapists' experience and viewpoints regarding the communication and development of physiotherapy knowledge in ABI rehabilitation trajectories. The study suggests that the physiotherapists experience dilemmas and conflicting values due to changes in the organization and provision of health care services in the aftermath of the Coordination reform, and emphasize how physiotherapy practice in ABI rehabilitation trajectories reside in complex social, cultural and political realities.

Collaborative physiotherapy practices in rehabilitation trajectories that span health care levels and organizational contexts offer opportunities facilitate the ABI patients' recovery, and to further develop physiotherapy knowledge and practice.

# List of publications

This thesis is based on the following articles:

- Irgens, E, Henriksen N & Moe S (2016): *Acquired brain injury rehabilitation: dilemmas in neurological physiotherapy across healthcare settings*. European Journal of Physiotherapy, DOI: 10.1080/21679169.2016.1181206
- Irgens, E, Henriksen N & Moe S (2018): *Variations in physiotherapy practice in neurological rehabilitation trajectories – an explorative interview and observational study*. Physiotherapy Theory and Practice, DOI: 10.1080/09593985.2018.1480679
- Irgens, E, Henriksen, N & Moe, S (2018): *Communicating information and professional knowledge in acquired brain injury rehabilitation trajectories – a qualitative study of physiotherapy practice*. Disability and Rehabilitation, DOI: 10.1080/09638288.2018.1544295

## **Abbreviations**

Abbreviations frequently in use:

ABI Acquired brain injury

ADL Activities of daily living

ART Outpatient rehabilitation services (abbreviation in Norwegian)

ESD Early Supported Discharge

PrPT Primary health care physiotherapist

SpPT Specialist health care physiotherapist

PT Physiotherapist

TBI Traumatic Brain Injury



# 1 Introduction

This thesis is based on a study of physiotherapists' perceptions and reflections regarding their practices in rehabilitation trajectories following acquired brain injury (ABI). Its title is "Ambiguity and professional accountability in physiotherapy practice – Acquired brain injury rehabilitation across health care levels".

Norway ranks among the highest of all OECD (the Organization for Economic Co-operation and Development) nations in public health spending per capita. The Norwegian Ministry of Health and Care Services has argued that insufficient coordination and the increase in health care service expenditure are unsustainable. More people are falling ill, the population is aging, more people need help for longer periods, more diseases are becoming treatable, and the queues in the specialist health care level are increasing. In recent decades, there has been a shift in the organization of health and care services. The implementation of the Coordination Reform in 2012 represents such a shift in the service organization and the provision of health and care for the Norwegian population. The aim of the Coordination Reform has been to ensure that each citizen can receive appropriate treatment – at the right place and right time (Norwegian Ministry of Health and Care Services, 2009b) - in response to three primary challenges:

- Patients' needs for coordinated services are not sufficiently met
- There is too little effort to limit and prevent disease
- The population demographics and the range of illnesses are changing

Several measures have been taken to meet these challenges, including economic incentives, reorganization of health and care services in terms of responsibilities, and increased emphasis on cooperation across health care levels. The Norwegian Ministry of Health and Care Services proposed a new, extended role for the municipalities that emphasized prevention, early intervention efforts, low-threshold initiatives, and interdisciplinary measures.

Furthermore, the municipalities' responsibility for rehabilitation was emphasized in a National Strategy for Habilitation and Rehabilitation in 2007 (Norwegian Ministry of Health and Care Services, 2007) that stated that rehabilitation should be offered at the lowest effective level of care.

Against this backdrop of the recent efforts to reform the organization of health and care services in Norway, this study aimed to explore physiotherapy practices in rehabilitation trajectories for people recovering from acquired brain injury (ABI). ABI is a major cause of disability and mortality both in Western countries (Bender et al., 2016; Sollid et al., 2008; Sundstrøm, Sollid, Wentzel-Larsen, & Wester, 2007) and worldwide (Rutland-Brown, Langlois, Thomas, & Xi, 2006; Undén, Ingebrigtsen, & Romner, 2013), and rehabilitation following ABI requires complex interventions across health care levels. Physiotherapy services are considered important in neurological rehabilitation as part of a multidisciplinary approach that spans professions and health care levels (Baque, Sakzewski, Barber, & Boyd, 2016). The scope and complexity of ABI and the subsequent rehabilitation efforts, which often involve both the specialist and primary health care levels, require the coordination of services and collaborative practices across health care levels. Consequently, rehabilitation following ABI includes several factors addressed in the recent reforms introduced in Norway. In this context, we chose to investigate aspects of ABI rehabilitation trajectories from the perspective of physiotherapists.

We performed a qualitative interview and observational study of 19 physiotherapists involved in the rehabilitation trajectory of 10 people recovering from ABI. The point of departure was the patients' initial hospital rehabilitation. We interviewed the treating physiotherapists and performed field observations of physiotherapy treatment sessions both prior to hospital/institutional discharge and once the patient was back in his or her home community. Furthermore, we performed one follow-up interview with the community physiotherapist 3 months after the initial interview. We also collected hospital discharge papers, which validated the background information regarding the patients and the initial phase of the rehabilitation trajectory.

This thesis is organized in 9 chapters. Chapter 2 provides an overview of the background of the project by describing chosen aspects of knowledge regarding acquired brain injuries; the organization and development of health care services in Norway; rehabilitation and continuity of care; and physiotherapy and rehabilitation trajectories. Chapter 3 presents the aim of the study and the three articles. Chapter 4 outlines the theoretical framework and perspectives utilized to discuss the results of this study. Chapter 5 presents the study's methodology and methods related to recruitment procedures, data collection, data analysis as well as the ethical and methodological considerations. Chapter 6 presents a summary of the three articles,

whereas chapter 7 contains a discussion of the results of the three articles in context. Chapter 8 and 9 presents the concluding remarks and possible implications; and some possible implications for physiotherapy practice in neurological rehabilitation, respectively.

## 2 Background

### 2.1 Acquired brain injury

Patients with ABI comprise a heterogeneous group suffering from brain damage due to a variety of causes. However, one characteristic of ABI is that it often involves complex functional disabilities and requires protracted and extensive health and care services.

Acquired brain injury (ABI) is a common term for sudden damage to the brain caused by either traumatic or nontraumatic injury. Congenital abnormalities, degenerative diseases, and brain injuries occurring during birth or the neonatal period are usually not included in the ABI definition. ABI includes numerous conditions, such as head trauma due to external forces, hypoxia, toxic or metabolic insult, infection, and ischemic or hemorrhagic stroke. Although stroke is often included in the ABI definition, most research seems to concentrate on either stroke populations or nonstroke ABI populations (usually TBI). Early intervention and high-intensity treatment have been shown to be beneficial for optimizing rehabilitation efforts.

Due to the heterogeneity of ABIs, which range from traumatic head injuries in young adults due to sports and traffic accidents, e.g., to strokes in the elderly population, the incidence of ABI has proven difficult to determine. Furthermore, research generally avoids extrapolating results from mixed population studies, which has proven to be challenging when relating findings to the entire ABI population. Additionally, there are large differences in the characteristics of ABI populations among countries and continents, and there is considerable variety in the methodological approaches used in epidemiological studies regarding ABI (Tagliaferri, Compagnone, Korsic, Servadei, & Kraus, 2006).

The estimated annual incidence rate of ABI in Western society has been shown to vary considerably. Several countries report on various types of ABI, such as TBI and stroke. Among Western countries, several report a stroke incidence of 100-300 (Béjot, Bailly, Durier, & Giroud, 2016; Ellekjaer & Selmer, 2007) per 100 000, and the incidence of hospital-treated TBI is reported to be 100-300 per 100 000 (Cassidy et al., 2004; Ingebrigtsen, Mortensen, & Romner, 1998; Rutland-Brown et al., 2006; Tagliaferri et al., 2006; Truelsen et al., 2006). The death rate following TBI in Europe is reported to be approximately 15 per 100 000 (Tagliaferri et al., 2006), although the incidence of TBI-related deaths was shown to vary significantly among the Nordic countries (Sundstrøm et al., 2007). The mortality rate following TBI varies considerably between developed and developing countries, among

Western countries and even among different regions within the same country (Truelsen et al., 2006). Stroke is a major cause of nontraumatic brain injuries and is the second leading cause of death worldwide. Although rates of stroke mortality in Western countries have decreased the past two centuries, the annual number of people who suffer from stroke and the overall global burdens of stroke are high and increasing (Béjot et al., 2016; Feigin et al., 2014). Furthermore, the incidence of stroke is still rising in developing countries.

## **2.2 Health care service developments and reformative work in Norway and Western countries**

Public health and care services in Norway are regulated by acts and regulations that aim to ensure each citizen's right to receive adequate and individually tailored services. The state is responsible for all hospitals, including regional university and local hospitals, which are organized into four regional health authorities; in contrast, most other health and care services are the responsibility of local authorities. In this context, ABI rehabilitation spans health care levels and sectors. In Norway, the governmental authorities represented by the Norwegian Ministry of Health and Care Services are responsible for directing health policy and regulating resources and health professionals. Most of the Norwegian health and care services provided at both the specialist and primary health levels are free of charge or subsidized, which underscores the governmental responsibility assumed in a welfare state (Vike, 2004). In the international context, the standard of Norwegian health and care services is considered high (Norwegian Ministry of Health and Care Services, 2015a). Equal and universal access to health and care services is a leading principle in Norway and most other welfare countries in Europe and other Western societies. Nevertheless, many of these countries have identified similar challenges related to the provision of health and care services and have initiated various health care reforms to address these issues (Grimsmo & Magnussen, 2015). The fragmentation of health and care services in primary care, inadequate preventive health care efforts, and unsustainable health- and care-related costs are common challenges across Western societies (Bauld et al., 2005; Bidgood, 2013; Grimsmo & Magnussen, 2015; Steel & Cylus, 2012; Vrangbæk & Sørensen, 2013).

Reformative work within health and care services in Western societies in recent years has focused on the improvement of both service provision quality and economic rationalization.

This dual focus presents challenges related to the planning, prioritization and provision of health and care services as the health care system needs to be evaluated in terms of performance and resource expenditure as well as service quality and the safety and well-being of patients and clinicians (Croker, Sheehan, & Iedema, 2014). The introduction and implementation of the Coordination Reform in Norway emphasized improved collaboration between specialist and primary health care services to reduce the fragmentation of health care service provision across health care levels. This reformative work substantiated the trends towards earlier hospital discharge and increased responsibility for health and care services, including rehabilitation services, among municipalities. The coordination of health care services is of special importance following ABI given the complex and extensive patient needs (Norwegian Ministry of Health and Care Services, 2009b; Scottish Intercollegiate Guidelines Network (SIGN), 2013). Currently, Norwegian municipalities report difficulties with adjusting their provision of rehabilitation services to align with changes in the rehabilitation services provided at the specialist level. To date, municipalities have only increased their resources and competence to a limited degree in the face of earlier hospital discharges and increased responsibility for providing rehabilitation services (Office of the Auditor General of Norway, 2016). The Norwegian Ministry of Health and Care Services confirms a need for increased capacity, increased competence, new services and better organization of primary health and care services (Norwegian Ministry of Health and Care Services, 2015a).

### **2.3 Rehabilitation and continuity of care**

Rehabilitation comprises a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment, as defined by the World Health Organization (WHO) (2011). Until 2018, the Ministry of Health and Care Services in Norway (1999) defined rehabilitation as time-limited planned processes with clear aims and means, involving several actors who cooperate to enable users to pursue optimal functional levels and coping skills, independence and participation socially and in the community. The definition included a time aspect, goal-oriented planning, cooperation among health and care service providers and the pursuit of optimal function and coping in society. In 2018, a new definition was adopted (Norwegian Ministry of Health and Care Services, 2018) that highlighted the user perspective in planning and setting goals for rehabilitation



interventions and removed the previous time-limited perspective on rehabilitation processes to emphasize that some individuals may need life-long interventions.

In recent years, the foundation of the rehabilitation definition has been contested. Hammel (2006) argues that the rehabilitation field's focus on the reacquisition of normal bodily functions following illness and injuries is too prominent and calls for increased attention to the disability aspect. She argues that the main goal of rehabilitation services should be for patients "to live well" with impairment despite functional deficits, with an emphasis on social opportunities, privileges and status. The main goal of her argument is to contest assumptions that underlie the field of rehabilitation and to include more and complementary perspectives. Inspired by anthropological perspectives and social theories, she emphasizes the liminal phase of a person's transition between different statuses in society, the "*ambiguous state of being between states of being*" (Hammel, 2006, p. 288), and relates this to rehabilitation practices. In anthropology, the liminal phase of transition is closely related to a person's sense of self and identity as it describes rites of passage, i.e., the period between a previous and a new status in society (Turner, 1995).

Within the field of rehabilitation, the period of enablement (Whyte, 2014; Whyte & Barrett, 2012) following injury or disease can be considered a liminal phase of transition (Murphy, 1990; Murphy, Scheer, Murphy, & Mack, 1988). The rehabilitation phase following ABI may be long and often involves institutionalization and the disruption of the patient's previous social life. The anthropologist Murphy described long-term physical impairment as a state of being "*neither sick nor well, neither dead nor fully alive, neither out of society nor wholly in it*" (1990, p. 131). This liminal phase of transition often coincides with the rehabilitation period from hospitalization following brain injuries to the resumption of everyday life. Hammel (2006) calls for a stronger focus on the ambiguity that patients feel following the disruption of a way of living that they once took for granted and questions the strong emphasis on reacquisition of normal physical function rather than the social dimensions of disability and "living well" despite impairments. Furthermore, she claims that the process of reintegration and re-establishing identity and everyday life extends beyond the first phase of rehabilitation, as the consequences of disabilities first become evident after everyday life is resumed.

In recent years, the length of in-hospital rehabilitation stays has decreased (Bender et al., 2016; Rollnik & Janosch, 2010), and several studies have investigated the effects of earlier hospital discharge combined with extra support in the homecoming phase (Hankey & Langhorne, 2006; Hofstad, Gjelsvik, Næss, Eide, & Skouen, 2014; Langhorne, Bernhardt, & Kwakkel, 2011; Rasmussen et al., 2016; Siemonsma et al., 2014). In Norway, this focus has been reinforced by the implementation of recent health care reforms that introduced incentives to meet the challenges of health and care service provision (Norwegian Ministry of Health and Care Services, 2009b). Although some economic incentives have been removed, such as municipalities' co-financing of health services provided at the specialist (hospital) level (Monkerud & Tjerbo, 2016), the trend towards earlier hospital discharge has continued. Consequently, municipalities will have to continue to provide rehabilitation in the community setting via institutional, outpatient or home-based services. This situation increases the importance of both the transitional phase after the institutionalized hospital stay and the municipalities' responsibility for further rehabilitation efforts in the patients' home communities.

Feiring (2012) describes one trend health and care development in Norway as the dynamic between political-administrative and professional practices in the field of rehabilitation have become more complex: namely, administrative control is being strengthened at the same time that the voices of private and professional actors are increasingly heard. This trend is seen in the development of greater cooperation and more intermingling of governing strategies (both hierarchical and traditional), private interests and public solutions and an increase in horizontal networking (collaboration and participation in management systems across administrative levels and sectors at the interface between public and private). Such changes are supported by an article by Solvang, Hanisch and Reinhardt (2016) that advocates an extended view of rehabilitation practices that positions individuals with disabilities, professionals and governmental authorities as agents that act on the micro (individual), meso (organizational) and macro (political/jurisdictional) levels of society. From this perspective, rehabilitation practice is characterized as a cross-disciplinary field in which different actors are invested. Feiring (2012) concludes that rehabilitation has become a knowledge practice characterized by a synthesis of management strategies, professional theories, experiences and reflections, and client experiences.

## **2.4 Physiotherapy practices and rehabilitation trajectories**

The first Norwegian physiotherapy association and education program were established in 1895 and 1897, respectively (Thornquist, 2014). Historically, physiotherapists in Norway have worked as either private practitioners who provide physiotherapy services to a limited part of the population, mainly people of working age, or in hospitals (Thornquist, 2014). The Municipal Health Care Reform of 1984 in Norway, accompanied by The Municipal Health Care Act, established municipal responsibility for providing physiotherapy services to all residents. The government introduced operating grants for private practitioners and government grants for municipally employed physiotherapists to provide better access to and distribution of physiotherapy services in the municipalities. The introduction of municipal responsibility for providing physiotherapy services and the economic incentives introduced led to an increase in the number of physiotherapists working in the municipalities. This led to better access to physiotherapy services for children and adults with disabilities and chronic diseases and has had a positive impact on the physiotherapy profession in Norway.

In a 2009 report on physiotherapy services at the primary health care level from the Ministry of Health and Care Services (2009a), private practitioners reported having special interest and competence in sports, manual therapy and orthopedics, whereas employed physiotherapists reported special interest in providing physiotherapy for children and adolescents, neurology patients and geriatric patients. This finding shows a distribution of physiotherapy services for a variety of diagnoses and groups of patients in the municipalities. However, at the beginning of the twenty-first century, the growth in full-time equivalent (FTE) physiotherapists in Norway ceased to develop despite an increasing population and an increased demand for physiotherapy services (Norwegian Ministry of Health and Care Services, 2009a; The National Statistical Institute of Norway, 2012). Issues regarding the insufficiency of physiotherapy resources have been actualized by the increased municipal responsibility for providing rehabilitation services as physiotherapy is considered an important part of rehabilitative efforts (The Norwegian Physiotherapy Association, 2012; Veerbeek et al., 2014). Furthermore, physiotherapy services in the municipalities have been characterized as generalized given the variety in diagnosis encountered in this setting (Aadal, Pallesen, Arntzen, & Moe, 2018; Kaale & Nanna, 2002); in contrast, specialist health care physiotherapists more often work in specialized hospital units, providing physiotherapy

services to defined groups of diagnoses. Consequently, the level of specialization in the physiotherapy profession is affected by workplace affiliation and responsibilities.

In rehabilitation trajectories following ABI, patients often move across health care levels for diagnosis, treatment and rehabilitation. This transitional phase has been subject to extensive research to improve coordinated care (Bodenheimer, 2008; Coleman & Boulton, 2003; Laver et al., 2014; Turner, Fleming, Ownsworth, & Cornwell, 2008). Several studies have explored how patients and their partners and next of kin perceive these transitions. However, we have found few studies investigating physiotherapists' perceptions and viewpoints of rehabilitation trajectories following ABI, particularly in relation to reform initiatives. Searches were conducted in different databases, including Pedro, Cinahl, PubMed, Medline and Embase, to identify articles relevant to the main objective of this study and to investigate physiotherapists' experiences and perceptions of the rehabilitation trajectories of people with ABI. We used various terms and keywords independently or in combination when searching the databases: "Physiotherap\*", "physical therap\*", "experience\*", "perception\*", "attitude\*", "view\*", "rehabilitation", "brain injur\*", "head injur\*", "traumatic brain injur\*", "acquired brain injur\*", "stroke", "cerebrovascular accident\*", "cva", "reform\*", "change\*", "improvement\*". We searched for articles published from 1970 to date and found few studies that explicitly dealt with physiotherapists' experiences and perceptions regarding ABI rehabilitation trajectories. However, we also searched for articles focusing on similar aspects of ABI rehabilitation trajectories, and we read the reference lists to identify other relevant studies. While the broad scope of the literature searches made it challenging to investigate all emerging topics thoroughly, they provided an overview of previous studies related to our study aim.

In a review study on the transition from hospital to home for individuals with ABI (Turner et al., 2008), qualitative studies focused on patients and caregivers' perspectives. These studies and others highlighted that the transition from hospital to home was a stressful, emotional and challenging time that challenged the individuals' sense of personal identity, autonomy and life perspectives (Conneeley, 2003; Fraser, 1999; Nalder, Fleming, Cornwell, Shields, & Foster, 2013; Olofsson, Andersson, & Carlberg, 2005; Paterson, Kieloch, & Gmiterek, 2001; Rittman et al., 2004; Unsworth, 1996). One of the studies also included the viewpoints of the health care professionals involved and identified discrepancies between the perceptions of ABI patients' family members and those of the professionals regarding the information and

teaching provided during the transition process (Paterson et al., 2001). Furthermore, several articles on continuity and coordination of care were found; these focused on various aspects that affected patient transitions (Bodenheimer, 2008; Coleman & Boulton, 2003; Moore, Wisnivesky, Williams, & McGinn, 2003) and the communication of information during patient transitions from the perspectives of various health care professionals (Callen, Alderton, & McIntosh, 2008; Kim et al., 2013; Kripalani et al., 2007; Thornquist, 2007).

### **3 Aims of the study**

The foundation of the work presented in this thesis was the implementation of reform initiatives that aimed to improve health care services in Norway, including neurological rehabilitation following ABI (Norwegian Ministry of Health and Care Services, 2009b, 2011b). The reform expanded municipal responsibility for providing rehabilitation services following brain injuries, along with economic incentives to transfer patients from hospitals earlier. Physiotherapy services play an important part in rehabilitation efforts following ABI. The organization of health care services make up the bedrock for providing efficient and good quality physiotherapy services, and reform initiatives altering and allocating responsibilities within the health care system may affect the service provision. Our rationale for this study was to explore the physiotherapy practices in ABI rehabilitation trajectories by investigating how the involved physiotherapists experienced the process of transferring patients and coordinating physiotherapy services in the aftermath of the reform. Few studies have examined physiotherapists' experiences following reforms that involved both the specialist and primary health care level, and based on this rationale, we asked the following research questions:

- 1) How do physiotherapists experience and address challenges arising from the implementation of redistributed responsibilities in neurological rehabilitation following the Coordination Reform in Norway?
- 2) How do physiotherapists perceive physiotherapy practice variations across health care levels in neurological physiotherapy?
- 3) How do physiotherapists experience the way patient information is communicated across health care levels in ABI rehabilitation, and what factors do the physiotherapists consider to facilitate and impede the transfer of knowledge?



## **4 Theoretical framework**

This section will present an account of the theoretical framework of this dissertation. First, I will describe the social constructionist perspective applied in this study. Next, I will discuss theoretical perspectives that are relevant to the analysis and discussion of the results. Theories on professionalism and accountability, practice knowledge and communities of practice provided complementary perspectives and conceptions that contributed to the interpretations and discussions in this thesis.

### **4.1 Social constructionist theories and interactionist perspectives**

Complex processes that include both various participants and different contexts characterize the field of health care in general and neurological rehabilitation specifically. This complexity led to the application of the social constructionist perspective in this study as we acknowledge the multiple and bilateral influences of a variety of political, organizational, institutional and personal factors to individuals' descriptions, explanations and accounts of the world in which they live (Burr, 2015; Gergen, 1985; Solvang et al., 2016). Theories of institutionalization, legitimation and socialization processes provide an explanatory framework as we try to understand how individuals' subjective meanings are formed and developed in interaction with others and are influenced by the historical and cultural norms of the society in which they live (Berger & Luckmann, 1984). Habitual actions and human behaviors in specific contexts can be understood as typifications of habits that are institutionalized within a social environment. These typifications often serve as rules that are taken for granted within the society in which they occur and play an important role in defining which actions and opinions are considered normal and acceptable.

In applying this perspective, we emphasize the relevance of established habits and norms that are taken for granted within the specific social communities of practices in which they occur (Berger & Luckmann, 1984; Lock & Strong, 2010; Wenger, 2000). Furthermore, Mahoney and Thelen (2010b) emphasized the importance of the interaction between the overall political context and the institutions themselves. This interaction is important for explaining how and why institutional changes occur and emphasizing the dynamic components built into the institutions. As such, institutions often represent compromises and sometimes-contested settlements that are vulnerable to shifts and may be subject to power relations, the mobilization of resources and the interrelations among different institutions (Mahoney &

Thelen, 2010a). Social constructionism often aims to question fundamental assumptions in societies and is concerned with language, action and processes and considers the environment, culture, personal interactions, and practices in context (Young & Collin, 2004). These considerations provided relevant insights as we sought to investigate the rehabilitation processes following neurological injuries in the aftermath of reform. Although we specifically investigated the physiotherapy perspective on neurological rehabilitation services, the institutional framework and contextual variations as patients move along the rehabilitation trajectory influence individuals' opinions and perceptions. Therefore, it was important to apply a theoretical framework that accounted for factors that may influence human and social practices to increase our understanding of the physiotherapists' actions and expressed perceptions within the broader institutional and political context (Andrews, 2012; Berger & Luckmann, 1984; Gergen, 1985; Mahoney & Thelen, 2010b).

The interactionist perspective is relevant in studies of professional practice (Måseide, 2008). It emphasizes the relationship between professionals' actions and the contextual aspects that affect interactions (Måseide, 2003); that is, the actions are socially situated (Goffman, 1983). The sociology of knowledge includes a number of different scholars, and one debate that has emerged over time is regards the roles of macro and micro perspectives in sociology. Various structuralists emphasize the ability of social arenas to explain human behavior, whereas others highlight the importance of individuals' capacities for shaping their social surroundings (Lock & Strong, 2010). Although the notion of conjoining social and individual life was proposed by Berger and Luckman several years ago (1984) as they built on phenomenological insights (Alvesson & Sköldbberg, 2009; Schütz & Luckmann, 1974), there has been a divide among scholars who emphasize one perspective or the other. However, within the discipline of sociology, several scholars have influenced contemporary social constructionism by bringing the social and the individual perspectives together (Lock & Strong, 2010). Burr (2015) calls for a social constructionism that is capable of bridging the gap between individual experience and social structure, inspired by interactionist perspectives that aim to transcend the dualisms of social science. Lock and Strong (2010) and Burr (2015) provide examples of the influence of interactionist perspectives by highlighting the work of Garfinkel (1967), Goffman (1971) (1986), Giddens (1976) and Davies & Harré (1990); in various ways, these authors emphasize how we construct and, through our interactions, sustain the varying contextual and cultural features of social reality. Considering the background and rationale of our study, both macro

and micro perspectives of social life were meaningful for understanding the relationships between political and organizational preconditions for providing rehabilitation services and the interaction and cooperation among professionals on the individual level.

## **4.2 Professionalism and accountability**

Professionalism can be viewed as a set of institutions that allow the professional worker to make a living and control his or her own work. Freidson (2001) emphasizes two characteristics of professional work: the work is so specialized as to be inaccessible without the required training and experience, and the work cannot be standardized or rationalized. Although Freidson uses “skills” and “knowledge” interchangeably, he considers both terms essential to professional practice as they complement one another (Freidson, 2001). He distinguishes between formal substantive knowledge and the tacit facilitating skills of applying the knowledge to the actual case or situation. Citing Polyani (1962) and Schön (1991), he relates performative aspects to the un verbalized or un verbalizable practical dimension of knowledge. The practical dimension of health care professions involves engaging and intervening in other peoples’ lives and highlights both the use of formal specialized knowledge and the execution of moral, political and legal discretion (Grimen, 2008).

Within the area of health and care services, the idea of a professional embodies a moral conviction that each patient will receive the type and amount of care that is needed (Purtilo & Doherty, 2016). At the same time, the professional will have to take into account institutional policies and practice and work within the available resources and limitations of the professional context. Given professionals’ delegated jurisdictions, they are required to base their work on discretionary judgements and the individual needs of the patient. As street-level bureaucrats (Lipsky, 1980), they must advocate for and regulate public services in accordance with normative expectations regarding the quality and content of the services, the moral and just distribution of services, and the benefit of the individual patient (Molander & Terum, 2008). According to Vike (2004), these various considerations may be experienced as contradictory as professionals are supposed to provide good-quality welfare services while simultaneously distributing limited resources among those who need them the most. The dilemmas associated with executing discretionary powers as street-level bureaucrats may be

related to the discrepancy between the politically approved ambitions of the welfare state and the resources available for completing these tasks.

In recent decades, the self-regulatory mechanisms controlled by the professional fields themselves (Abbott, 1988; Freidson, 2001) have been challenged by changes in the postindustrial and knowledge societies (Noordegraaf, 2007). These challenges have been described as a weakening of professionals' authority and integrity and are largely connected to increased organizational control mechanisms linked to managerialism and new public management (Evetts, 2013; Freidson, 2001; Reed, 1996), which are characterized by an increased focus on accountability, evidence-based interventions and effectiveness. However, by reinterpreting professionalism according to the effects of societal forces on professional work (that is, relating the developments to wider social and societal trends and developments), Noordegraaf (2016) proposes a broader theoretical and analytical perspective on professional work that acknowledges that professionalism is affected by more than managerial reforms. He holds that professional work is affected by a variety of changes in society, such as the commercialization and privatization of health care systems, increasingly complex cases, increased cooperation within and across professions, demographic changes within workforces, new technologies and altered distributions of responsibilities. He describes the "new" professionalism as more dependent on connectivity in terms of connecting to other professionals, other disciplines, and "outside worlds". The role of professionals is increasingly characterized by heterogeneity within the profession and is influenced by societal tendencies within a more complicated service reality.

### **4.3 Practice knowledge and communities of practice**

The physiotherapy profession is largely practice oriented as the body and movement are central to physiotherapy practice. Physiotherapists are often ambassadors of physical activity and make extensive use of active interventions for patients with various disabilities. This approach requires close, often bodily interaction with the patient in terms of guiding exercises and movements and providing physical and cognitive support to enable patients to regain their functional abilities. Because of its status as a recognized profession in most countries worldwide, the body of knowledge regarding physiotherapy is increasing, and research on various aspects of physiotherapy practice is growing. Consequently, the physiotherapy

profession is both theoretical and practical. The theoretical and practical dimensions of the profession imply both explicit and tacit forms of knowledge. The explicit forms of knowledge are often easier to express and describe in words and writing, whereas the tacit dimensions of practice have been described to be incorporated into the performative aspects of the physiotherapy role and not possible to fully express in words (Molander, 1996; Schön, 1991). Although research plays an important part in the development of professional knowledge and practice and some of the practical dimensions of physiotherapy practice have proven more difficult to convey scientifically, Higgs et al. (2004) argues that practitioners and researchers should continue to search for new tools for investigating, describing and measuring it. In practice-oriented professions, clinical reasoning is viewed as a bridge between practice and knowledge (Higgs, Jones, Edwards, & Beeston, 2004). Clinical reasoning is the utilization of practice knowledge, research theories and experience as the basis from which professionals act in practice situations. Furthermore, the clinical reasoning process contributes to an awareness that enables practitioners to identify the limitations of their current knowledge and generate new knowledge.

Schön (1991) and Molander (1996) elaborate on aspects of practice knowledge in their emphasis on the professionals' abilities to handle situations of insecurity, instability and conflicting values. Schön argues that a technical rationality position that regards practical knowledge as the application of universal theories and principles to a unique situation is insufficient to explain the complex processes of professional practice (Dahlgren, Richardson, & Kalman, 2004; Schön, 1991). Grimen (2008) characterizes the body of professional knowledge as a complex phenomenon that includes theoretical insights, practical skills and experience. Molander and Schön emphasize the dialogical dimensions of knowledge development in practice-oriented professions. They accentuate embodied knowledge, which refers to development of expert knowledge in practice and the transfer of such knowledge through interaction in action. Molander considers the articulated and tacit dimensions to be different aspects of professional knowledge. This conceptualization helps us to understand clinical encounters and practice situations - both interactions with patients and interaction and cooperation among physiotherapists in relation to a patient - as ways of developing professional knowledge.

Eraut (2000) claims that most human learning does not occur in formal contexts, such as formally organized learning programs or events, but in nonformal learning in everyday life

situations. According to Eraut, this is also true of professional practice knowledge, although he argues that the tacit dimensions of personal knowledge and “know-how” are difficult to describe and explain explicitly. Furthermore, the context in which professionals acquire and use knowledge influences and shapes its content. The aforementioned clinical reasoning process contributes to the generation of new knowledge. While some propose learning aspects of clinical reasoning (cf. Higgs et al. (2004)) that focus largely on individuals’ personal professional development, others place increased emphasis on the social dimensions of learning and professional development (e.g., Lave & Wenger (1991), Wenger-Trayner & Wenger-Trayner (2015) and Wenger (1998, 2000)). The development of professional practice knowledge can be understood in light of theories of socially situated activities (Lave & Chaiklin, 1993) and knowledge production (Wenger, 2000). The emphasis on situated practices in professional work highlights the complex and intertwined processes of learning and professional development, as knowledge acquisition requires reconceptualization as a cultural and social product. This understanding of the importance of the social and cultural context in which practices develop emphasizes both the underpinning theoretical assumptions and the sociopolitical dimensions of physiotherapy knowledge and practice (Gibson, Nixon, & Nicholls, 2010; Gibson & Teachman, 2012). Wenger (2000) proposes a theory on learning as social participation, a process of active participation in the practices of social communities, and the construction of identities in relation to these communities. By identifying how we experience life as meaningful and how we practice, participate and identify ourselves in the context of our communities, he presents a broader conceptual framework of learning theories.

Wenger argues that the concept of learning as participation is caught in the middle of social theories that give primacy to social structure and those that give primacy to action, e.g., social structure vs. situated experience. He further argues that the various traditions within social theory contribute insights regarding how we learn and how we theorize about learning. He proposes that an expanded perspective on learning, informed by the various traditions of social theory, forms a conceptual framework in which learning can be related to aspects of how we perceive and act in social life. From this perspective, professional practices are considered mini-cultures that involve the history of social learning in a specific context (e.g., organizations or work places) (Wenger-Trayner & Wenger-Trayner, 2015). The field of professional practice is considered too complex and dynamic to be a mere implementation of prescription or the simple application of research (Wenger-Trayner & Wenger-Trayner, 2015,



p. 17), and it is characterized by ongoing negotiations as changes occur. It is suggested that learning in this context focuses on potential tensions and conflicts between practices to generate new insights. This is an interesting perspective to consider when investigating collaborative practices between professionals in different social communities of practice.

## 5 Methodology and methods

The overall aim of this study was to derive new knowledge regarding neurological physiotherapy practice in a context characterized by alterations in organization and responsibilities following reform initiatives. We investigated physiotherapists' experiences of neurological rehabilitation trajectories for people recovering from ABIs in the context of a reforming health care system.

*“Let fully understanding nature be God’s business; as humans, is to understand how we, through our institutions, create versions of truth”* – (Lock and Strong (2010) referring to Vico, 1744)

Ethnographic approaches, understood as detailed ways of witnessing human events in the context in which they occur, can be useful as an overarching approach to examine health care services and health care professionals (Savage, 2000). The ethnographic approach can incorporate a range of methods and sources of data for analysis, such as interviews, observations and other forms of field work, including a mix of qualitative and quantitative methods (Ellen, 1984). In this study, the social constructionist perspective and ethnographic framework allowed us to include several sources of data for analyzing physiotherapists' actions and perceptions within the field of neurological rehabilitation.

### 5.1 Recruitment and participants

This study recruited physiotherapists from both the specialist and primary health care levels, as we followed the rehabilitation trajectories of ten people recovering from ABIs from their stay in specialized in-hospital rehabilitation units to continued rehabilitation in their home communities. In four cases, the patients either returned home pending further specialist health care rehabilitation at private rehabilitation institutions or were rehospitalized due to complications. Physiotherapists and patients were initially recruited from three in-hospital rehabilitation units in northern Norway. We obtained consent from hospital authorities (Appendix 1) before the first author arranged meetings to describe the study to the specialist health care physiotherapists at each of the three rehabilitation units. Following the meetings, an informational letter regarding the study was provided to each rehabilitation unit, along with consent sheets and contact information in case of further questions (Appendix 2). As one of the in-hospital rehabilitation units was not able to provide eligible patients or physiotherapists willing to participate during the data collection period, the participants in this

study were recruited from two specialist health care rehabilitation units. We asked the physiotherapists to be attentive to patients who fulfilled the inclusion criteria of the study and at the same time to consider participating themselves. To be included in the study, the patients had to be admitted to the in-hospital rehabilitation unit following an ABI, have the ability to give fully informed consent, and be considered in need of further physiotherapy services after hospital discharge. We chose to exclude patients who were not capable of providing informed consent. We considered the possibility of seeking family consent for patients with reduced cognitive abilities; however, because the nature of the investigations involved at least two patient encounters, we decided to avoid situations in which the patients' integrity might be compromised by our presence.

We asked the physiotherapists to ensure that personnel who did not actively participate in the patients' treatment provided the patients with information regarding the study and gave the patient time to read and consider the written information (Appendix 3). The personnel collected the written consent form and returned them in a postage-paid envelope. When consent from the patient and the specialist health care physiotherapist was obtained, we pursued consent from the municipal authorities in the patients' home community (Appendix 4) and provided information to the primary health care physiotherapist who would provide further physiotherapy services and sought his/her consent to participate (Appendix 5). All municipalities and all primary health care physiotherapists who were approached gave their consent.

As we followed the rehabilitation trajectories of 10 people with acquired brain injuries, eight specialist health care physiotherapists providing rehabilitation at the specialist health care level and eleven primary health care physiotherapists from nine different municipalities participated in the study. Nine of the physiotherapists at the primary health care level were employed in municipal physiotherapy units and inpatient rehabilitation institutions, and two were self-employed at private physiotherapy clinics. The level of postgraduate training varied among the included physiotherapists. At the specialist health care level, two of the physiotherapists held a master's degree, whereas the remainder had a bachelor's degree. Four of the specialist health care physiotherapists were specialists in neurological physiotherapy with approval from the Norwegian Physiotherapy Association. Three of the specialist health care physiotherapists had worked for more than 10 years.

The primary health care physiotherapists generally had taken fewer postgraduate courses and were less likely to have neurological physiotherapy specializations, although two were specialists approved by the Norwegian Physiotherapy Association. None of the primary health care physiotherapists held master's degrees. Six of the primary health care physiotherapists had more than 10 years of working experience, and the remainder had less than 10 years of experience.

The ten patients in this study included eight men and two women ranging from 30 to 80 years of age. Three of the patients were younger than 40 years, four were younger than 60 years, and three were over 60 years of age. They were all admitted to a specialist rehabilitation unit in a hospital due to ABI, and they were transferred from either dedicated stroke units, neurological units or intensive care units. They acquired brain injuries due to cerebral infarction, cerebral hemorrhage, tumor, or encephalitis, and six of the patients underwent surgical interventions during the hospital stay. The patients' family circumstances varied; seven lived with partners, and three lived alone. Two of the patients still had parental responsibilities for underage children, five had adult children, and the remainder had no children.

## 5.2 Data collection

The data collection period lasted from April 2013 to January 2015. In preparation for data collection, we performed a pilot interview with one primary health care physiotherapist. This gave us the opportunity to test whether the setting and questions would facilitate participants' reflections and perceptions regarding neurological rehabilitation. The pilot participant confirmed that the situation felt comfortable and that the questions were relevant and enabled the participant to reflect and discuss professional opinions and experiences. Furthermore, the pilot interview provided us with the opportunity to adjust both the interview (Appendix 6 &7) and observational (Appendix 8) guides according to our experiences and the pilot participant's feedback.

The first author conducted the in-depth interviews of the physiotherapists and the field observations of single physiotherapy treatment sessions. For each patient's rehabilitation trajectory, we sought to perform the first interview and field observation during the last week of the patients' stay in the in-hospital rehabilitation unit. Furthermore, we collected medical discharge summaries and interdisciplinary and physiotherapy reports from the patients' hospital stay. On some occasions, the rehabilitation unit decided to extend the patients' stay following data collection, which led to delays in data collection at the primary health care level. Although the physiotherapists were encouraged to schedule the interviews after the field observation of the physiotherapy treatment session, on three occasions, the physiotherapists asked to complete the interview in advance due to tight time schedules.

For four of the rehabilitation trajectories, the patients were admitted to a second rehabilitation center that provided in-patient rehabilitation services. In these cases, we performed an additional in-depth interview of the physiotherapist and a field observation of a single physiotherapy treatment session within the last week of the patients' stay. On one occasion, the physiotherapist provided a short account of the patient's rehabilitation stay by phone as this physiotherapist had been interviewed regarding a previous patient and felt that another face-to-face interview would be less likely to provide complementary information regarding the rehabilitation efforts. Consequently, no physiotherapy treatment session was observed on this occasion.

We aimed to perform data collection in primary health care within the first two weeks after the patients had returned to their home community. We scheduled the interviews and field

observations at the convenience of the participants. On three occasions, the patients only stayed home for six to 19 days while they awaited a second rehabilitation stay at a private rehabilitation center. In these cases, we chose to delay the data collection in the patients' home community until after the second rehabilitation stay. One of the patients was rehospitalized prior to the planned data collection due to a brain injury-related complication. Consequently, we performed interviews and field observations when the patient was discharged from the hospital and treatment was resumed.

Finally, we ended the data collection for each rehabilitation trajectory by performing a follow-up interview with the primary health care physiotherapists approximately three months after the initial interview in the patients' home community. The three-month period between the initial interview and the follow-up interview was chosen due to the time limitations of the study project.

### **5.2.1 Interviews**

The participants were interviewed in a venue of their preference, and all participants chose a secluded room at their workplace. The participants were encouraged to provide a venue for the interviews that minimized the risk of interruption, although we were interrupted during two of the interviews. On these occasions, the participants were provided with prompts to continue on the topic discussed prior to the disruption. The interviews were semistructured, and the questions were posed in a conversational manner to facilitate rich descriptions and reflections (Brinkmann & Kvale, 2015), often related to the previously observed treatment situation. The interview lasted from 45-90 minutes and was audiotaped with a sound recorder. We used an interview guide to ensure that aspects of interest related to the research questions were addressed during the interviews. During the conversation, the participants were asked follow-up questions, or their utterances were rephrased by the interviewer for confirmation and to facilitate elaboration on the viewpoints and reflections conveyed (Brinkmann & Kvale, 2015; Polit & Beck, 2008). This allowed the participant to confirm, highlight or add nuance to his or her perceptions and opinions over the course of the conversation. When the participants discussed aspects of interest in more general terms, they were encouraged to provide examples and relate the discussion to the participating patient. The specialist and primary health care physiotherapists involved in each rehabilitation trajectory were connected to the same ABI patient. This provided an opportunity to investigate each case across time and organizational levels. Furthermore, the primary health care physiotherapists were



reinterviewed three months later regarding the course of the rehabilitation process and prospects for further functional improvements. As a result, we had the opportunity to refine and develop questions over time to adapt the interviews to emerging aspects of interest and changes in circumstances. The time between the interviews with the specialist and primary health care physiotherapists and between the first and the follow-up interview with the primary health care physiotherapist allowed for further preparations prior to the next interview. The interview and the observation the physiotherapy treatment sessions provided useful insights and made it easier to pursue themes of special interest and continue the conversation regarding issues that were not sufficiently discussed in previous interviews. Preparations for further interviews were informed and influenced by different viewpoints and themes that were emphasized during conversations, as observing the participant both within and across the rehabilitation trajectories raised different issues in the interviews. Consequently, the interviews conducted in this study provided various perspectives and nuanced descriptions regarding the research questions.

### **5.2.2 Observations**

The study included field observations of authentic physiotherapy treatment sessions at both the specialist and primary health care levels. The first author videotaped one physiotherapy treatment session prior to discharge from the specialist rehabilitation unit and one physiotherapy treatment session after the patient's return to his or her home community. In the cases of a second institutional stay, another physiotherapy treatment session was videotaped prior to discharge from this institution. Furthermore, following each field observation, field notes were recorded to capture the observers' experiences and thoughts immediately after the observation was over. Every field observation began with the introduction of the observer, including information regarding the observation, to ensure that the participant felt comfortable (Heath, Hindmarsh, & Luff, 2010). The participants were told to conduct the treatment session as usual and not make any accommodations for the observer in terms of organizing the room or ensuring an adequate view. The participants were told that the observer would stay secluded during the session but would occasionally move to capture the content of the session. The participants were given the opportunity to ask questions prior to the video recording. As mentioned previously, the field observation preceded the interviews with the participating physiotherapists in most cases, which created a context-specific basis for the conversations to come during the interview. On the three occasions in

which the interviews were performed prior to the field observations, the relationship to the participating patient receiving treatment from the physiotherapist was clarified in advance. The physiotherapist was encouraged to relate discussions to the patients' treatment and rehabilitation process as experienced up to that point.

The observations of the physiotherapy treatment sessions lasted from 40-60 minutes. The field observations were documented with a handheld video camera with a zoom lens. This allowed the observer to move discretely in the room to obtain a better view of the patient-therapist interaction and occasionally zoom in on areas of special interest, e.g., specific handling techniques. During debriefing after the observation and video recordings were conducted, the majority of the participants stated that they paid little attention to the observer's presence, although they were initially aware of the observer. A few participants stated that they were more or less attentive to the observer's presence throughout the entire treatment session, although they stated that this awareness did not influence their choice of action during the session. Some of the participants made contact through comments or glances at the beginning of the therapy session; the observer responded politely to these before withdrawing from further interaction to avoid interrupting the patient-therapist interaction. As a result, the observer's presence had an influence on the therapy session observed, as several authors have noted (Angrosino & Rosenberg, 2011; Fangen, 2010; Heath et al., 2010). It is likely that this influence, which arose from either nervousness or curiosity, may have affected the course of the therapy session and interaction in some way. Nevertheless, as the participants did not express discomfort during therapy or the debriefing, it is unlikely that the influence was negative in terms of quality of the therapy provided.

### **5.2.3 Discharge summaries and reports**

The discharge summaries, interdisciplinary reports and physiotherapy reports were obtained after the patients' hospital discharge. Either the participating physiotherapist or another health care professional at the specialist rehabilitation unit provided a written copy of all discharge papers that accompanied the patient upon discharge. These papers always included the discharge summary and an interdisciplinary report; occasionally, there was also an accompanying physiotherapy report. Several of the participating physiotherapists stated that they write increasingly fewer physiotherapy reports and are more likely to include all relevant written documentation in the interdisciplinary report. The discharge papers served to complement and validate information conveyed during the field observations and interviews,

such as medical history, family relations, diagnosis, interventions, the time course of the hospital admission and the course of treatment while hospitalized. Moreover, they provided a helpful overview of the ten rehabilitation trajectories for comparison.

### **5.3 Data analysis**

Interpretation and attempts to understand and explain the results of qualitative research represent a process that begins during the interaction between the researcher and the study participants (Brinkmann & Kvale, 2015). The participants may become aware of new aspects and perspectives based on questions asked during interviews as a result of self-analysis and increased attention to situational factors during observations. Furthermore, the interview situation requires “on-line interpretation” of participants’ responses and answers; that is, the researcher must adjust to the participant during the interview or observation. As such, the process of analyzing data began during the interview or observation situation itself. Moreover, we recruited participants and conducted interviews and field observations over a long period of time. Consequently, data collection and data analysis overlapped, and the preliminary analysis conducted in earlier phases of the data collection period created a foundation for aspects of special interest in subsequent interviews and field observations. This dialectical relationship between data collection and data analysis in qualitative research is considered beneficial for conducting more focused interviews and field observations (Heath et al., 2010).

The systematic and structured analysis of interview transcripts, summaries of field observations and discharge papers was conducted via a process of coding, categorizing, interpreting and representing data (Brinkmann & Kvale, 2015; Creswell, 2013). The first author analyzed the data using a four-step systematic text condensation approach (Brinkmann & Kvale, 2015; Malterud, 2012), which was complemented by the second and third authors. The research material was analyzed by applying an inductive-deductive approach, in which explanations and interpretations of the results were based on both the empirical data and the previously described theoretical preconceptions (Alvesson & Sköldberg, 2009; Blaikie, 2010; Tjora, 2017).

In the first step of the four-step analysis, the authors discussed the transcripts of the interviews and observations critically to reach congruence and ensure that relevant aspects, commonalities and discrepancies in the data material were further addressed (Malterud, 2001). The results were also presented and discussed in research group meetings, which provided both validation of the preliminary analysis and additional perspectives for further analysis. This process provided an overview of the data and led to the identification of preliminary themes associated with the research question.

The next step was to identify meaningful units related to the research question and the preliminary themes. Meaningful units are utterances, sentences and even paragraphs that seem to be related to the preliminary themes. The meaningful units were decontextualized using a labeling code that highlighted the essence of the unit and was related to the preliminary theme. This allowed further discussions and negotiations regarding commonalities and differences within and across the thematically organized code groups.

In the third step of the analytical process, the code groups were analyzed in relation to the research question and theoretical preconceptions, and interrelated code groups were merged. The summaries of the thematically organized codes were reconceptualized in the last step by writing the content of each theme in a third-person format. The results were validated against the original transcripts, and the various themes were given headings that highlighted the findings. The results section provides further examples using illustrative quotes.

Summaries of the physiotherapy treatment observations were used to different extents in the three articles. In articles 1 and 3, the observational data were used primarily to validate the interviewees' statements regarding context, surroundings and the patients' level of function. In article 2, the summaries of the physiotherapy treatment observations were included in the analysis of the interview transcripts to complement the interviewees' descriptions.

## **5.4 Ethical considerations**

This study was approved by The Norwegian Social Science Data Service (NSD) (Appendix 9). We also consulted the Regional Medical Research Ethics Committee (REK) regarding the study, but they determined that the study did not require their approval (Appendix 10). The study was conducted according to the principles of the World Medical Association (WMA) Declaration of Helsinki (World Medical Association, 2013). All participants were informed about their rights to withdraw from the study without stating a reason. None of the participants withdrew from the study. The patients included in this study were limited to those capable of providing informed consent. The participants were assured that confidentiality would be maintained. We compiled information regarding the participants from a variety of sources: interviews, videotaped observations of physiotherapy treatment and hospital discharge papers. This process led to the collection of comprehensive information regarding both the physiotherapists and patients, and we balanced the presentation of information and stories to minimize identification without changing significant characteristics of the stories (Brinkmann & Kvale, 2015). All videos, audio files and written materials were stored on a secure, password-protected data storage device available only to the first author and deleted or depersonalized in due time according to the NSD Services instructions.

## **5.5 Methodological considerations**

### **5.5.1 Reflexivity**

The background and position of the investigator(s) are important aspects to consider in relation to the researchers' contributions to the construction of knowledge (Brinkmann & Kvale, 2015; Malterud, 2001). The first and third authors' background as physiotherapists with special interest in rehabilitation played an important role in establishing closeness and sensitivity during the interview and observation situations, both when preparing interview and observational guides and when conducting and analyzing the interviews and observations. The first author's experience with neurological rehabilitation was advantageous for designing and asking relevant questions during the interviews and physiotherapy treatment observations. This positioned insight (Paulgaard, 1997) helped the author to raise issues relevant to neurological physiotherapy practice and ask follow-up questions to facilitate both confirmation of and elaboration on important issues (Brinkmann & Kvale, 2015). However, sharing professional identities and experiences with the interviewees can also present a challenge to analytical distance in a study (Polit & Beck, 2008) as preconceptions and assumptions may remain unarticulated and uncontested during both the preparation and the conduct of the study (Paulgaard, 1997). The first author tried to be attentive to the effect of his physiotherapy background by engaging in the interview and observations in an open-minded manner.

However, the interviewees may have provided answers that involved implications or assumptions based on the physiotherapy background of both the interviewer and the interviewees. The second author's sociology background contributed complementary perspectives on the field of study, which enabled further discussions regarding the interpretation of the results. Thus, the variation in the authors' background and professional knowledge contributed to maintain analytical distance when preparing the interview and observation guides and during the analytical process.

The preliminary results of the study were also presented at research group meetings. The members of this research group represented several professions and methodological backgrounds and provided valuable contributions to the interpretation of the study results. This also contributed to the authors' awareness of both positive and negative experiences of the interviewees during both the remaining interviews and the overall analytical process.

### **5.5.2 Reliability and validity - Trustworthiness**

Reliability and validity mirrors the trustworthiness and consistency of the qualitative research approach and the research findings (Brinkmann & Kvale, 2015). The reliability of qualitative research can be related to the consistency and transparency of the various steps of the research conducted. In our study, we tried to address how the interviewer asked questions by developing an interview guide, testing the interview guide prior to the study, and being aware of both the relevance of the questions asked and the way the interview was conducted. This made the first author increasingly aware of asking open-ended questions and crosschecking answers by rephrasing or providing summaries of the interviewees' answers.

We provided an account of the various steps of the study by describing the recruitment procedures, the participating physiotherapists and patients, and the processes of conducting the interviews and observations and collecting the patients' discharge summaries. Furthermore, we accounted for our preconceptions and presented the background for conducting this study, and we described the theoretical perspectives that contributed to the focus of the study and the subsequent interpretations of the study's results (Malterud, 2016). The process used to analyze the study results has been described in a stepwise manner following a systematic text condensation approach, and the use of observational data has been described. In this way, the descriptions of the research process contribute to increased transparency, enabling readers to recognize and follow the methodical considerations of the study and inviting them to assess and critique the appropriateness and logic of our interpretations (Brinkmann & Kvale, 2015; Malterud, 2001, 2012; Polit & Beck, 2008).

This study is based on a limited number of participants situated in one region in Norway. Consequently, the results and subsequent analysis and findings may not necessarily be transferable to other contexts. However, similarities across rehabilitation trajectories and health care levels in this study help to increase the credibility of the study. Furthermore, participant validation during interviews, the validation of the analysis in research group meetings, and consistency in comparison to other adjacent studies indicates that the insights gained from this study may be transferable to and recognizable in similar populations and contexts.

As mentioned previously, three of the interviews were conducted prior to observations of the relevant physiotherapy treatment sessions. The physiotherapists were encouraged to relate the



interview and discussions to the actual patients' treatment and rehabilitation process. However, the inconsistency in the order of observations and interviews on these occasions may have affected the scope and content of the interviews as the interviewer had less opportunity to relate the questions and discussions to the actual patient.

The limited length of the data collection period in our study (i.e., a follow-up interview was conducted three months after the first interview with the primary health care physiotherapist) did not allow an extensive exploration of these issues. An extended understanding of rehabilitation terminology suggests that studies on transitional care following ABIs may profit from longer data collection periods (Hammell, 2006). Our follow-up procedure implies that the opportunity to explore important aspects related to the included patients' resumption of everyday life following ABI was limited to a three-month period. The inclusion of a prolonged data collection phase in this study may have shed further light on aspects of reintegration into society and the relevance and success of the rehabilitation efforts during the transition from hospital to municipality.

In this study, we focused primarily on physiotherapy practice in the context of ABI rehabilitation trajectories. However, the importance of multidisciplinary approaches in ABI rehabilitation has been emphasized, indicating the significance of multiprofessional cooperation. Although cooperation with other health care professionals was occasionally mentioned in the interviews, empirical data regarding these aspects are scarce and consequently were not highlighted in the published articles. An increased focus on collaboration across professional boundaries might have provided additional perspectives and extended the interpretations and discussions in this study.

The fact that the research design in this study included data collection procedures to a small degree should be mentioned. In this regard, the recruited physiotherapists were not instructed to register potential participants who fulfilled the inclusion criteria, nor were they instructed to systematically report which patients who declined to participate upon request. Consequently, a thorough discussion of possible bias related to the participating ABI patients was difficult to achieve. Furthermore, one of the inclusion criteria was related to the patients' cognitive abilities. The physiotherapists were asked to consider whether the patients were able to provide fully informed consent. We decided to use this inclusion criterion both because we conducted the interviews and observations under vulnerable circumstances characterized by

transitions between contexts and because we required the patients to participate over a longer period of time as we followed the rehabilitation process from their institutionalization to their return to their home communities. As the data collection period progressed, several of the specialist health care physiotherapists reported several patients they thought would be eligible for the study except for the criterion of being able to give fully informed consent. As a result, the patient recruitment period was longer than we had predicted. Cognitive impairments are common following ABIs (Whyte, Skidmore, Aizenstein, Ricker, & Butters, 2011). Including patients who were not capable of providing fully informed consent may have provided further insight into the physiotherapists' perceptions of the rehabilitation services provided as cognitive impairments may prompt additional questions and challenges.

In the first article, we discuss the specialist health care physiotherapists' ability to predict future outcomes and recommend further action in primary health care following hospital discharge. The physiotherapists experienced challenges related to earlier hospital discharge; they felt the time available to assess the patient and evaluate necessary measures was decreased. This challenge arose partly because patients were being transferred earlier from acute care units and required longer before rehabilitation efforts could be initiated. We argue that the rehabilitation trajectories in this study contrast with the positive effects reported in early supported discharge (ESD) studies as specialist health care was involved to a small degree at the primary health care level. However, some of the informants at both health care levels mentioned outpatient rehabilitation services (ART), a specialist health care service that offers counseling and facilitates continued community rehabilitation efforts for persons with prolonged and complex rehabilitation needs (The Norwegian Directorate of Health, 2018). In response to follow-up questions, informants at both health care levels expressed uncertainty regarding the content and extent of the ART's contribution to the rehabilitation process of the current patients. For a minority of the rehabilitation trajectories under study, the physiotherapists said they were aware of the ART's presence but were uncertain of how they contributed except by participating in one meeting or another. The limited information regarding the ART's involvement in the rehabilitation trajectories made it difficult to describe and interpret the significance of their contributions. Our study's research design, research questions, and choice of informants proved less suitable for investigating these aspects of the rehabilitation process.

Recent studies in the Norwegian context analyzing the effects of the Coordination Reform conclude that the goal of improving and expanding rehabilitation services in the municipalities was not met according to expectations (Monkerud & Tjerbo, 2016). However, these studies point towards possibly unintended consequences of the introduced economic incentives in terms of increased cost sharing and earlier hospital discharge. The use of private rehabilitation institutions that provide services similar to those of the public hospital rehabilitation units increased in the aftermath of the Coordination Reform implementation. Either the Norwegian Health Economics Administration (Helfo) or public hospitals, through contractual agreements with private institutions, bore the cost of providing rehabilitation services through private institutions. Consequently, the municipalities bore less of the costs of earlier hospital discharge than expected (Monkerud & Tjerbo, 2016). Furthermore, very little expansion of the municipal rehabilitation service sector in Norwegian municipalities was detected following the Coordination Reform (Stig & Lütz, 2013). The consequences of these mechanisms may play an important role in the way the public health care sector organizes and allocates health care service provision. Although these factors were considered beyond the scope of this study, the political and organizational consequences of reform measures require further investigation and may add perspective to studies of health care professionals' perceptions of the provision of rehabilitation services.

## **6 Summary of the results**

This thesis focuses on different aspects of physiotherapists' perceptions of the provision of rehabilitation services for people recovering from ABI. By exploring physiotherapy practices within the field of neurological rehabilitation, specifically within the context of actual patients' rehabilitation trajectories, we sought to investigate physiotherapists' perceptions and experienced challenges of the changes following the Coordination Reform, physiotherapy practice variations across health care levels, and the communication of information and physiotherapy knowledge during patients' transitions from the hospital to their home communities.

### **6.1 Article 1**

In the first article, we explored the physiotherapists' experiences of providing physiotherapy services for people with ABI in a context characterized by reformative efforts. Interviews with physiotherapists in both specialist and primary health care services were complemented by nonparticipatory field observations of physiotherapy treatment sessions.

The physiotherapists conveyed various concerns related to the redistribution of responsibilities between specialist and primary health care, and they experienced dilemmas related to physiotherapy service provision as a result of contextual limitations and resource insufficiency within the primary health care sector. The specialist health care physiotherapists described a situation characterized by defined settings and adequate resources. However, they experienced a shift in the process of transferring patients from acute care to rehabilitation units and discharging patients from hospitals. In their opinions, earlier transitions between hospital units and health care levels resulted in lower functional abilities upon hospital discharge and less basis for providing information and recommendations during the transition from specialist to primary health care. The primary health care physiotherapists experienced the patients' low functional abilities as challenging in terms of both the organization and resource insufficiency of the physiotherapy services and the patients' need to balance rehabilitation with everyday life. Additionally, several of the specialist health care physiotherapists described low expectations regarding the intensity of future follow-up, and they sometimes found themselves adjusting the expectations of the patients and their next of kin upon hospital discharge.

We applied theoretical perspectives of professionalism and discussed how the physiotherapists' perceptions of professional dilemmas in the aftermath of reform seemed to affect their clinical reasoning and professional practice. The article discussed how the results of political governance and measures affected clinical reasoning and decision-making and described resource insufficiency in the municipalities that influenced the ability to offer intensive physiotherapy. The constraints experienced in the primary health care sector appeared to limit the implementation of reform initiatives. Discussions regarding prioritization and resource allocation in the municipal context, involving both health care professionals and municipal authorities, may facilitate the effects of reformative work. Knowledge and expectations regarding resource insufficiency in the municipal context appeared to influence the information and recommendations that were communicated during the transition from hospital to home. In the article, we also discussed how the homecoming phase involved the patients' efforts to re-establish everyday life. Based on the physiotherapists' experiences, we highlighted the importance of paying attention to patients' current situation and municipal resource insufficiencies when planning and timing hospital discharge following acquired brain injuries.

## **6.2 Article 2**

In the second article, we aimed to describe and increase knowledge regarding the variations in physiotherapy practice for people with ABI across health care levels in northern Norway. We performed qualitative interviews with physiotherapists and field observations of physiotherapy treatments during the rehabilitation trajectories of 10 people with ABI. We performed systematic text analysis of the transcribed interviews and the summaries of the field observations. The hospital discharge papers validated the details of the rehabilitation process and patient information.

The physiotherapists in the specialist health care described the use of a more uniform intervention strategy during the physiotherapy sessions, with emphasis on quality of movement and reacquisition of function. The primary health care physiotherapists explained how the patients' contextual limitations and everyday life demands made it necessary to balance interventions targeting quality of movement with interventions that enabled patients to manage daily routines. The primary health care physiotherapists described a preference for outpatient treatment to adequately address functional recovery, and they emphasized the importance of the patients' next of kin in providing motivation for continued rehabilitation in the home community.

In this article, we applied interactional and social constructionist perspectives and discussed how variations in physiotherapy interventions and clinical reasoning may be understood in light of institutional- and culture-dependent processes. The physiotherapists at both health care levels shared common viewpoints regarding intervention strategies and the patients' reacquisition of function following ABIs. However, the traditional distribution of responsibilities and predispositions, which are affected by historical, cultural and contextual factors, may explain variations in the organization and performance of physiotherapy interventions. The contextual differences between rehabilitation in hospital units and in patients' home contexts were highlighted in terms of the need to target compensatory treatment strategies to enable the patients to manage at home. The primary health care physiotherapists often organized the interventions at outpatient clinics to address both movement quality and safety aspects. We discussed how the understanding and interpretation of these professional choices of action may be extended by adding perspectives on the social processes of habituation, typifications and institutionalization.

### **6.3 Article 3**

In the third article, we aimed to explore the communication of information and professional knowledge during transitions between health care levels within the field of neurological physiotherapy. We performed interviews with 19 physiotherapists from specialist and primary health care who were involved in the rehabilitation trajectories of 10 people with ABIs. We transcribed the interviews verbatim and analyzed the transcripts using a four-step systematic text condensation process.

The primary health care physiotherapists in our study found the written information in hospital discharge papers useful, although they called for increased consistency regarding which parts of the written documentation were distributed to primary health care physiotherapists during the transition process. Nonetheless, they emphasized the need for both verbal communication and clinical patient-oriented collaboration to complement the written information. The importance of personal liaisons among professionals was highlighted at both health care levels as the physiotherapists sought collaboration regarding aspects that were difficult to convey in writing. Such aspects included concerns regarding the potential for recovery or uncertainty regarding the patients' cognitive abilities, as the written reports were perceived as definitive. Furthermore, the physiotherapists called for the exchange of practical knowledge regarding handling and intervention choices related to the actual patient, and they advocated for closer clinical collaboration across health care levels. The primary health care physiotherapists also sought increased bidirectional exchange of information and knowledge as the home environment and the patients' priorities in their home communities differed from those of the institutionalized hospital environment.

In this article, we related our findings to previous research results emphasizing comprehensive, good-quality written reports and the need to establish effective and reliable procedures for communication. We applied sociological perspectives regarding communities of practices and the interrelation between different social agents and societal levels in our discussion of the relevance of institutional settings and organization and the potential benefits of further development of reciprocal communication. The results indicated that close collaboration and reciprocal communication of information regarding the patient and contextual aspects may improve continuity of care related to the patients' specific rehabilitation trajectories and enhance mutual learning among physiotherapists and other health care professionals.

## **7 General discussion of the results**

This thesis focuses on physiotherapists' perceptions and reflections regarding the provision of physiotherapy services during the rehabilitation trajectories of people recovering from ABIs in the aftermath of reform. In this section, I will discuss the various aspects in context, relate the findings to theoretical perspectives and further elaborate on the themes actualized in the articles.

The three articles explored different aspects of the physiotherapists' reflections and opinions regarding ABI rehabilitation. The point of departure was an emphasis on the transitional phase of ABI rehabilitation across health care settings in the context of reformative efforts. The reforms initiated in recent years are characterized by a dual focus; they aim for both economic rationalization and improving the quality of health and care services (Bauld et al., 2005; Bidgood, 2013; Grimsmo & Magnussen, 2015; Norwegian Ministry of Health and Care Services, 2009b; Steel & Cylus, 2012; Vrangbæk & Sørensen, 2013). This has led to challenges regarding the organization of health care services and the distribution of economic resources and responsibilities among different organizational levels of health and care services. Based on these changes and reports from various clinicians, we hypothesized that physiotherapists experience greater challenges in coordinating care for people recovering from ABIs.

### **7.1 Rehabilitation policies and reformative work**

The results of this study point to challenges and dilemmas in the provision of physiotherapy services related to differences in context and organization between specialist and primary health care services. The physiotherapists explained that these changes were due in part to the health care reform initiatives launched in recent years. Their opinions are supported by recent evaluations of the Coordination Reform (Office of the Auditor General of Norway, 2016; The Research Council of Norway, 2016) showing that resource allocation did not seem to support the increased responsibility of the primary health care sector. According to the evaluation reports, the primary health care sector seemed minimally prepared to take over these responsibilities as increases in resources and health care service levels have been difficult to detect. Solvang, Hanisch & Reinhardt (2016) highlight the need to relate rehabilitation practice and research to different levels of society and social agents to enhance the



understanding of the rehabilitation field. The results from the first article emphasize the consequences of the governmental authorities' aim towards a shift in responsibility for providing rehabilitation services. Organizational conditions affect professionals' actions and priorities within rehabilitation trajectories. In light of sociocultural and interactionist perspectives, we have tried to acknowledge the impact of political and organizational conditions on professional practice. The use of sociocultural perspectives provided a theoretical framework for discussing how institutional frames and traditions of professional practices may be difficult to change swiftly.

The sociological interest in reformative work and governing has led to the identification of trends and paradoxes that can be partly explained by social systems and social interaction. Vabø (2014b) describes how social and constructionist perspectives contribute to explanations for delays in the implementation of reforms in various organizations. The ideas and goals of reformative work must always be interpreted in light of and within the specific setting or organization (Christensen, Egeberg, Læg Reid, Roness, & Røvik, 2015; Vabø, 2014b). Consequently, changes occur in interactions between participants, who actively interpret their actions in light of various frames of reference and understandings. The implementation of the Coordination Reform in Norway, which used various means and incentives to fulfill the reform intentions, seemed to become unsynchronized among regions and health care levels.

In the initial stages of the reform's implementation, the authorities introduced economic incentives to ensure more rapid transfer of ready-to-discharge patients from hospitals to primary health care. The municipalities were instructed to establish municipal emergency services and to bear the financial responsibility for patients who were ready for discharge from specialist health care. The shift in financial responsibility for ready-for-discharge patients has been successful in terms of both earlier hospital discharge and a reduction in the number of excess hospitalization days for patients who are considered ready for discharge (Office of the Auditor General of Norway, 2016). Furthermore, the municipalities' responsibilities for providing health care and rehabilitation services increased.

A report from the Office of the Auditor General of Norway (Office of the Auditor General of Norway, 2016) and recent studies (Bruvik, Drageset, & Abrahamsen, 2017; Haukelien, Vike, & Vardheim, 2015; The Research Council of Norway, 2016) on the Coordination Reform

suggest that the municipalities have experienced challenges in accommodating the shift in responsibility for health care and rehabilitation services. Despite the reallocation of economic resources from the specialist health care level to the municipalities, the consequences of the reform seem to affect the quality of the primary health care services. The results of our study support these conclusions, as the physiotherapists argued that contextual limitations and resource insufficiency presented challenges to providing good quality services following ABI. The physiotherapists provided accounts of professional dilemmas; they found it challenging to balance professional judgements with the lack of resources they experienced after the implementation of the Coordination Reform, especially in the municipalities. As a result, the physiotherapists highlighted the political and organizational circumstances that affected physiotherapy practice.

In article 1, the informants described the limited efforts to increase resources and competence to meet the increased responsibility for providing health care services for increasingly impaired patients in the municipalities. As one of the specialist health care physiotherapists stated during the interview, the intensity of physiotherapy in the municipality is not considered enough for many of the ABI patients. This viewpoint is supported by research indicating that higher intensity task-oriented rehabilitation efforts may lead to earlier and better functional abilities following ABI (Charrette et al., 2016; Hellweg & Johannes, 2008; Scottish Intercollegiate Guidelines Network (SIGN), 2013). The tension between political governance and the jurisdiction and responsibilities of physiotherapists (Carpenter, 2010; Holdar, Wallin, & Heiwe, 2013; Smith, Higgs, & Ellis, 2007) and other health professionals (Forsner, Hansson, Brommels, Wistedt, & Forsell, 2010; Gunnarsson & Warren Stomberg, 2009; Hancock & Easen, 2006) has been the subject of previous studies and can be related to contradictory values in government and management (Vabø, 2014a). The values of government in many Western welfare countries are multiple (Hood, 1991a) and can be characterized by three partially contrasting factors: cost effectiveness; predictable and equal treatment; and flexibility to adapt to shifting and dynamic situations and contexts (Vabø, 2014a). The physiotherapists in our study indicated that these conflicting values presented challenges to discretionary judgements and actions; increased municipal responsibilities and resource limitations affected treatment intensity and prioritization between groups of patients (article 1) and led to the bureaucratization (municipal allocation offices – article 3) and privatization (communication and collaboration between private practitioners and public

services – article 3) of health care services. The physiotherapists experienced little or no involvement from the municipal authorities regarding prioritizing and planning physiotherapy services (article 1). These findings may be related to the changes in central governing strategies in health care, which have introduced new accountability arrangements over the past decades (Vabø, 2012).

Trends towards the centralization of power through control mechanisms (Fimreite, Flo, Selle, & Tranvik, 2007) and reforms affected by the ideas of a market-like public sector (new public management - NPM) (Hood, 1991b; Vabø, 2012) hold local authorities increasingly accountable to the central government. The introduction of management through objectives, standardization, more detailed reporting systems and individual rights legislation may have narrowed local authorities' scope of action and self-rule (Fimreite et al., 2007). The central government's tools of control, such as KOSTRA/IPLOS<sup>1</sup> measurements and the implementation of the purchaser-provider model in home care, have affected the organization of health care services in Norway (Vabø, 2011, 2012). In the purchaser-provider model, decision-making power regarding municipal care services was handed over to specialized need assessors in intermediary allocation offices and separated from the responsibility for providing services (Vabø, 2012). The citizens were entitled to care according to predetermined assessment criteria. However, the tension between the value of equal rights to services for all citizens and the tailoring of services for those with unstable and conflicting needs created dilemmas in the discretionary work of health care professionals.

In our study, some of the most populous municipalities also assigned physiotherapy services through application and delegation by assessors in the intermediary allocation offices. The physiotherapists described the allocation office representatives as active participants in the planning and coordination of rehabilitation trajectories (article 3). However, the physiotherapists were concerned about the bureaucratization of the transition process; they experienced the redistribution of written information via the allocation offices as time-consuming. Furthermore, allocation office representatives' control over the transition process

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<sup>1</sup> KOSTRA – Local authorities' state reporting system; IPLOS – National information system for all care recipients in Norwegian municipalities

by withholding information regarding the patient's destination and further rehabilitation led to frustration and delays in the communication of information across health care levels.

The Office of the Auditor General of Norway (2016) stated that the average hospitalization length decreased by 52 % in the first four-year period of the Coordination Reform implementation. Most municipalities and a majority of hospitals claimed that patients were discharged earlier from hospitals, and 95 % of the municipalities perceived the patients as sicker upon hospital discharge since the implementation of the Coordination Reform. Furthermore, a majority of the municipalities stated that the earlier hospital discharge complicated primary health care services' ability to provide good quality health care services (Office of the Auditor General of Norway, 2016). During the same period, the number of rehospitalizations of patients was reported to increase by approximately 10 %, and both the municipalities and the hospitals highlighted the earlier hospital discharge to be possible explanations for the increase in rehospitalizations. A recent comparative study on the discharge of older patients from hospitals to a nursing home in Norway before and after the Coordination Reform (Bruvik et al., 2017) showed that the patients in the postreform period were older and had shorter survival during short-term stays in the nursing home following hospital discharge. The median age increased from 85 to 88 years, and mortality increased from 36 % to 51 % at 6 months, and from 45 % to 60 % at 12 months following hospital discharge. Although the results were generated from a small retrospective study of 363 patients (186 patients before and 177 patients after the introduction of the Coordination Reform) from a single nursing home, the authors hypothesized that the nursing homes face higher throughput and less clarified patients following the Coordination Reform. Consequently, the authors called for increased competence and staffing in nursing homes to meet treatment needs of patients following the Coordination Reform. The physiotherapists in our study expressed similar viewpoints regarding physiotherapy services in primary health care rehabilitation; they called for increased competence in and resource allocation to primary health care following the Coordination Reform.

## **7.2 Organization of health care services and continuity of care**

A main result from articles 1 and 2 was related to the physiotherapists' experiences of contextual and organizational differences across health care levels and how these differences affected professional choices and prioritization. The dilemmas encountered were related to the selection of intervention strategies, the weighting of reacquisition versus functional compensation following brain injuries, treatment intensity, and home versus outpatient treatment settings in primary care. The contextual differences between the specialist and primary health care levels were considered important in terms of the scope, content and expectations of physiotherapy treatment. The physiotherapists expressed concerns regarding the alterations in rehabilitation pathways and the increased municipal responsibility for providing rehabilitation services at the primary health care level and indicated constraints (Nalette, 2010) in their practice.

Health organizations are complex enterprises that are expected to ensure and promote health and care while simultaneously taking into account the welfare of the employees, economic factors and the efficiency of the organization (Orvik, 2004; Orvik & Axelsson, 2012). Orvik (2012) introduces a concept of organizational health in health organizations and suggests that an emphasis on the organizational competence of health care professionals may contribute to increased reflection on and attention to tensions between the quality of patient care and the efficiency of service. Such an emphasis may strengthen health care professionals' ability to identify and act on dilemmas that arise from the diversity of value aspects they encounter in their work. The physiotherapist concerns described in article 1 illustrate how conflicting interests contribute to an increased discrepancy between political ideals and professionals' reality (Orvik, 2004). One of the primary health care physiotherapists illustrated this with the notion of pressing yet another sardine into an already full box. This discrepancy can potentially lead to moral distress (Carpenter, 2010) among the health care professionals involved as the increased responsibilities following the reform seem difficult to fulfill.

Accountability related to the discretionary work of professionals may be divided into two forms, i.e., structural mechanisms and epistemic mechanisms (Molander, 2013; Molander, Grimen, & Eriksen, 2012). Structural mechanisms aim to restrict the scope of action in discretionary work, whereas epistemic mechanisms relate to ways to improve the conditions and the quality of discretionary reasoning as the basis of professional action. Vabo & Vabø (2014) and Molander (2013) describe how the discretionary reasoning is most often regulated

by structural mechanisms, i.e., the scope of action in discretionary work is regulated and restricted. However, the structural mechanisms that intend to regulate the discretionary space of street-level bureaucrats do not necessarily ease the burden or reduce the scope of discretionary work, as the execution of the discretion in each actual case becomes increasingly more complex (Vike, 2004). The role of the municipal allocation offices (the purchaser-provider model) in the more populous municipalities, as discussed earlier, is related to the physiotherapists' experiences of bureaucratization and delays in the communication of information. Furthermore, separating the allocation of services from the provision of physiotherapy services does not seem to reduce the dilemmas physiotherapists face, as they must still make professional choices regarding treatment strategies, treatment intensity and location.

Several of the physiotherapists conveyed concerns regarding the impact of resource insufficiency (in terms of physiotherapists, distances, constraints in the patients' own homes) on their ability to provide good quality physiotherapy and regarding the possibility that patients may be reluctant and unmotivated to receive home-based interventions. Previous studies on patients' motivation for home exercises (Caeiro, Ferro, & Costa, 2013; Mayo, 2016; Mayo, Fellows, Scott, Cameron, & Wood-Dauphinee, 2009) and negative perceptions regarding the public sector moving into their private spheres (Tamm, 1999) support the challenges the physiotherapists expressed regarding providing home-based rehabilitation. In a review on various home-based stroke rehabilitation interventions, Mayo (2016) proposed the need for the early identification of motivated patients and to develop appropriate implementation strategies to provide focused interventions. She argued that rehabilitation for stroke has proven powerful and effective but requires tailored intervention approaches for the individual patient. Furthermore, a recent review on facilitators and barriers in the home setting after stroke (Marcheschi, Von Koch, Pessah-Rasmussen, & Elf, 2018) concluded that the physical environment did not receive sufficient attention in the planning of home-based rehabilitation. The review highlights the lack of information and attention to the psychosocial and emotional processes that mediate the interaction between stroke survivors and their home setting. Physiotherapists' clinical reasoning and professional judgement seem central to tailoring and selecting the most efficient intervention strategy in each case, which highlights the dilemmas associated with weighing patient considerations against available resources. These dilemmas include considerations regarding the benefits and potential barriers of the

home environment (Ekstam, Uppgard, Von Koch, & Tham, 2007; Erikson, Park, & Tham, 2010; Wottrich, von Koch, Tham, & Jensen, 2007) and the ambiguity the patients may experience during the liminal phase of transition from hospitalization to resuming everyday life in their home communities (Hammell, 2006). However, in article 2, we argued that the differences in contexts between the specialist and primary health care level can be considered frameworks that may constrain physiotherapy practices and that the frameworks are affected by socially and culturally embedded perceptions and expectations. Understanding the physiotherapists' opinions and justification of actions in light of theories of institutionalized and culture-dependent processes (Berger & Luckmann, 1984; Burr, 2015; Gibson & Teachman, 2012; Lock & Strong, 2010) may also reflect how alterations in context and organization may challenge traditional (institutionalized) rehabilitation practices and physiotherapists' frames of reference, and may contribute to understand professional choices of treatment preferences. As such, providing sufficient attention to the physical and home environment may represent a challenge to the traditional physiotherapy practice.

The introduction of standardized care pathways is another example of a structural mechanism that intends to make professional reasoning easier and secure the equal provision of health and care services. The standardized pathways describe the preferred and expected way to provide health and care services for a specific diagnosis. Such pathways may be referred to as fast-track programs, integrated fast-track rehabilitation, pathway-controlled fast-track rehabilitation, coherent care pathways, etc. Standardized pathways are being actualized within the field of neurological rehabilitation; the final implementation of standardized care pathways following stroke, the most common ABI, is planned for 2019 (The Norwegian Directorate of Health, 2017, 2019). It is likely that measures to increase municipal resources will be needed to implement the requirements of the standardized care pathways.

The need for individualized and tailored interventions and choices of action are strongly connected to the individuals' unique situation. ABI can cause severe functional disabilities and require an extensive need for interventions from various health care professionals. The use of individual care coordinators to administer and coordinate service provision was described to a small degree in the interviews. In Norway, individual care coordination has been a statutory requirement of primary health care services for several years; since 2012, specialist health care services have also been required to provide individual care coordination. In a recent study on the introduction of coherent care pathways in the Norwegian health care

system, Høyem et al. (2018) investigated policy documents that introduced coordinator responsibilities for clinical personnel in hospitals. These documents were found to place extended personal responsibility on clinical personnel to coordinate interventions and collaboration across patients' conditions and contexts. In a qualitative study of Norwegian health care providers involved in care coordination for patients with complex needs, Høyem et al. (2018) found that the health care providers strived to balance the patients' needs with the resources available and described coordination activities that stretched beyond workflow routines and standardized pathways. These findings point to ways that health care management and organizational structures enable and facilitate service coordination and cooperation among health care professionals, an area that should receive further attention in the provision of health and care services.

The standardized care pathway provides a coherent description of how timely diagnosis and treatment can be provided at the right level of the health care service system, including communication, dialogue with the patient and the next of kin, responsibilities, and defined time limits during the course of treatment. However, the standardized care pathway includes only strokes, whereas the ABI population is characterized by variations in diagnosis, treatment and rehabilitation trajectories. However, the establishment of predictable and timed interventions for stroke rehabilitation may extend to care coordination in other brain injury rehabilitation trajectories as well. One characteristic of brain injury rehabilitation is its protracted course, which often includes primary health care. The standardized care pathways following stroke focus largely on the specialist health care level, whereas transitions and especially the subsequent municipal rehabilitation are to a lesser degree considered. This situation may contribute to uncertainty and differences in the organization and content of specialist and primary health care rehabilitation, and an increased focus on the scope and content of community rehabilitation efforts seems necessary. However, studies on municipality participation in the development and implementation of clinical pathways in primary health care call diagnosis-specific pathways into question, as the specialization of services and personnel at the primary health care level may not be sustainable (Grimsmo et al., 2016, 2018; Meese & Rønhovde, 2015; Røsstad, Garåsen, Steinsbekk, Sletvold, & Grimsmo, 2013). This is partly related to the generalist role of health care professionals and services at the primary health care level, which serves patients with a variety of diagnoses. The Research Council of Norway (2016) highlights that standardized care pathways in the



municipal context will be challenging due to the comorbidities of patients who need health and care services in the municipalities. Additionally, diagnoses that are commonly encountered in hospitals will be less frequent in the primary health care context, reducing the functionality of standardized care pathways. These results point toward a more generic care pathway in primary health care to take into account the contextual differences between specialist and primary health care and the comorbidities of the patients (Grimsmo et al., 2018).

### **7.3 Professional development and accountability in neurological physiotherapy**

The need for increased competence among physiotherapists to meet the increasingly complex patient needs encountered in the primary health care setting was emphasized in the interviews (article 3). One of the experienced primary health care physiotherapists stated during the interview that the level of expertise necessary to handle increasingly complex patients due to earlier hospital discharge was not accounted for in the current situation. In a report from 2015 (Haukelien et al., 2015), primary health care nurses presented similar viewpoints; they reported a lack of quality and competence at the primary health care level combined with increased complexity and workload following the Coordination Reform. Furthermore, governmental strategies (Norwegian Ministry of Health and Care Services, 2015a) and evaluation reports (Office of the Auditor General of Norway, 2016) of the effects and consequences of the Coordination Reform have highlighted the need for increased competence in the primary health care sector, and strategies and economic incentives to accommodate these needs were proposed by the Norwegian Ministry of Health and Care Services in 2015 (2015b). However, the results of our study also highlighted competence and professional development aspects within the physiotherapy profession itself (articles 2 and 3); treatment strategies, collaborative work, and communication of information were closely connected to the physiotherapists' clinical practice.

Rehabilitation trajectories across health care levels involve transitions between different institutions and work places and may involve several physiotherapists and other health care professionals. The communication of information during these transitions is important for securing care coordination (Bodenheimer, 2008; Cameron et al., 2016; Coleman & Boulton, 2003) to the benefit of patients (Abrahamson, Jensen, Springett, & Sakel, 2017; Piccenna, Lannin, Gruen, Pattuwage, & Bragge, 2016). The physiotherapists in our study highlighted the importance of various sources of information during patient transitions (article 3); they perceived written discharge summaries, oral discussions and clinical collaboration as complementary. These exchanges allowed the physiotherapists to elaborate on and discuss information with one another, respond to immediate questions and conjectures, and initiate collaboration in clinical settings. However, the physiotherapists called for increased emphasis on clinical collaboration and emphasized the practical dimensions of physiotherapy practice. Previous studies have shown that patient-centered clinical guidance from experienced neurological physiotherapists promotes the professional development of primary health care

physiotherapists (Normann, Sorgaard, Salvesen, & Moe, 2014). This finding is supported by knowledge that professional guidance in clinical settings is beneficial to professional development in physiotherapy (French & Dowds, 2008).

In our study, most of the physiotherapists at both health care levels considered the quality of movements following brain injuries an important aspect of neurological physiotherapy (article 2), and they emphasized the potential for reacquiring function after ABI via rehabilitation efforts. However, the specialist health care physiotherapists expressed concerns regarding the early introduction of compensatory strategies when patients are transferred to the primary health care level. Several of the primary health care physiotherapists in our study shared this concern but felt constrained by the context of primary health care and providing rehabilitation in patients' homes. Lower levels of patient function upon hospital discharge than previously experienced, less suitable venues for physiotherapy treatment, and the immediate need for patients to deal with everyday life challenged the physiotherapists' ability to address quality of movement and the reacquisition of functions. In our analysis, the physiotherapists experienced dilemmas and conflicts regarding the reacquisition of function and helping patients function well at home and in their new social settings. In their opinions, the contextual differences and resource limitations at the primary health care level made it challenging to provide ideal or preferred intervention strategies that focused on reacquisition of function and quality of movements. However, insights regarding the influence of the traditions and cultures of community of practices (Wenger-Trayner & Wenger-Trayner, 2015; Wenger, 1998, 2000) may also raise questions regarding the physiotherapists' hesitancy to engage in rehabilitation efforts that utilize the patients' home environments to a larger degree.

The physiotherapists called for increased competence at the primary health care level and proposed collaboration in clinical settings to enhance the development of physiotherapy practice knowledge. Furthermore, the primary health care physiotherapists highlighted the significance of mutuality in both communication of information and the development of practice knowledge. They stated that the mutual exchange of information and knowledge could enhance the bidirectional understanding of organizational, cultural and environmental differences. These perspectives suggest a need for adjustments in the way health care professionals collaborate in rehabilitation trajectories. Acknowledging the distinct affordances and constraints in the patient's home environment may enable physiotherapists in specialist health care to optimize the interventions while the patient is still in the hospital setting and

direct the treatment strategies in accordance with the patient's home environment. However, the alteration in rehabilitation trajectories in favor of earlier transition from acute care to the rehabilitation unit and from hospital to home challenge the scope and content of the different aspects of the rehabilitation trajectory following ABI.

The disability literature emphasizes the distinction between treatment and rehabilitation: rehabilitation should be seen as a process of learning to live well with an impairment in the context of ones' environment (Hammell, 2006) rather than the provision of a cure (Reynolds, 2005). Issues related to continued rehabilitation following the initial subacute phase post-ABI are interesting in terms of both functional recovery and the resumption of everyday life activities. A recent study in Norway evaluated exercise and coaching programs that lasted as long as 24 months after stroke onset (Askim et al., 2018). Although individualized community-based coaching did not improve the maintenance of motor function compared to standard care, the study's aim and design indicate increasing research interest in possible strategies to help stroke survivors achieve a more active lifestyle. The researchers hypothesized that more personalized and multimodal approaches, earlier interventions, increased intensity and even longer follow-up periods may prove beneficial. In this regard, complementary perspectives regarding social and subjective aspects of both the rehabilitation process and the resumption of everyday life after brain injury may shed further light on personal, social and even organizational factors that are important for sustaining an active and meaningful lifestyle following ABI.

The physiotherapists' desire for the communication of information and clinical collaboration reflects the increasing complexity of rehabilitation, which spans health care levels and involves multiple health care professionals. The emphasis on collaboration, social interaction and relationship building reflects these complex and intertwined rehabilitation processes and may enhance bidirectional understanding and learning across communities of practice. Such collaboration may be one way to address the increasing social accountability expected from physiotherapists and health care workers.

## **8 Concluding remarks and possible implications for practice**

In this study, we investigated physiotherapy practice within the field of neurological rehabilitation as we followed the rehabilitation trajectories of 10 people with ABI. We applied a sociocultural perspective that integrated the theoretical perspectives of social interaction, communication and the construction and development of professional knowledge to explore physiotherapists' perspective on rehabilitation following ABI in the aftermath of reform in Norway.

The ambiguity of the Coordination Reform in Norway, which aimed for both quality improvement and economic rationalization, has had considerable impact on the organization and provision of health care services. In light of social constructionist theories and interactionist perspectives on social communities of practice and professional development, we have argued that contemporary physiotherapy practices reside in complex and intertwined social, cultural and political realities. Our interpretations of the physiotherapists' reflections and increased attention to their role as health care professionals in this context may contribute an increased understanding of the social and political processes that affect physiotherapy practice. The conflicting values of health care governance in Norway, actualized by the implementation of the Coordination Reform in 2012, challenge physiotherapists' content and scope of action as health care professionals. Simultaneously, health care professionals are increasingly responsible for implementing and exercising politically initiated reform efforts and serving as a crossroads for the organization and management of health and care services. The need for health professionals to be socially accountable is growing (Fleet et al., 2008) and corresponds to the increasingly complex terrain in which health professionals operate. More complex, multimorbid patients, alterations in management strategies and policy guidelines, and increased collaboration across health care levels challenge the traditional practice of physiotherapists and other health professionals, including multi-professional cooperation. These organizational and clinical challenges should also be reflected in the education of health care professionals. Fleet (2008) calls for increased attention to social accountability in professional learning to enable health care professionals to understand and take into account the linkages among professionals, institutions, and government policies in professional work. However, as the organization and management of health and care services change, it will still

be crucial that the prerequisites and resources available for providing good quality rehabilitation services are in line with existing demands.

Collaborative physiotherapy practices in rehabilitation trajectories that span health care levels and organizational contexts offer unique opportunities to further develop physiotherapy knowledge and practice. Enhancing mutual learning and the bidirectional communication of knowledge between various contexts of physiotherapy practice offer opportunities to optimize and tailor physiotherapy interventions and coordinated rehabilitation efforts following ABIs. Integrating and further developing the knowledge base and practical dimensions of physiotherapy knowledge, the “know-how”, requires arenas for communication and clinical collaboration.

## 9 Future directions

The effects of political shifts and governing strategies have implications for all health care professionals, and it is necessary to bring attention to the mutually dependent interplay of health professionals, organizations, administrative and political bodies. Further attention should be directed towards strategies and arenas for encouraging mutual understanding and learning in the physiotherapy profession and for developing competence and practice knowledge to optimize patient care across health care levels.

Further research on rehabilitation practices must call for attention to collaborative work across professional boundaries and include the perspectives of both patients and their next of kin. One aspect of interdisciplinary collaboration, emphasized in Proposition nr. 1 (2007-2008) of the Storting: National Strategy for Habilitation and Rehabilitation 2008-2011 (Norwegian Ministry of Health and Care Services, 2007) and actualized by the fusion of the Law on Health Services and the Law on Social Services into the Law on Health and Care Services in the Municipalities (Norwegian Ministry of Health and Care Services, 2011a), is cooperation across traditionally divided services. This cooperation points to issues related to collaborative work that transcend the organization of different service areas (health, care and social services).

The extent and contents of care coordination and outpatient rehabilitation services (ART) is interesting in terms of collaborative work across health care settings and should be subject to further investigations. Furthermore, the collaboration and coordination among various health and care services depends on the social, cultural and political systems in which they are situated, and health professionals' roles as change agents in reformative work should be the subject of further investigations.

## References

- Aadal, L., Pallesen, H., Arntzen, C., & Moe, S. (2018). *Municipal Cross-Disciplinary Rehabilitation following Stroke in Denmark and Norway: A Qualitative Study* (Vol. 2018).
- Abbott, A. (1988). *The system of professions : an essay on the division of expert labor*. Chicago: University of Chicago Press.
- Abrahamson, V., Jensen, J., Springett, K., & Sakel, M. (2017). Experiences of patients with traumatic brain injury and their carers during transition from in-patient rehabilitation to the community: a qualitative study. *Disability and Rehabilitation, 39*(17), 1683-1694. doi:10.1080/09638288.2016.1211755
- Alvesson, M., & Sköldberg, K. (2009). *Reflexive methodology : new vistas for qualitative research* (2nd ed.). London: Sage.
- Andrews, T. (2012). What is social constructionism. *Grounded Theory Review, 11*(1), 39-46.
- Angrosino, M., & Rosenberg, J. (2011). Observations on observation. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research* (4 ed.). Los Angeles: SAGE.
- Askim, T., Langhammer, B., Ihle-Hansen, H., Gunnes, M., Lydersen, S., & Indredavik, B. (2018). Efficacy and Safety of Individualized Coaching After Stroke: the LAST Study (Life After Stroke). *Stroke, 49*(2), 426.
- Baque, E., Sakzewski, L., Barber, L., & Boyd, R. N. (2016). Systematic review of physiotherapy interventions to improve gross motor capacity and performance in children and adolescents with an acquired brain injury. *Brain Injury, 1*-12. doi:10.3109/02699052.2016.1147079
- Bauld, L., Judge, K., Barnes, M., Benzeval, M., Mackenzie, M., & Sullivan, H. (2005). Promoting Social Change: The Experience of Health Action Zones in England. *Journal of Social Policy, 34*(03), 427-445. doi:doi:10.1017/S0047279405008858
- Béjot, Y., Bailly, H., Durier, J., & Giroud, M. (2016). Epidemiology of stroke in Europe and trends for the 21st century. *La Presse Médicale, 45*(12, Part 2), e391-e398. doi:<https://doi.org/10.1016/j.lpm.2016.10.003>
- Bender, A., Adrion, C., Fischer, L., Huber, M., Jawny, K., Straube, A., & Mansmann, U. (2016). Long-term Rehabilitation in Patients With Acquired Brain Injury: A Randomized Controlled Trial of an Intensive, Participation-Focused Outpatient Treatment Program. *Deutsches Ärzteblatt International, 113*(38), 634-641. doi:10.3238/arztebl.2016.0634
- Berger, P. L., & Luckmann, T. (1984). *The social construction of reality : a treatise in the sociology of knowledge*. Harmondsworth: Penguin.



- Bidgood, E. (2013). Healthcare Systems: Sweden & localism - an example for the UK? Retrieved from [http://www.civitas.org.uk/reports\\_articles/briefing-healthcare-systems-sweden-localism-an-example-for-the-uk/](http://www.civitas.org.uk/reports_articles/briefing-healthcare-systems-sweden-localism-an-example-for-the-uk/)
- Blaikie, N. (2010). *Designing social research : the logic of anticipation* (2nd ed.). Cambridge: Polity Press.
- Bodenheimer, T. (2008). Coordinating Care — A Perilous Journey through the Health Care System. *New England Journal of Medicine*, 358(10), 1064-1071. doi:doi:10.1056/NEJMhpr0706165
- Brinkmann, S., & Kvale, S. (2015). *InterViews : learning the craft of qualitative research interviewing* (3rd ed.). Thousand Oaks, Calif.: Sage.
- Bruvik, F., Drageset, J., & Abrahamsen, J. F. (2017). From hospitals to nursing homes – the consequences of the Care Coordination Reform. *Sykepleien Forskning*(60613), e-60613. doi:10.4220/Sykepleienf.2017.60613
- Burr, V. (2015). *Social constructionism* (3rd ed.). London: Routledge.
- Caeiro, L., Ferro, J. M., & Costa, J. (2013). Apathy secondary to stroke: a systematic review and meta-analysis. *Cerebrovasc Dis*, 35(1), 23-39. doi:10.1159/000346076
- Callen, J. L., Alderton, M., & McIntosh, J. (2008). Evaluation of electronic discharge summaries: A comparison of documentation in electronic and handwritten discharge summaries. *International Journal of Medical Informatics*, 77(9), 613-620. doi:<http://dx.doi.org/10.1016/j.ijmedinf.2007.12.002>
- Cameron, J. I., O'Connell, C., Foley, N., Salter, K., Booth, R., Boyle, R., . . . Committees, S. F. C. S. B. P. (2016). Canadian Stroke Best Practice Recommendations: Managing transitions of care following Stroke, Guidelines Update 2016. *International Journal of Stroke*, 11(7), 807-822. doi:10.1177/1747493016660102
- Carpenter, C. (2010). Moral distress in physical therapy practice. *Physiother Theory Pract*, 26(2), 69-78. doi:10.3109/09593980903387878
- Cassidy, D. J., Carroll, L. J., Peloso, P. M., Borg, J., von Holst, H., Holm, L., . . . Coronado, V. G. (2004). Incidence, risk factors and prevention of mild traumatic brain injury: Results of the WHO collaborating centre task force on mild traumatic brain injury. *J Rehabil Med*(Suppl. 43), 28-60.
- Charrette, A. L., Lorenz, L. S., Fong, J., O'Neil-Pirozzi, T. M., Lamson, K., Demore-Taber, M., & Lilley, R. (2016). Pilot study of intensive exercise on endurance, advanced mobility and gait speed in adults with chronic severe acquired brain injury. *Brain Injury*, 30(10), 1213-1219. doi:10.1080/02699052.2016.1187766

- Christensen, T., Egeberg, M., Lægreid, P., Roness, P. G., & Røvik, K. A. (2015). *Organisasjonsteori for offentlig sektor [Organization theory for the public sector]* (3. ed.). Oslo: Universitetsforl.
- Coleman, E. A., & Boulton, C. (2003). Improving the Quality of Transitional Care for Persons with Complex Care Needs. *Journal of the American Geriatrics Society*, 51(4), 556-557. doi:10.1046/j.1532-5415.2003.51186.x
- Conneeley, A. L. (2003). Quality of Life and Traumatic Brain Injury: A One-Year Longitudinal Qualitative Study. *The British Journal of Occupational Therapy*, 66(10), 440-446. doi:10.1177/030802260306601002
- Creswell, J. W. (2013). *Qualitative inquiry & research design : choosing among five approaches* (3 ed.). Los Angeles: Sage.
- Crocker, A., Sheehan, D., & Iedema, R. (2014). Healthcare Systems and Spaces. In J. Higgs, A. Crocker, D. Tasker, J. Hummell, & N. Patton (Eds.), *Health Practice Relationships* (pp. 17-26). Rotterdam: SensePublishers.
- Dahlgren, M. A., Richardson, B., & Kalman, H. (2004). Redefining the reflective practitioner. In J. Higgs, B. Richardson, & M. A. Dahlgren (Eds.), *Developing practice knowledge for health professionals* (pp. 15-34). London: Butterworth Heinemann.
- Davies, B., & Harré, R. (1990). Positioning: The Discursive Production of Selves. *Journal for the Theory of Social Behaviour*, 20(1), 43-63. doi:10.1111/j.1468-5914.1990.tb00174.x
- Ekstam, L., Uppgaard, B., Von Koch, L., & Tham, K. (2007). Functioning in everyday life after stroke: a longitudinal study of elderly people receiving rehabilitation at home. *21(4)*, 434-446. doi:doi:10.1111/j.1471-6712.2006.00488.x
- Ellekjaer, H., & Selmer, R. (2007). Hjerneslag - like mange rammes, men prognosen er bedre [Stroke - similar incidence, better prognosis]. *Tidsskr Nor Laegeforen*, 127(6), 740-743.
- Ellen, R. (1984). *Ethnographic research : a guide to general conduct*. London: Academic Press.
- Eraut, M. (2000). Non-formal learning and tacit knowledge in professional work. *British Journal of Educational Psychology*, 70(1), 113-136. doi:10.1348/000709900158001
- Erikson, A., Park, M., & Tham, K. (2010). Place Integration through Daily Activities 1 Year after Stroke. *OTJR: Occupation, Participation and Health*, 30(2), 68-77. doi:10.3928/15394492-20090922-01
- Evetts, J. (2013). Professionalism: Value and ideology. *Current Sociology*, 61(5-6), 778-796. doi:10.1177/0011392113479316
- Fangen, K. (2010). *Deltagende observasjon [Participatory Observation]* (2 ed.). Bergen: Fagbokforl.
- Feigin, V. L., Forouzanfar, M. H., Krishnamurthi, R., Mensah, G. A., Connor, M., Bennett, D. A., . . . Naghavi, M. (2014). Global and regional burden of stroke during 1990-2010: Findings from

- the Global Burden of Disease Study 2010. *The Lancet*, 383(9913), 245-255.  
doi:10.1016/S0140-6736(13)61953-4
- Feiring, M. (2012). Rehabilitation—Between management and knowledge practices: An historical overview of public action in Norwegian welfare reforms. *Policy and Society*, 31(2), 119-129.  
doi:<http://dx.doi.org/10.1016/j.polsoc.2012.04.003>
- Fimreite, A. L., Flo, Y., Selle, P., & Tranvik, T. (2007). Når sektorbåndene slites - utfordringer for den norske velferdsmodellen [When ties between sectors are worn out - Challenges in the Norwegian welfare model]. *Tidsskrift for samfunnsforskning*, 48(2), 165-307.
- Fleet, L. J., Kirby, F., Cutler, S., Dunikowski, L., Nasmith, L., & Shaughnessy, R. (2008). Continuing professional development and social accountability: A review of the literature. *Journal of Interprofessional Care*, 2008, Vol.22(S1), p.15-29, 22(S1), 15-29.  
doi:10.1080/13561820802028360
- Forsner, T., Hansson, J., Brommels, M., Wistedt, A. A., & Forsell, Y. (2010). Implementing clinical guidelines in psychiatry: a qualitative study of perceived facilitators and barriers. *BMC Psychiatry*, 10, 8. doi:10.1186/1471-244X-10-8
- Fraser, C. (1999). The Experience of Transition for a Daughter Caregiver of a Stroke Survivor. *Journal of Neuroscience Nursing*, 31(1), 9-16. doi:10.1097/01376517-199902000-00002
- Freidson, E. (2001). *Professionalism. The Third Logic*. Cambridge: Polity Press.
- French, H. P., & Dowds, J. (2008). An overview of Continuing Professional Development in physiotherapy. *Physiotherapy*, 94(3), 190-197.  
doi:<http://dx.doi.org/10.1016/j.physio.2007.09.004>
- Garfinkel, H. (1967). *Studies in ethnomethodology*. Englewood Cliffs, N. J: Prentice-Hall.
- Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist*, 40(3), 266-275. doi:10.1037/0003-066X.40.3.266
- Gibson, B. E., Nixon, S. A., & Nicholls, D. A. (2010). Critical Reflections on the Physiotherapy Profession in Canada. *Physiotherapy Canada*, 62(2), 98-100. doi:doi:10.3138/physio.62.2.98
- Gibson, B. E., & Teachman, G. (2012). Critical approaches in physical therapy research: Investigating the symbolic value of walking. *Physiother Theory Pract*, 28(6), 474-484.  
doi:10.3109/09593985.2012.676936
- Giddens, A. (1976). *New rules of sociological method : a positive critique of interpretative sociologies*. London: Hutchinson.
- Goffman, E. (1971). *The presentation of self in everyday life*. Harmondsworth: Penguin Books.
- Goffman, E. (1983). The Interaction Order: American Sociological Association, 1982 Presidential Address. *American Sociological Review*, 48(1), 1-17. doi:10.2307/2095141

- Goffman, E. (1986). *Frame analysis : an essay on the organization of experience*. Boston: Northeastern University Press.
- Grimen, H. (2008). Profesjon og kunnskap [Profession and Knowledge]. In A. Molander & L. I. Terum (Eds.), *Profesjonsstudier [Studies on Professions]* (pp. s. 71-86). Oslo: Universitetsforl.
- Grimsmo, A., Løhre, A., Røsstad, T., Gjerde, I., Heiberg, I., & Steinsbekk, A. (2016). Helhetlige pasientforløp – gjennomføring i primærhelsetjenesten [Comprehensive clinical pathways - Implementation in primary care]. *Tidsskrift for omsorgsforskning*, 2(02), 78-87.
- Grimsmo, A., Løhre, A., Røsstad, T., Gjerde, I., Heiberg, I., & Steinsbekk, A. (2018). Disease-specific clinical pathways – are they feasible in primary care? A mixed-methods study. *Scandinavian Journal of Primary Health Care*, 36(2), 152-160. doi:10.1080/02813432.2018.1459167
- Grimsmo, A., & Magnussen, J. (2015). *Norsk samhandlingsreform i et internasjonalt perspektiv [The Norwegian coordination reform in an international perspective]*. Retrieved from <https://www.forskningsradet.no/prognett-evasam/Forside/1253972204829>:
- Gunnarsson, B. M., & Warren Stomberg, M. (2009). Factors influencing decision making among ambulance nurses in emergency care situations. *Int Emerg Nurs*, 17(2), 83-89. doi:10.1016/j.ienj.2008.10.004
- Hammell, K. W. (2006). *Perspectives on Disability and Rehabilitation*. Philadelphia: Churchill Livingstone Elsevier.
- Hancock, H. C., & Easen, P. R. (2006). The decision-making processes of nurses when extubating patients following cardiac surgery: an ethnographic study. *Int J Nurs Stud*, 43(6), 693-705. doi:10.1016/j.ijnurstu.2005.09.003
- Hankey, G. J., & Langhorne, P. (2006). Services for Reducing the Duration of Hospital Care for Acute Stroke Patients. *Stroke*, 37(1), 276-277. doi:10.1161/01.STR.0000195128.01213.4b
- Haukelien, H., Vike, H., & Vardheim, I. (2015). *Samhandlingsreformens konsekvenser i de kommunale helse- og omsorgstjenestene: Sykepleieres erfaringer [The consequences of the Coordination Reform for the primary health care services: The nurses' experiences]*. Retrieved from <https://www.telemarksforsking.no/publikasjoner/samhandlingsreformens-konsekvenser-i-de-kommunale-helse-og-omsorgstjenestene/2794>
- Heath, C., Hindmarsh, J., & Luff, P. (2010). Video in qualitative research: Analysing social interaction in everyday life. In. Los Angeles: SAGE.
- Hellweg, S., & Johannes, S. (2008). Physiotherapy after traumatic brain injury: A systematic review of the literature. *Brain Injury*, 22(5), 365-373. doi:10.1080/02699050801998250

- Higgs, J., Andresen, L., & Fish, D. (2004). Practice knowledge - its nature, sources and contexts. In J. Higgs, B. Richardson, & M. A. Dahlgren (Eds.), *Developing practice knowledge for health professionals* (pp. 51-70). London: Butterworth Heinemann.
- Higgs, J., Jones, M., Edwards, I., & Beeston, S. (2004). Clinical reasoning and practice knowledge. In *Developing Practice Knowledge for Health Professionals* (pp. 181-199). Oxford: Butterworth-Heinemann.
- Hofstad, H., Gjelsvik, B. E. B., Næss, H., Eide, G. E., & Skouen, J. S. (2014). Early supported discharge after stroke in Bergen (ESD Stroke Bergen): three and six months results of a randomised controlled trial comparing two early supported discharge schemes with treatment as usual. *BMC Neurology*, *14*, 239. doi:10.1186/s12883-014-0239-3
- Holdar, U., Wallin, L., & Heiwe, S. (2013). Why do we do as we do? Factors influencing clinical reasoning and decision-making among physiotherapists in an acute setting. *Physiother Res Int*, *18*(4), 220-229. doi:10.1002/pri.1551
- Hood, C. (1991a). *Administrative argument*. Aldershot: Dartmouth.
- Hood, C. (1991b). A PUBLIC MANAGEMENT FOR ALL SEASONS? *Public Administration*, *69*(1), 3-19. doi:10.1111/j.1467-9299.1991.tb00779.x
- Høyem, A., Gammon, B. D., Berntsen, G. K. R., & Steinsbekk, A. (2018). Policies Make Coherent Care Pathways a Personal Responsibility for Clinicians: A Discourse Analysis of Policy Documents about Coordinators in Hospitals.
- Høyem, A., Gammon, D., Berntsen, G., & Steinsbekk, A. (2018). Keeping one step ahead: A qualitative study among Norwegian health-care providers in hospitals involved in care coordination for patients with complex needs. *International Journal of Care Coordination*, *21*(1-2), 15-25. doi:10.1177/2053434518764643
- Ingebrigtsen, T., Mortensen, K., & Romner, B. (1998). The epidemiology of hospital-referred head injury in northern Norway. *Neuroepidemiology*, *17*(3), 139-146.
- Kaale, H., & Nanna, H. (2002). Fysioterapi under kommunehelsereforma 20 år etter [Physiotherapy during the primary health care reform 20 years later]. *Fysioterapeuten*, *69*(14), 20-24.
- Kim, W., Charchian, B., Chang, E. Y., Liang, L.-J., Dumas, A. J., Perez, M., . . . Kim, H. S. (2013). Strengthening Information Capture in Rehabilitation Discharge Summaries: An Application of the Siebens Domain Management Model. *PM&R*, *5*(3), 182-188. doi:<http://dx.doi.org/10.1016/j.pmrj.2013.01.003>
- Kripalani, S., LeFevre, F., Phillips, C. O., Williams, M. V., Basaviah, P., & Baker, D. W. (2007). Deficits in communication and information transfer between hospital-based and primary care

- physicians: Implications for patient safety and continuity of care. *JAMA*, 297(8), 831-841.  
doi:10.1001/jama.297.8.831
- Langhorne, P., Bernhardt, J., & Kwakkel, G. (2011). Stroke rehabilitation. *The Lancet*, 377(9778), 1693-1702. doi:[http://dx.doi.org/10.1016/S0140-6736\(11\)60325-5](http://dx.doi.org/10.1016/S0140-6736(11)60325-5)
- Lave, J., & Chaiklin, S. (1993). *Understanding Practice : Perspectives on Activity and Context*. Cambridge: Cambridge University Press.
- Lave, J., & Wenger, E. (1991). *Situated learning : legitimate peripheral participation*. Cambridge: Cambridge University Press.
- Laver, K., Lannin, N. A., Bragge, P., Hunter, P., Holland, A. E., Tavender, E., . . . Gruen, R. (2014). Organising health care services for people with an acquired brain injury: an overview of systematic reviews and randomised controlled trials. *BMC Health Services Research*, 14(1), 397. doi:10.1186/1472-6963-14-397
- Lipsky, M. (1980). *Street-level bureaucracy : dilemmas of the individual in public services* (30th anniversary expanded ed.). New York: Russell Sage Foundation.
- Lock, A., & Strong, T. (2010). *Social constructionism : sources and stirrings in theory and practice*. Cambridge: Cambridge University Press.
- Mahoney, J., & Thelen, K. A. (2010a). *Explaining institutional change : ambiguity, agency, and power*. Cambridge New York: Cambridge University Press.
- Mahoney, J., & Thelen, K. A. (2010b). A theory of gradual institutional change. In J. Mahoney & K. A. Thelen (Eds.), *Explaining institutional change: ambiguity, agency, and power*. Cambridge New York: Cambridge University Press.
- Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *The Lancet*, 358(9280), 483-488.
- Malterud, K. (2012). Systematic text condensation: A strategy for qualitative analysis. *Scandinavian Journal of Public Health*, 40(8), 795-805. doi:10.1177/1403494812465030
- Malterud, K. (2016). Theory and interpretation in qualitative studies from general practice: Why and how? *Scand J Public Health*, 44(2), 120-129. doi:10.1177/1403494815621181
- Marcheschi, E., Von Koch, L., Pessah-Rasmussen, H., & Elf, M. (2018). Home setting after stroke, facilitators and barriers: A systematic literature review. 26(4), e451-e459.  
doi:doi:10.1111/hsc.12518
- Mayo, N. E. (2016). Stroke Rehabilitation at Home: Lessons Learned and Ways Forward. *Stroke*, 47(6), 1685-1691. doi:10.1161/strokeaha.116.011309

- Mayo, N. E., Fellows, L. K., Scott, S. C., Cameron, J., & Wood-Dauphinee, S. (2009). A longitudinal view of apathy and its impact after stroke. *Stroke*, *40*(10), 3299-3307.  
doi:10.1161/STROKEAHA.109.554410
- Meese, J., & Rønhovde, L. (2015). Prosjektorganisering som strategi for kunnskapsoverføring og læring i forbindelse med samhandlingsreformen [Project organizing as a strategy for knowledge transfer and learning related to the Care Coordination Reform]. *Nordiske organisasjonsstudier*, *17*(3), 86-108.
- Molander, A. (2013). Profesjonelt skjønn i velferdsstaten : mekanismer for ansvarliggjøring [Professional discretion in the welfare state : Mechanisms of accountability]. In A. Molander & J. C. Smeby (Eds.), *Profesjonsstudier II [Studies on Professions II]* (pp. S. 44-54). Oslo: Universitetsforlaget.
- Molander, A., Grimen, H., & Eriksen, E. O. (2012). Professional Discretion and Accountability in the Welfare State. *Journal of Applied Philosophy*, *29*(3), 214-230. doi:10.1111/j.1468-5930.2012.00564.x
- Molander, A., & Terum, L. I. (2008). *Profesjonsstudier [Studies on Professions]*. Oslo: Universitetsforl.
- Molander, B. (1996). *Kunnskap i handling [Knowledge in Action]* (2. ed.). Göteborg: Daidalos.
- Monkerud, L. C., & Tjerbo, T. (2016). The effects of the Norwegian Coordination Reform on the use of rehabilitation services: panel data analyses of service use, 2010 to 2013. *BMC Health Services Research*, *16*(1), 353. doi:10.1186/s12913-016-1564-6
- Moore, C. M. D., Wisnivesky, J. M. D., Williams, S. M. D., & McGinn, T. M. D. (2003). Medical errors related to discontinuity of care from an inpatient to an outpatient setting. *Journal of General Internal Medicine*, *18*(8), 646-651. doi:<http://dx.doi.org/10.1046/j.1525-1497.2003.20722.x>
- Murphy, R. F. (1990). *The body silent*. New York: Norton.
- Murphy, R. F., Scheer, J., Murphy, Y., & Mack, R. (1988). Physical disability and social liminality: A study in the rituals of adversity. *Soc Sci Med*, *26*(2), 235-242.  
doi:[https://doi.org/10.1016/0277-9536\(88\)90244-4](https://doi.org/10.1016/0277-9536(88)90244-4)
- Måseide, P. (2003). Medical talk and moral order: Social interaction and collaborative clinical work. *Text & Talk - Interdisciplinary Journal for the Study of Discourse*, *23*(3), 369.  
doi:10.1515/text.2003.016
- Måseide, P. (2008). Profesjonar i interaksjonsteoretisk perspektiv [Professions in an interaction theory perspective]. In A. Molander & L. I. Terum (Eds.), *Profesjonsstudier [Studies on professions]*. Oslo: Universitetsforlaget.

- Nalder, E., Fleming, J., Cornwell, P., Shields, C., & Foster, M. (2013). Reflections on life: Experiences of individuals with brain injury during the transition from hospital to home. *Brain Injury, 27*(11), 1294-1303. doi:10.3109/02699052.2013.823560
- Nalette, E. (2010). Constrained physical therapist practice: an ethical case analysis of recommending discharge placement from the acute care setting. *Phys Ther, 90*(6), 939-952. doi:10.2522/ptj.20050399
- Noordegraaf, M. (2007). From "Pure" to "Hybrid" Professionalism: Present-Day Professionalism in Ambiguous Public Domains. *Administration & Society, 39*(6), 761-785. doi:10.1177/0095399707304434
- Noordegraaf, M. (2016). Reconfiguring Professional Work: Changing Forms of Professionalism in Public Services. *Administration & Society, 48*(7), 783-810. doi:10.1177/0095399713509242
- Normann, B., Sorgaard, K. W., Salvesen, R., & Moe, S. (2014). Clinical guidance of community physiotherapists regarding people with MS: professional development and continuity of care. *Physiother Res Int, 19*(1), 25-33. doi:10.1002/pri.1557
- Norwegian Ministry of Health and Care Services. (1999). St.mld nr. 21 (1998-1999) Ansvar og meistring [Report No. 21 (1998-1999) to the Storting. Responsibility and coping]. Retrieved from <https://www.regjeringen.no/no/dokumenter/stmeld-nr-21-1998-99/id431037/sec1>
- Norwegian Ministry of Health and Care Services. (2007). Særtrykk av St.prp.nr.1(2007-2008) kapittel 9: Nasjonal strategi for habilitering og rehabilitering 2008-2011 [Offprint from Proposition nr. 1 (2007-2008) to the Storting: National strategy for habilitation and rehabilitation 2008-2011]. Retrieved from <https://www.regjeringen.no/globalassets/upload/hod/sha/sartrykk-av-st.prp.nr.1-kapittel-9.pdf>
- Norwegian Ministry of Health and Care Services. (2009a). Spørreundersøkelse om fysioterapi i kommunehelsetjenesten [Survey regarding Physiotherapy in the Primary Health Care Services]. Retrieved from <https://www.regjeringen.no/no/dokumenter/sporreundersokelse-om-fysioterapi-i-komm/id547278/?q=rappport%20om%20fysioterapi%20i%20kommunehelsetjenesten>
- Norwegian Ministry of Health and Care Services. (2009b). St.mld nr. 47 (2008-2009) Samhandlingsreformen. Rett behandling - på rett sted - til rett tid [Report No. 47 (2008-2009) to the Storting. The Coordination Reform. Proper treatment - at the right place and right time]. Retrieved from [https://www.regjeringen.no/contentassets/d4f0e16ad32e4bbd8d8ab5c21445a5dc/en-gb/pdfs/stm200820090047000en\\_pdfs.pdf](https://www.regjeringen.no/contentassets/d4f0e16ad32e4bbd8d8ab5c21445a5dc/en-gb/pdfs/stm200820090047000en_pdfs.pdf)



- Norwegian Ministry of Health and Care Services. (2011a). Lov-2011-06-24-30: Lov om kommunale helse og omsorgstjenester [Law-2011-06.24-30: Law on Health and Care Services in the Municipalities].
- Norwegian Ministry of Health and Care Services. (2011b). Nevroplan 2015, Del-plan til Omsorgsplan 2015 [Neuroplan 2015, Sub-plan to Careplan 2015]. Retrieved from <https://www.regjeringen.no/contentassets/cca646be99be45af96eaec07a7739234/nevroplan2015.pdf?id=2291615>
- Norwegian Ministry of Health and Care Services. (2015a). St.mld nr. 26 (2014-2015) Fremtidens primærhelsetjeneste - nærhet og helhet [Report No. 26 (2014-2015) to the Storting. The primary health and care services of tomorrow - localised and integrated]. Retrieved from <https://www.regjeringen.no/no/dokumenter/meld.-st.-26-2014-2015/id2409890/>
- Norwegian Ministry of Health and Care Services. (2015b). St.prp. nr. 1 S HOD (2015-2016): For budsjettåret 2016 [Proposition nr. 1 S (2015-2016) to the Storting: For the Budget year 2016]. Retrieved from <https://www.regjeringen.no/no/dokumenter/prop.-1-s-hod-20152016/id2455520/sec1>
- Norwegian Ministry of Health and Care Services. (2018). Forskrift 10. april 2018 nr. 556 om habilitering og rehabilitering, individuell plan og koordinator [Regulation 10. April 2018 nr. 556 concerning habilitation and rehabilitation, individual plan and coordinator]. Retrieved from [https://lovdata.no/dokument/SF/forskrift/2011-12-16-1256/KAPITTEL\\_2#%C2%A73](https://lovdata.no/dokument/SF/forskrift/2011-12-16-1256/KAPITTEL_2#%C2%A73)
- Office of the Auditor General of Norway. (2016). Riksrevisjonens undersøkelse av ressursutnyttelse og kvalitet i helsetjenesten etter innføringen av samhandlingsreformen [The Office of the Auditor General's investigation of resource utilisation and quality in the health service following the introduction of the Coordination Reform]. Retrieved from <https://www.riksrevisjonen.no/en/Reports/Pages/CoordinationReform.aspx>
- Olofsson, A., Andersson, S. O., & Carlberg, B. (2005). 'If only I manage to get home I'll get better'- Interviews with stroke patients after emergency stay in hospital on their experiences and needs. *Clin Rehabil*, 19(4), 433-440. doi:10.1191/0269215505cr788oa
- Orvik, A. (2004). *Organisatorisk kompetanse : i sykepleie og helsefaglig samarbeid [Organizational competence : in nursing and health professional cooperation]*. Oslo: Cappelen akademisk forl.
- Orvik, A., & Axelsson, R. (2012). Organizational health in health organizations: towards a conceptualization. *Scand J Caring Sci*, 26(4), 796-802. doi:10.1111/j.1471-6712.2012.00996.x
- Paterson, B., Kieloch, B., & Gmiterek, J. (2001). 'They Never Told Us Anything': Postdischarge Instruction for Families of Persons with Brain Injuries. 26(2), 48-53. doi:doi:10.1002/j.2048-7940.2001.tb01925.x

- Paulgaard, G. (1997). Feltarbeid i egen kultur : innenfra, utefra eller begge deler? [Field work in own culture : from within, from outside or both?]. In G. Paulgaard (Ed.), *Metodisk feltarbeid* (pp. s. 70-93). Oslo: Universitetsforlaget.
- Piccenna, L., Lannin, N. A., Gruen, R., Pattuwage, L., & Bragge, P. (2016). The experience of discharge for patients with an acquired brain injury from the inpatient to the community setting: A qualitative review. *Brain Injury, 30*(3), 241-251. doi:10.3109/02699052.2015.1113569
- Polanyi, M. (1962). *Personal knowledge : towards a post-critical philosophy* (Corr. ed. ed.). Chicago London: The University of Chicago Routledge & Kegan Paul.
- Polit, D. F., & Beck, C. T. (2008). *Nursing research : generating and assessing evidence for nursing practice* (8. ed.). Philadelphia, Pa.: Wolters Kluwer/Lippincott Williams & Wilkins.
- Purtilo, R. B., & Doherty, R. (2016). *Ethical Dimensions in the Health Professions* (6 ed.). Missouri: Elsevier.
- Rasmussen, R. S., Østergaard, A., Kjær, P., Skerris, A., Skou, C., Christoffersen, J., . . . Overgaard, K. (2016). Stroke rehabilitation at home before and after discharge reduced disability and improved quality of life: A randomised controlled trial. *Clin Rehabil.* doi:10.1177/0269215515575165
- Reed, M. I. (1996). Expert Power and Control in Late Modernity: An Empirical Review and Theoretical Synthesis. In (Vol. 17, pp. 573-597). Thousand Oaks, CA.
- Reynolds, F. (2005). *Communication and clinical effectiveness in rehabilitation*. Edinburgh ; New York: Elsevier/Butterworth-Heinemann.
- Rittman, M., Faircloth, C., Boylstein, C., Gubrium, J. F., Williams, C., Van Puymbroeck, M., & Ellis, C. (2004). The experience of time in the transition from hospital to home following stroke. *Journal of rehabilitation research and development, 41*(3A), 259. doi:10.1682/JRRD.2003.06.0099
- Rollnik, J. D., & Janosch, U. (2010). Current Trends in the Length of Stay in Neurological Early Rehabilitation. *Deutsches Ärzteblatt International, 107*(16), 286-292. doi:10.3238/arztebl.2010.0286
- Rutland-Brown, W., Langlois, J. A., Thomas, K. E., & Xi, Y. L. (2006). Incidence of Traumatic Brain Injury in the United States, 2003. *Journal of Head Trauma Rehabilitation, 21*(6), 544-548.
- Røsstad, T., Garåsen, H., Steinsbekk, A., Sletvold, O., & Grimsmo, A. (2013). Development of a patient centred care pathway across health care providers: a qualitative study. *13*(1). doi:10.1186/1472-6963-13-121
- Savage, J. (2000). Ethnography and health care. *BMJ, 321*(7273), 1400-1402.

- Schütz, A., & Luckmann, T. (1974). *The structures of the life-world*. London: Heinemann.
- Schön, D. A. (1991). *The reflective practitioner : how professionals think in action*. Aldershot: Avebury.
- Scottish Intercollegiate Guidelines Network (SIGN). (2013). Brain injury rehabilitation in adults. Retrieved from <http://www.sign.ac.uk/pdf/sign130.pdf>
- Siemonsma, P., Döpp, C., Alpay, L., Tak, E., Meeteren, N. v., & Chorus, A. (2014). Determinants influencing the implementation of home-based stroke rehabilitation: a systematic review. *Disability and Rehabilitation*, 36(24), 2019-2030. doi:doi:10.3109/09638288.2014.885091
- Smith, M., Higgs, J., & Ellis, E. (2007). Physiotherapy decision making in acute cardiorespiratory care is influenced by factors related to physiotherapist and the nature and context of the decision: a qualitative study. *Aust J Physiother*, 53(4), 261-267.
- Sollid, S., Sundstrøm, T., Kock-Jensen, C., Juul, N., Eskesen, V., Bellander, B.-M., . . . Romner, B. (2008). Skandinaviske retningslinjer for prehospital håndtering av alvorlige hodeskader [Scandinavian guidelines for pre-hospital management of serious head injuries]. *Tidsskr Nor Laegeforen*(128), 1524-1527.
- Solvang, P. K., Hanisch, H., & Reinhardt, J. D. (2016). The rehabilitation research matrix: producing knowledge at micro, meso, and macro levels. *Disability and Rehabilitation*, 1-7. doi:10.1080/09638288.2016.1212115
- Steel, D., & Cylus, J. (2012). United Kingdom (Scotland): Health system review. *Health Systems in Transition*, 14(9), 1-150.
- Stig, K., & Lütz, I. P. (2013). *Financing of Health Care in the Nordic Countries*. Retrieved from <https://norden.diva-portal.org/smash/get/diva2:968753/FULLTEXT01.pdf>
- Sundstrøm, T., Sollid, S., Wentzel-Larsen, T., & Wester, K. (2007). Head Injury Mortality in the Nordic Countries. *Journal of Neurotrauma*, 24(1), 147-153. doi:10.1089/neu.2006.0099
- Tagliaferri, F., Compagnone, C., Korsic, M., Servadei, F., & Kraus, J. (2006). A systematic review of brain injury epidemiology in Europe. *Acta Neurochirurgica*, 148(3), 255-268. doi:10.1007/s00701-005-0651-y
- Tamm, M. (1999). What does a home mean and when does it cease to be a home? Home as a setting for rehabilitation and care. *Disabil Rehabil*, 21(2), 49-55.
- The National Statistical Institute of Norway. (2012). Referat KOSTRA arbeidsgruppemøte mai 2012 [Report KOSTRA workgroupmeeting may 2012]. Retrieved from [https://www.ssb.no/offentlig-sektor/kommune-stat-rapportering/\\_attachment/228841?ts=14d7b4d0250](https://www.ssb.no/offentlig-sektor/kommune-stat-rapportering/_attachment/228841?ts=14d7b4d0250)
- The Norwegian Directorate of Health. (2017). Hjerneslag - pakkeforløp (Fase 1) - Pakkeforløp for behandling og rehabilitering ved hjerneslag [Stroke - Standardized Care Pathway (Phase 1) -

- Standardized Care Pathway for Treatment and Rehabilitation following Stroke]. Retrieved from <https://helsedirektoratet.no/retningslinjer/hjerneslag-pakkeforlop-fase-1>
- The Norwegian Directorate of Health. (2018). Rehabilitering, habilitering, individuell plan og koordinator - Veileder om rehabilitering, habilitering, individuell plan og koordinator IS-2651 [Rehabilitation, Habilitation, Individual Plan and Coordinator - Guidelines for Rehabilitation, Habilitation, Individual Plan and Coordinator IS-2651]. Retrieved from <https://helsedirektoratet.no/retningslinjer/rehabilitering-habilitering-individuell-plan-og-koordinator>
- The Norwegian Directorate of Health. (2019). Hjerneslag - pakkeforløp (fase 2 - rehabilitering og oppfølging) - Pakkeforløp for behandling og rehabilitering ved hjerneslag (Høringsutkast) [Stroke - Standardized Care Pathway (Phase 2 - rehabilitation and follow-up) - Standardized Care Pathway for Treatment and Rehabilitation following Stroke (Consultation draft)] Retrieved from <https://helsedirektoratet.no/horinger/hjerneslag-pakkeforlop-fase-2-rehabilitering-og-oppfolging>
- The Norwegian Physiotherapy Association. (2012). Hva er fysioterapi "What is physiotherapy". Retrieved from <http://www.fysio.no/FAG/Hva-er-fysioterapi>
- The Research Council of Norway. (2016). *Evaluering av samhandlingsreformen - Sluttrapport fra styringsgruppen for forskningsbasert følgeevaluering av samhandlingsreformen (EVASAM)* [Evaluation of The Coordination Reform - Final Report from The Steering Group for Formative Dialogue Research of The Coordination Reform (EVASAM)]. Retrieved from Oslo:
- Thornquist, E. (2007). Fysioterapeuters journaler - En sykehusundersøkelse [Physiotherapy journals - A hospital survey]. *Fysioterapeuten*(3), 19-24.
- Thornquist, E. (2014). Fysioterapeutene - Fra kosmologi til fagpolitikk [The Physiotherapists - From Cosmology to Academic Politics]. In R. Slagstad & J. Messel (Eds.), *Profesjonshistorier [Profession stories]*. Oslo: Pax forlag.
- Tjora, A. H. (2017). *Kvalitative forskningsmetoder i praksis [Qualitative research methods in practice]* (3. ed.). Oslo: Gyldendal akademisk.
- Truelsen, T., Piechowski-Jóźwiak, B., Bonita, R., Mathers, C., Bogousslavsky, J., & Boysen, G. (2006). Stroke incidence and prevalence in Europe: A review of available data. *European Journal of Neurology*, 13(6), 581-598. doi:10.1111/j.1468-1331.2006.01138.x
- Turner, B. J., Fleming, J. M., Ownsworth, T. L., & Cornwell, P. L. (2008). The transition from hospital to home for individuals with acquired brain injury: A literature review and research

- recommendations. *Disability and Rehabilitation*, 30(16), 1153-1176.  
doi:10.1080/09638280701532854
- Turner, V. W. (1995). *The ritual process : structure and anti-structure*. New York: Aldine de Gruyter.
- Undén, J., Ingebrigtsen, T., & Romner, B. (2013). Scandinavian guidelines for initial management of minimal, mild and moderate head injuries in adults: an evidence and consensus-based update. *BMC Medicine*, 11(1), 50. doi:10.1186/1741-7015-11-50
- Unsworth, C. (1996). Clients' perceptions of discharge housing decisions after stroke rehabilitation. *The American journal of occupational therapy : official publication of the American Occupational Therapy Association*, 50(3), 207. doi:10.5014/ajot.50.3.207
- Vabo, S. I., & Vabø, M. (2014). *Velferdens organisering [The organization of welfare]*. Oslo: Universitetsforl.
- Vabø, M. (2011). Changing governance, changing needs interpretations: implications for universalism. *International Journal of Sociology and Social Policy*, 31(3/4), 197-208. doi:10.1108/01443331111120618
- Vabø, M. (2012). Norwegian home care in transition – heading for accountability, off - loading responsibilities. *Health & social care in the community*, 20(3), 283-291. doi:10.1111/j.1365-2524.2012.01058.x
- Vabø, M. (2014a). Dilemmaer i velferdens organisering [Dilemmas in the organization of welfare]. In S. I. Vabo & M. Vabø (Eds.), *Velferdens organisering [The organization of welfare]* (pp. 11-28). Oslo: Universitetsforlaget.
- Vabø, M. (2014b). Reformtrender og endringsparadokser [Reform trends and change paradoxes]. In S. I. Vabo & M. Vabø (Eds.), *Velferdens organisering [The organization of welfare]* (pp. 62-78). Oslo: Universitetsforlaget.
- Veerbeek, J. M., van Wegen, E., van Peppen, R., van der Wees, P. J., Hendriks, E., Rietberg, M., & Kwakkel, G. (2014). What is the evidence for physical therapy poststroke? A systematic review and meta-analysis. *PLoS One*, 9(2), e87987. doi:10.1371/journal.pone.0087987
- Vike, H. (2004). *Velferd uten grenser : den norske velferdsstaten ved veiskillet [Welfare without boundaries: The Norwegian welfare state at a crossroad]*. Oslo: Akribe.
- Vrangbæk, K., & Sørensen, L. M. (2013). Does municipal co-financing reduce hospitalisation rates in Denmark? *Scandinavian Journal of Public Health*, 41(6), 616-622. doi:10.1177/1403494813484553
- Wenger-Trayner, E., & Wenger-Trayner, B. (2015). Learning in a landscape of practice: A framework. In E. Wenger-Trayner, M. Fenton-O'Creevy, S. Hutchinson, C. Kubiak, & B. Wenger-Trayner

- (Eds.), *Learning in landscapes of practice: boundaries, identity, and knowledgeability in practice-based learning* (pp. 13-30). Oxfordshire, England  
New York: Routledge. Retrieved from <https://www.taylorfrancis.com/books/e/9781317692539>.
- Wenger, E. (1998). *Communities of practice : learning, meaning, and identity*. Cambridge: Cambridge University Press.
- Wenger, E. (2000). Communities of Practice and Social Learning Systems. *Organization*, 7(2), 225-246. doi:10.1177/135050840072002
- Whyte, E., Skidmore, E., Aizenstein, H., Ricker, J., & Butters, M. (2011). Cognitive Impairment in Acquired Brain Injury: A Predictor of Rehabilitation Outcomes and an Opportunity for Novel Interventions. *PM&R*, 3(6, Supplement), S45-S51.  
doi:<https://doi.org/10.1016/j.pmrj.2011.05.007>
- Whyte, J. (2014). Contributions of Treatment Theory and Enablement Theory to Rehabilitation Research and Practice. *Arch Phys Med Rehabil*, 95(1, Supplement), S17-S23.e12.  
doi:<https://doi.org/10.1016/j.apmr.2013.02.029>
- Whyte, J., & Barrett, A. M. (2012). Advancing the Evidence Base of Rehabilitation Treatments: A Developmental Approach. *Arch Phys Med Rehabil*, 93(8, Supplement), S101-S110.  
doi:<https://doi.org/10.1016/j.apmr.2011.11.040>
- World Health Organization. (2011). World Report on Disability 2011. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK304079/>
- World Medical Association. (2013). WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects. Retrieved from <http://www.wma.net/en/30publications/10policies/b3/>
- Wottrich, A. W., von Koch, L., Tham, K., & Jensen, G. M. (2007). The meaning of rehabilitation in the home environment after acute stroke from the perspective of a multiprofessional team.(Research Report). *Physical Therapy*, 87(6), 778. doi:10.2522/ptj.20060152
- Young, R. A., & Collin, A. (2004). Introduction: Constructivism and social constructionism in the career field. *Journal of Vocational Behavior*, 64(3), 373-388.  
doi:<http://dx.doi.org/10.1016/j.jvb.2003.12.005>

## Article 1

Irgens, EI, Henriksen N & Moe S (2016): *Acquired brain injury rehabilitation: dilemmas in neurological physiotherapy across healthcare settings*. European Journal of Physiotherapy, DOI: 10.1080/21679169.2016.1181206

## Article 2

Irgens, EI, Henriksen N & Moe S (2018): *Variations in physiotherapy practice in neurological rehabilitation trajectories – an explorative interview and observational study*. *Physiotherapy Theory and Practice*, DOI: 10.1080/09593985.2018.1480679



## Article 3

Eirik Lind Irgens, Nils Henriksen & Siri Moe (2018): Communicating information and professional knowledge in acquired brain injury rehabilitation trajectories – a qualitative study of physiotherapy practice, *Disability and Rehabilitation*, DOI: [10.1080/09638288.2018.1544295](https://doi.org/10.1080/09638288.2018.1544295)

## **Appendices**

1. Informational letter hospital authorities
2. Informed consent physiotherapist in specialist health care
3. Informed consent patients
4. Informational letter municipal authorities
5. Informed consent physiotherapist in primary health care
6. Interview guide specialist health care
7. Interview guide primary health care
8. Observational guide
9. Approval from the Norwegian Social Science Data Services, NSD
10. Response from the Regional Committee for Medical and Health Research Ethics (REK)



## Forespørsel om deltakelse i forskningsprosjektet

### ”Behandlingskjeden fra spesialist- til kommunehelsetjenesten: Fysioterapitjenester til pasienter med nevrologiske lidelser”

#### Bakgrunn og hensikt

Dette er et spørsmål til deres avdeling om å delta i en forskningsstudie for å se nærmere på behandlingsskjeden for personer med nevrologiske lidelser som trenger rehabilitering etter akutt funksjonstap. Studien utføres som et ledd i et doktorgradsarbeid ved Institutt for helse- og omsorgsfag ved det helsevitenskapelige fakultetet på Universitetet i Tromsø. Det er Universitetet i Tromsø som er ansvarlig for denne studien.

Studien har som målsetting å se på fysioterapitjenestens involvering og oppfølging i rehabilitering av pasienter med nevrologiske lidelser fra spesialisthelsetjenesten til kommunehelsetjenesten. Den har som mål å fremskaffe kunnskap om overføring, koordinering og oppfølging av fysioterapitjenestene som en del av det totale rehabiliteringstilbudet. Som følge av ny helselovgivning har krav og rammebetingelser for rehabilitering av nevrologiske pasienter endret seg. Studien vil vektlegge konsekvensene dette har for kunnskapsoverføring og rammebetingelser for oppfølging i det enkelte pasientforløp. Studien kan bidra til å gi kunnskap om tilrettelegging av tjenester for å gi best mulig behandlingstilbud til denne pasientgruppen.

Deres avdeling er sentral i rehabilitering av nevrologiske pasienter, og det er ønskelig å få tilgang til å forespørre fysioterapeutene i avdelingen om å delta i studien. Alle aktuelle fysioterapeuter vil få eget informasjons- og samtykkeskriv, og det er frivillig å delta i studien.

#### Hva innebærer studien?

For å fremskaffe denne kunnskapen er det ønskelig å gjennomføre et intervju med oppfølgende fysioterapeut for å få innsikt i hvordan overføring av kunnskap og koordinering av tjenester foregår på tvers av helsetjenestenivå. Det er også ønskelig å observere og ta opp på video fysioterapibehandling av den aktuelle pasienten før utskrivelse fra sykehuset. I forbindelse med gjennomføringen av prosjektet vil fysioterapeuten bli bedt om å hente ut epikrise, fysioterapirapport og eventuelt tverrfaglig rapport som er utarbeidet i forbindelse med behandlingen. Det kan bli aktuelt å delta som observatør på samarbeidsmøter vedrørende det aktuelle rehabiliteringsforløpet. Det forutsettes at pasienten har samtykket på eget skriv. Alle personopplysninger vil anonymiseres under bearbeidelse av materialet.

Prosjektet er tilrådd av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste (NSD).

#### Mulige fordeler og ulemper

Det vil ikke være nødvendig med ekstra forberedelser eller merarbeid for fysioterapeutene i forbindelse med deltagelse i studien foruten identifisering av nevrologiske pasienter med rehabiliteringspotensiale, gjennomføring av intervju og doktorgradsstudentens tilstedeværelse under behandlingstimen. Det er ønskelig at en tredjeperson i avdelingen, som ikke har direkte behandlingsansvar for pasienten, kan påta seg oppgaven med å viderefremme informasjon om studien muntlig og skriftlig (eget informasjons- og samtykkeskriv) til den aktuelle pasienten.



### **Hva skjer med informasjonen fra studien?**

Informasjonen som framkommer skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennerende opplysninger. Video-opptakene vil bli oppbevart nedlåst under arbeidet med doktorgradsprosjektet, og vil bli slettet etter at prosjektet er avsluttet, innen utgangen av 2016. Filmen vil kun bli brukt som hjelp til å beskrive det som skjer i behandlingen i relasjon til den øvrige oppfølgingen, og ingen bilder eller videofilm vil bli brukt i presentasjonen av resultatene i oppgaven.

I løpet av arbeidet med oppgaven kan videoen bli vist til veilederne i doktorgradsprosjektet. Alle som er involvert i prosjektet har taushetsplikt.

Det vil ikke være mulig å identifisere deltakerne i resultatene av studien når disse publiseres.

### **Frivillig deltakelse**

Det er frivillig å delta i studien. Deltakerne kan når som helst og uten å oppgi noen grunn trekke sitt samtykke til å delta i studien. Dersom de senere ønsker å trekke seg eller har spørsmål til studien, kan de kontakte doktorgradsstudent Eirik Lind Irgens på telefonnummer 90 89 53 32 eller på e-post [eirik.l.irgens@uit.no](mailto:eirik.l.irgens@uit.no). De kan også kontakte hovedveileder, førsteamanuensis Siri Moe ved Institutt for helse- og omsorgsfag på Universitetet i Tromsø på telefonnummer 776 45265 eller på e-post [siri.moe@uit.no](mailto:siri.moe@uit.no).

### **Rett til innsyn og sletting av opplysninger**

Deltakerne har rett til å få innsyn i hvilke opplysninger som er registrert om dem, og har videre rett til å få korrigert eventuelle feil vi har registrert. Dersom deltakerne ønsker å trekke seg fra studien, kan de kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.



Forespørsel til fysioterapeut  
i spesialisthelsetjenesten

## Forespørsel om deltakelse i forskningsprosjektet

### ”Behandlingskjeden fra spesialist- til kommunehelsetjenesten: Fysioterapitjenester til pasienter med nevrologiske lidelser”

#### **Bakgrunn og hensikt**

Dette er et spørsmål til deg om å delta i en forskningsstudie for å se nærmere på behandlingsskjeden for personer med nevrologiske lidelser som trenger rehabilitering etter akutt funksjonstap. Studien utføres som et ledd i et doktorgradsarbeid ved Institutt for helse- og omsorgsfag ved det helsevitenskapelige fakultetet på Universitetet i Tromsø. Det er Universitetet i Tromsø som er ansvarlig for denne studien.

Du er valgt ut til å forespørres om å delta i studien fordi du er oppfølgende fysioterapeut for en pasient som har behov for rehabilitering etter akutt funksjonstap.

Studien har som målsetting å se på fysioterapitjenestens involvering og oppfølging i rehabilitering av pasienter med nevrologiske lidelser fra spesialisthelsetjenesten til kommunehelsetjenesten. Den har som mål å fremskaffe kunnskap om overføring, koordinering og oppfølging av fysioterapitjenestene som en del av det totale rehabiliteringstilbudet. Som følge av ny helselovgivning har krav og rammebetingelser for rehabilitering av nevrologiske pasienter endret seg. Studien vil vektlegge konsekvensene dette har for kunnskapsoverføring og rammebetingelser for oppfølging i det enkelte pasientforløp. Studien kan bidra til å gi kunnskap om tilrettelegging av tjenester for å gi best mulig behandlingstilbud til denne pasientgruppen.

#### **Hva innebærer studien?**

For å fremskaffe denne kunnskapen er det ønskelig å gjennomføre et intervju med deg for å få innsikt i hvordan overføring av kunnskap og koordinering av tjenester foregår på tvers av helsetjenestenivå. Det er også ønskelig å observere og ta opp på video fysioterapibehandling for utskrivelse fra sykehuset. Doktorgradsstudenten kommer til å bevege seg noe rundt i rommet under videobservasjonen, men vil så langt det er mulig unngå å forstyrre dere. I forbindelse med gjennomføringen av prosjektet vil du bli bedt om å hente ut epikrise, fysioterapirapport og eventuelt tverrfaglig rapport som er utarbeidet i forbindelse med behandlingen. Det kan bli aktuelt å delta som observatør på samarbeidsmøter vedrørende det aktuelle rehabiliteringsforløpet. Alle personopplysninger vil anonymiseres under bearbeidelse av materialet.

Prosjektet er tilrådd av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste (NSD).

#### **Mulige fordeler og ulemper**

Det vil ikke være nødvendig med ekstra forberedelser eller merarbeid i forbindelse med deltagelse i studien, og det er ikke forventet at studien vil medføre noen ekstra belastning for deg, foruten gjennomføring av intervju og doktorgradsstudentens tilstedeværelse under behandlingstimen.



### **Hva skjer med informasjonen om deg?**

Informasjonen som framkommer skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjenner opplysninger. Video-opptakene vil bli oppbevart nedlåst under arbeidet med doktorgradsprosjektet, og vil bli slettet etter at prosjektet er avsluttet innen utgangen av 2016. Filmen vil kun bli brukt som hjelp til å beskrive det som skjer i behandlingen i relasjon til den øvrige oppfølgingen, og ingen bilder eller videofilm vil bli brukt i presentasjonen av resultatene i oppgaven.

I løpet av arbeidet med oppgaven kan videoen bli vist til veilederne i doktorgradsprosjektet. Alle som er involvert i prosjektet har taushetsplikt.

Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

### **Frivillig deltakelse**

Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dersom du ønsker å delta, undertegner du samtykkeerklæringen nederst på siden. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke uten at det påvirker din øvrige behandling. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte doktorgradsstudent Eirik Lind Irgens på telefonnummer 90 89 53 32 eller på e-post [eirik.l.irgens@uit.no](mailto:eirik.l.irgens@uit.no). Du kan også kontakte hovedveileder, førsteamanuensis Siri Moe ved Institutt for helse- og omsorgsfag på Universitetet i Tromsø på telefonnummer 776 45265 eller på e-post [siri.moe@uit.no](mailto:siri.moe@uit.no).

### **Retten til innsyn og sletting av opplysninger om deg**

Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigeret eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

## **Samtykke til deltakelse i studien**

Jeg har mottatt skriftlig informasjon og er villig til å delta i studien

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(Signert av prosjektdeltaker, dato)



## Forespørsel om deltakelse i forskningsprosjektet

### ”Behandlingskjeden fra spesialist- til kommunehelsetjenesten: Fysioterapitjenester til pasienter med nevrologiske lidelser”

#### **Bakgrunn og hensikt**

Dette er et spørsmål til deg om å delta i en forskningsstudie for å se nærmere på behandlingsskjeden for personer med nevrologiske lidelser som trenger rehabilitering etter akutt funksjonstap. Studien utføres som et ledd i et doktorgradsarbeid ved Institutt for helse- og omsorgsfag ved det helsevitenskapelige fakultetet på Universitetet i Tromsø. Det er Universitetet i Tromsø som er ansvarlig for denne studien.

Du er valgt ut til å forespørres om å delta i studien fordi du er innlagt på sykehus for rehabilitering etter akutt funksjonstap. Din identitet er ukjent helt til du eventuelt samtykker i å delta i denne studien ved å returnere samtykkeerklæringen.

Studien har som målsetting å se på fysioterapitjenestens involvering og oppfølging i din rehabilitering fra spesialisthelsetjenesten til kommunehelsetjenesten. Den har som mål å fremskaffe kunnskap om overføring, koordinering og oppfølging av fysioterapitjenestene som en del av det totale rehabiliteringstilbudet. Som følge av ny helselovgivning har krav og rammebetingelser for rehabilitering av nevrologiske pasienter endret seg. Studien vil vektlegge konsekvensene dette har for kunnskapsoverføring og rammebetingelser for oppfølging i det enkelte pasientforløp. Studien kan bidra til å gi kunnskap om tilrettelegging av tjenester for å gi best mulig behandlingstilbud til denne pasientgruppen.

#### **Hva innebærer studien?**

For å fremskaffe denne kunnskapen er det ønskelig å observere og ta opp på video en fysioterapibehandling på sykehus og når du er skrevet ut til hjemkommunen. Behandlingen vil ikke skille seg ut fra den som normalt gis, men doktorgradsstudenten vil være til stede i rommet for å filme fra behandlingen begynner og til den avsluttes. Doktorgradsstudenten kommer til å bevege seg noe rundt i rommet i løpet av behandlingstimen, men vil så langt det er mulig unngå å forstyrre dere. I forbindelse med gjennomføringen av prosjektet vil fysioterapeuten på sykehuset bli bedt om å hente ut epikrise, fysioterapirapport og eventuelt tverrfaglig rapport som er utarbeidet i forbindelse med behandlingen. Øvrig informasjon fra journalene vil ikke være tilgjengelig for de som gjennomfører studien. Fysioterapeutene vil bli intervjuet, og det kan bli aktuelt å delta som observatør på samarbeidsmøter vedrørende rehabiliteringsforløpet. Personopplysninger vil anonymiseres under bearbeidelse av materialet.

Prosjektet er tilrådd av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste (NSD).

#### **Mulige fordeler og ulemper**

Det vil ikke gjennomføres ekstra undersøkelser i forbindelse med deltagelse i studien, og det er ikke forventet at studien vil medføre noen ekstra belastning for deg, foruten at doktorgradsstudenten vil være tilstede under behandlingen for å videofilme det som skjer.



### **Hva skjer med informasjonen om deg?**

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennerende opplysninger. Videoopptak og journalopplysninger vil bli oppbevart nedlåst under arbeidet med doktorgradsprosjektet, og vil bli slettet etter at prosjektet er avsluttet innen utgangen av 2016. Filmen vil kun bli brukt som hjelp til å beskrive det som skjer i behandlingen, og ingen bilder eller videofilm vil bli brukt i presentasjonen av resultatene i oppgaven.

I løpet av arbeidet med prosjektet kan videoen bli vist til veilederne i doktorgradsprosjektet. Alle som er involvert i gjennomføringen av studien har taushetsplikt.

Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

### **Frivillig deltakelse**

Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dette vil ikke få konsekvenser for din videre behandling. Dersom du ønsker å delta, undertegner du samtykkeerklæringen nederst på siden. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke uten at det påvirker din øvrige behandling. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du ta kontakt med doktorgradsstudent Eirik Lind Irgens på telefonnummer 90 89 53 32 eller på e-post [eirik.lirgens@uit.no](mailto:eirik.lirgens@uit.no). Du kan også kontakte hovedveileder, førsteamanuensis Siri Moe ved Institutt for helse- og omsorgsfag på Universitetet i Tromsø på telefonnummer 776 45265 eller på e-post [siri.moe@uit.no](mailto:siri.moe@uit.no).

### **Retten til innsyn og sletting av opplysninger om deg**

Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigeret eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

## **Samtykke til deltakelse i studien**

Jeg har mottatt skriftlig informasjon og er villig til å delta i studien. Videre samtykker jeg til at taushetsplikten til behandlende fysioterapeut oppheves ved bruk av intervju og innhenting av relevante journalopplysninger skrevet i forbindelse med aktuell behandling.

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(Signert av prosjektdeltaker, dato)





## Forespørsel om deltakelse i forskningsprosjektet

### ”Behandlingskjeden fra spesialist- til kommunehelsetjenesten: Fysioterapitjenester til pasienter med nevrologiske lidelser”

#### Bakgrunn og hensikt

Dette er et spørsmål til deres enhet/avdeling om å delta i en forskningsstudie for å se nærmere på behandlingsskjeden for personer med nevrologiske lidelser som trenger rehabilitering etter akutt funksjonstap. Studien utføres som et ledd i et doktorgradsarbeid ved Institutt for helse- og omsorgsfag ved det helsevitenskapelige fakultetet på Universitetet i Tromsø. Det er Universitetet i Tromsø som er ansvarlig for denne studien.

Studien har som målsetting å se på fysioterapitjenestens involvering og oppfølging i rehabilitering av pasienter med nevrologiske lidelser fra spesialisthelsetjenesten til kommunehelsetjenesten. Den har som mål å fremskaffe kunnskap om overføring, koordinering og oppfølging av fysioterapitjenestene som en del av det totale rehabiliteringstilbudet. Som følge av ny helselovgivning har krav og rammebetingelser for rehabilitering av nevrologiske pasienter endret seg. Studien vil vektlegge konsekvensene dette har for kunnskapsoverføring og rammebetingelser for oppfølging i det enkelte pasientforløp. Studien kan bidra til å gi kunnskap om tilrettelegging av tjenester for å gi best mulig behandlingstilbud til denne pasientgruppen.

Deres enhet/avdeling er sentral i rehabilitering av nevrologiske pasienter, og det er ønskelig å få tilgang til å forespørre fysioterapeutene i avdelingen om å delta i studien. Alle aktuelle fysioterapeuter vil få eget informasjons- og samtykkeskriv, og det er frivillig å delta i studien.

#### Hva innebærer studien?

For å fremskaffe denne kunnskapen er det ønskelig å gjennomføre et intervju med oppfølgende fysioterapeut for å få innsikt i hvordan overføring av kunnskap og koordinering av tjenester foregår på tvers av helsetjenestenivå. Det er også ønskelig å observere og ta opp på video fysioterapibehandling av den aktuelle pasienten etter utskrivelse til hjemkommunen. Det kan bli aktuelt å delta som observatør på samarbeidsmøter vedrørende det aktuelle rehabiliteringsforløpet. Pasienten og behandlende fysioterapeut i spesialisthelsetjenesten har allerede samtykket til å delta i studien i løpet av rehabiliteringsoppholdet i spesialisthelsetjenesten. Alle personopplysninger vil anonymiseres under bearbeidelse av materialet.

Prosjektet er tilrådd av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste (NSD).

#### Mulige fordeler og ulemper

Det vil ikke være nødvendig med ekstra forberedelser eller merarbeid for fysioterapeutene i forbindelse med deltagelse i studien foruten gjennomføring av intervju og doktorgradsstudentens tilstedeværelse under behandlingstimen.



Forespørsel til enhet/avdeling

### **Hva skjer med informasjonen fra studien?**

Informasjonen som framkommer skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Video-opptakene vil bli oppbevart nedlåst under arbeidet med doktorgradsprosjektet, og vil bli slettet etter at prosjektet er avsluttet, innen utgangen av 2016. Filmen vil kun bli brukt som hjelp til å beskrive det som skjer i behandlingen i relasjon til den øvrige oppfølgingen, og ingen bilder eller videofilm vil bli brukt i presentasjonen av resultatene i oppgaven.

I løpet av arbeidet med oppgaven kan videoen bli vist til veilederne i doktorgradsprosjektet. Alle som er involvert i prosjektet har taushetsplikt.

Det vil ikke være mulig å identifisere deltakerne i resultatene av studien når disse publiseres.

### **Frivillig deltakelse**

Det er frivillig å delta i studien. Deltakerne kan når som helst og uten å oppgi noen grunn trekke sitt samtykke til å delta i studien. Dersom de senere ønsker å trekke seg eller har spørsmål til studien, kan de kontakte doktorgradsstudent Eirik Lind Irgens på telefonnummer 90 89 53 32 eller på e-post [eirik.l.irgens@uit.no](mailto:eirik.l.irgens@uit.no). De kan også kontakte hovedveileder, førsteamanuensis Siri Moe ved Institutt for helse- og omsorgsfag på Universitetet i Tromsø på telefonnummer 776 45265 eller på e-post [siri.moe@uit.no](mailto:siri.moe@uit.no).

### **Rett til innsyn og sletting av opplysninger**

Deltakerne har rett til å få innsyn i hvilke opplysninger som er registrert om dem, og har videre rett til å få korrigert eventuelle feil vi har registrert. Dersom deltakerne ønsker å trekke seg fra studien, kan de kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.



Forespørsel til fysioterapeut  
i kommunehelsetjenesten

## Forespørsel om deltakelse i forskningsprosjektet

### ”Behandlingskjeden fra spesialist- til kommunehelsetjenesten: Fysioterapitjenester til pasienter med nevrologiske lidelser”

#### **Bakgrunn og hensikt**

Dette er et spørsmål til deg om å delta i en forskningsstudie for å se nærmere på behandlingskjeden for personer med nevrologiske lidelser som trenger rehabilitering etter akutt funksjonstap. Studien utføres som et ledd i et doktorgradsarbeid ved Institutt for helse- og omsorgsfag ved det helsevitenskapelige fakultetet på Universitetet i Tromsø. Det er Universitetet i Tromsø som er ansvarlig for denne studien.

Du er valgt ut til å forespørres om å delta i studien fordi du er oppfølgende fysioterapeut for en pasient som har behov for rehabilitering etter akutt funksjonstap. Pasienten og behandlende fysioterapeut i spesialisthelsetjenesten har allerede samtykket til å delta i studien i løpet av sitt rehabiliteringsopphold i spesialisthelsetjenesten.

Studien har som målsetting å se på fysioterapitjenestens involvering og oppfølging i rehabilitering av pasienter med nevrologiske lidelser fra spesialisthelsetjenesten til kommunehelsetjenesten. Den har som mål å fremskaffe kunnskap om overføring, koordinering og oppfølging av fysioterapitjenestene som en del av det totale rehabiliteringstilbudet. Som følge av ny helselovgivning har krav og rammebetingelser for rehabilitering av nevrologiske pasienter endret seg. Studien vil vektlegge konsekvensene dette har for kunnskapsoverføring og rammebetingelser for oppfølging i det enkelte pasientforløp. Studien kan bidra til å gi kunnskap om tilrettelegging av tjenester for å gi best mulig behandlingstilbud til denne pasientgruppen.

#### **Hva innebærer studien?**

For å fremskaffe denne kunnskapen er det ønskelig å gjennomføre intervju med deg, fortrinnsvis like etter utskrivelse og etter ca. 3 måneder, for å få innsikt i hvordan overføring av kunnskap og koordinering av tjenester foregår på tvers av helsetjenestenivå. Det er også ønskelig å observere og ta opp på video fysioterapibehandling i hjemkommunen. Doktorgradsstudenten kommer til å bevege seg noe rundt i rommet under videobservasjonen, men vil så langt det er mulig unngå å forstyrre dere. Det kan bli aktuelt å delta som observatør på samarbeidsmøter vedrørende det aktuelle rehabiliteringsforløpet. Alle personopplysninger vil anonymiseres under bearbeidelse av materialet.

Prosjektet er tilrådd av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste (NSD).

#### **Mulige fordeler og ulemper**

Det vil ikke være nødvendig med ekstra forberedelser eller merarbeid i forbindelse med deltagelse i studien, og det er ikke forventet at studien vil medføre noen ekstra belastning for deg, foruten gjennomføring av intervju og doktorgradsstudentens tilstedeværelse under behandlingstimen.



### **Hva skjer med informasjonen om deg?**

Informasjonen som framkommer skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjenner opplysninger. Video-opptakene vil bli oppbevart nedlåst under arbeidet med doktorgradsprosjektet, og vil bli slettet etter at prosjektet er avsluttet innen utgangen av 2016. Filmen vil kun bli brukt som hjelp til å beskrive det som skjer i behandlingen i relasjon til den øvrige oppfølgingen, og ingen bilder eller videofilm vil bli brukt i presentasjonen av resultatene i oppgaven.

I løpet av arbeidet med prosjektet kan videoen bli vist til veilederne i doktorgradsprosjektet. Alle som er involvert i prosjektet har taushetsplikt.

Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

### **Frivillig deltakelse**

Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dersom du ønsker å delta, undertegner du samtykkeerklæringen nederst på siden. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke uten at det påvirker din øvrige behandling. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte doktorgradsstudent Eirik Lind Irgens på telefonnummer 90 89 53 32 eller på e-post [eirik.l.irgens@uit.no](mailto:eirik.l.irgens@uit.no). Du kan også kontakte hovedveileder, førsteamanuensis Siri Moe ved Institutt for helse- og omsorgsfag på Universitetet i Tromsø på telefonnummer 776 45265 eller på e-post [siri.moe@uit.no](mailto:siri.moe@uit.no).

### **Retten til innsyn og sletting av opplysninger om deg**

Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigeret eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

## **Samtykke til deltakelse i studien**

Jeg har mottatt skriftlig informasjon og er villig til å delta i studien

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(Signert av prosjektdeltaker, dato)

## Appendix 6

### Intervjuguide, fysioterapeut i Spesialisthelsetjenesten

Innledende samtale om formålet med intervjuet

**Tema og spørsmål i intervjuguiden relateres til den spesifikke pasienten og det konkrete behandlingsforløpet som fysioterapeuten er involvert i.**

Fysioterapeutens bakgrunn	<ul style="list-style-type: none"><li>- Alder</li><li>- Utdanning</li><li>- Videreutdanning og kurs</li><li>- Praksisprofil i egen jobb, fordeling av pasienter</li></ul>
Rammevilkår for fagutøvelse	<ul style="list-style-type: none"><li>- Ressurser</li><li>- Lokaler</li><li>- Tid</li><li>- Behandlingsform/-muligheter</li><li>- Hva er positivt</li><li>- Hva er negativt</li><li>- Hva kunne vært gjort annerledes eller bedre</li></ul>
Samarbeid	<ul style="list-style-type: none"><li>- Andre fysioterapeuter</li><li>- Andre faggrupper</li><li>- Samhandlingsarenaer</li><li>- Kommunikasjonskanaler</li><li>- Informasjonsflyt</li></ul>
Egen rolle i rehabilitering	<ul style="list-style-type: none"><li>- Fysioterapeutens oppgaver</li><li>- Muligheter til å oppfylle forventninger fra pasienter, pårørende, kommunehelsetjenesten, andre faggrupper/samarbeidspartnere</li><li>- Endringer i roller og ansvar</li></ul>
Kunnskapsoverføring	<ul style="list-style-type: none"><li>- Hvem får du informasjon fra</li><li>- Hva får du informasjon om</li><li>- Hva mangler av informasjon</li><li>- Hva er din rolle i kunnskapsoverføring på tvers av helsetjenestenivå, til fysioterapeut, til andre fagutøvere, pårørende osv.</li></ul>
Prioriteringer	<ul style="list-style-type: none"><li>- Hva er høyt prioritert</li><li>- Må noe prioriteres ned – hva</li><li>- Hvem gjør prioriteringene</li><li>- Kunne det vært gjort annerledes</li></ul>
Ansvar og oppgaver innen ulike helsetjenestenivå	<ul style="list-style-type: none"><li>- Hva er tillagt spesialisthelsetjenesten</li><li>- Hva er tillagt kommunehelsetjenesten</li><li>- Har dette endret seg</li><li>- Hvilke konsekvenser har evt endringer hatt</li><li>- Kunnskapsnivå</li></ul>
Videre oppfølging	<ul style="list-style-type: none"><li>- Hva er viktig</li><li>- Forventninger til videre oppfølging</li><li>- Muligheter for videre oppfølging</li><li>- Fremmende og begrensende faktorer</li></ul>

## Appendix 7

## Intervjuguide, fysioterapeut i Kommunehelsetjenesten

Innledende samtale om formålet med intervjuet

**Tema og spørsmål i intervjuguiden relateres til den spesifikke pasienten og det konkrete behandlingsforløpet som fysioterapeuten er involvert i.**

Fysioterapeutens bakgrunn	<ul style="list-style-type: none"><li>- Alder</li><li>- Utdanning</li><li>- Videreutdanning og kurs</li><li>- Praksisprofil i egen jobb, fordeling av pasienter</li></ul>
Rammevilkår for fagutøvelse	<ul style="list-style-type: none"><li>- Ressurser</li><li>- Lokaler</li><li>- Tid</li><li>- Behandlingsform/-muligheter</li><li>- Hva er positivt</li><li>- Hva er negativt</li><li>- Hva kunne vært gjort annerledes eller bedre</li></ul>
Samarbeid	<ul style="list-style-type: none"><li>- Andre fysioterapeuter</li><li>- Andre faggrupper</li><li>- Samhandlingsarenaer</li><li>- Kommunikasjonskanaler</li><li>- Informasjonsflyt</li></ul>
Egen rolle i rehabilitering	<ul style="list-style-type: none"><li>- Fysioterapeutens oppgaver</li><li>- Muligheter til å oppfylle forventninger fra pasienter, pårørende, spesialisthelsetjenesten, andre faggrupper/samarbeidspartnere</li><li>- Endringer i roller og ansvar</li></ul>
Kunnskapsoverføring	<ul style="list-style-type: none"><li>- Hvem får du informasjon fra</li><li>- Hva får du informasjon om</li><li>- Hva mangler av informasjon</li><li>- Hva er din rolle i kunnskapsoverføring på tvers av helsetjenestenivå, til fysioterapeut, til andre fagutøvere, pårørende osv.</li></ul>
Prioriteringer	<ul style="list-style-type: none"><li>- Hva er høyt prioritert</li><li>- Må noe prioriteres ned – hva</li><li>- Hvem gjør prioriteringene</li><li>- Kunne det vært gjort annerledes</li></ul>
Ansvar og oppgaver innen ulike helsetjenestenivå	<ul style="list-style-type: none"><li>- Hva er tillagt spesialisthelsetjenesten</li><li>- Hva er tillagt kommunehelsetjenesten</li><li>- Har dette endret seg</li><li>- Hvilke konsekvenser har evt endringer hatt</li><li>- Kunnskapsnivå</li></ul>
Videre oppfølging	<ul style="list-style-type: none"><li>- Hva er viktig</li><li>- Forventninger til videre oppfølging</li><li>- Muligheter for videre oppfølging</li><li>- Fremmende og begrensende faktorer</li></ul>

### Observasjonsguide

Hensikten er å observere og beskrive behandlingsforløpet i forhold til miljø, oppgave(r) og deltakere.

<b>Kontekst</b>
<ul style="list-style-type: none"><li>- Hvordan er utformingen av rommet</li><li>- Hvem er til stede</li><li>- Belysning</li><li>- Kontraster</li><li>- Hvordan plasseres benker, utstyr, stoler etc.</li></ul>
<b>Tiltak</b>
<ul style="list-style-type: none"><li>- Utgangsstilling til pasienten</li><li>- Utgangsstilling fysioterapeut og synspedagog i forhold til pasienten</li><li>- Tidsbruk</li><li>- Tempo</li><li>- Bruk av hender</li><li>- Bruk av utstyr</li><li>- Samtale og stillhet</li><li>- Verbal og non-verbal instruksjon</li><li>- Rolle fysioterapeut</li><li>- Rolle synspedagog</li></ul>
<b>Aktivitet og endringer hos pasienten</b>
<ul style="list-style-type: none"><li>- Bruk av blick / blikkorientering</li><li>- Øye- og hodebevegelser</li><li>- Vektoverføringer</li><li>- Observerbar aktivitet/bevegelse</li><li>- Endring i verbale uttrykk og kroppslige uttrykk</li></ul>



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MH-bygget  
9037 TROMSØ

Vår dato: 26.10.2012

Vår ref: 31867 / 3 / MSI

Deres dato:

Deres ref:

## TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 18.10.2012. All nødvendig informasjon om prosjektet forelå i sin helhet 24.10.2012. Meldingen gjelder prosjektet:

31867 *Behandlingskjeden fra spesialist til kommunehelsetjenesten: Fysioterapitjenester til pasienter med nevrologiske lidelser*  
Behandlingsansvarlig *Universitetet i Tromsø, ved institusjonens overste leder*  
Daglig ansvarlig *Eirik Lind Irgens*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

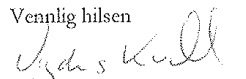
Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.


Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, [http://www.nsd.uib.no/personvern/forsk\\_stud/skjema.html](http://www.nsd.uib.no/personvern/forsk_stud/skjema.html). Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 31.12.2016, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

  
Vigdis Namtvedt Kvalheim

  
Marte Sivertsen

Kontaktperson: Marte Sivertsen tlf: 55 58 33 48  
Vedlegg: Prosjektvurdering



## Personvernombudet for forskning



### Prosjektvurdering - Kommentar

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Prosjektnr: 31867

Formålet er å se på fysioterapitjenestens involvering og oppfølging i rehabilitering av pasienter med nevrologiske lidelser fra spesialisthelsetjenesten til kommunehelsetjenesten. Utvalget vil bestå av ca. 20 fysioterapeuter og ca. 10 pasienter.

Personvernombudet forutsetter at taushetsplikten ikke er til hinder for den behandling av opplysninger som finner sted, og at det ikke innhentes personopplysninger om pasienter/brukere uten at samtykke foreligger.

Ifølge prosjektmeldingen skal det innhentes skriftlig samtykke basert på muntlig og skriftlig informasjon om prosjektet og behandling av personopplysninger. Personvernombudet finner informasjonsskrivene tilfredsstillende utformet i henhold til personopplysningslovens vilkår.

Data samles inn gjennom intervju og videoobservasjon, samt fra journal. Det vil i prosjektet bli registrert sensitive personopplysninger om helseforhold, jf. personopplysningsloven § 2 nr. 8 c).

Personvernombudet legger til grunn at behandlingen av personopplysninger er i samsvar med Universitetet i Tromsø sine rutiner for informasjonssikkerhet. Vi anbefaler at koblingsnøkkelen lagres adskilt fra det øvrige materialet.

Ingen enkeltpersoner vil gjenkjennes i publikasjoner.

Prosjektet skal avsluttes 31.12.2016 og innsamlende opplysninger skal da anonymiseres, og lyd- og video-opptak slettes. Anonymisering innebærer at direkte personidentifiserende opplysninger som navn/koblingsnøkkel slettes, og at indirekte personidentifiserende opplysninger (sammenstilling av bakgrunnsopplysninger som f.eks. yrke, alder, kjønn) fjernes eller grovkategoriseres slik at ingen enkeltpersoner kan gjenkjennes i materialet.



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<b>Region:</b> REK nord	<b>Saksbehandler:</b> Øyvind Strømseth	<b>Telefon:</b> 77620753	<b>Vår dato:</b> 22.10.2012	<b>Vår referanse:</b> 2012/1813/REK nord
			<b>Deres dato:</b> 18.10.2012	<b>Deres referanse:</b>

Vår referanse må oppgis ved alle henvendelser

Siri Moe  
Institutt for helse og omsorgsfag, Det helsevitenskapelige fakultet, MH bygget

Vi viser til forespørsel om framleggingsplikt for prosjektet **Behandlingstjenesten fra spesialist- til kommunehelsetjenesten. Fysioterapitjenester til pasienter med nevrologiske lidelser** av 18.10.2012.

For at et prosjekt skal være framleggingspliktig gjelder følgende:

De prosjekt som skal fremlegges for komiteen er prosjekt som dreier seg om "medisinsk og helsefaglig forskning på mennesker, humant biologisk materiale eller helseopplysninger", jf. § 2. "Medisinsk og helsefaglig forskning" er i § 4 a) definert som "virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom". Det er altså *formålet* med studien som avgjør om et prosjekt skal anses som framleggelsespliktig for REK eller ikke.

Prosjektet er etter vurdering fra REK ikke egnet til å fremskaffe ny kunnskap om helse og sykdom, men fokuserer på samhandling og samarbeid innen mellom ulike helsetjenestenivå.

Prosjektet skal således ikke vurderes etter helseforskningsloven.

Vi ber om at alle henvendelser sendes inn via vår saksportal: <http://helseforskning.etikkom.no> eller på e-post til: [post@helseforskning.etikkom.no](mailto:post@helseforskning.etikkom.no)

Vennligst oppgi vårt referansenummer i korrespondansen.

Med vennlig hilsen

May Britt Rossvoll  
sekretariatsleder

Øyvind Strømseth  
seniorrådgiver

**Kopi til:**

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**Besøksadresse:**  
MH-bygget Universitetet i  
Tromsø 9037 Tromsø

**Telefon:** 77646140  
**E-post:** rek-nord@asp.uit.no  
**Web:** <http://helseforskning.etikkom.no/>

All post og e-post som inngår i  
saksbehandlingen, bes adressert til  
REK nord og ikke til enkelte  
personer

Kindly address all mail and e-mails  
to the Regional Ethics Committee,  
REK nord, not to individual staff