

# Juridification of Health Care

The Act on Patients' Rights and Clinical Judgment

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Anna Stephansen (Banasiak)

Thesis for the Degree of Philosophiae Doctor (PhD)  
University of Bergen, Norway  
2018

UNIVERSITY OF BERGEN



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*Anna Stephansen (Banasiak)*

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## **Abstract**

This thesis explores how the patients' right to information and participation (the RTIP) is interpreted by the Norwegian Directorate of Health, and how the corresponding legal regulations and clinical practice are assessed by clinical practitioners. The process of regulation through the RTIP is called juridification. Through case study research design, I explore the characteristics of written recommendatory guidelines for clinical practice and their influence on the clinicians' assessments in the field of psychiatry. The intention of this work is to provide insights into how the regulation through the RTIP has affected the process of informing patients and involving them in treatment.

I choose the institutional approach as the guiding theoretical framework for this study and assume that clinical reasoning may to some extent be the outcome of either pragmatic considerations, consequence-oriented action, or rule-following. Furthermore, using the clinicians' subjective understandings as a starting point for the analysis, I assume that they are active, interpretative and creative actors making autonomous judgments which may not always follow the specific legislative regulations or accepted professional conventions.

I define three dimensions in the context of this study - legislative, organizational and professional - focusing on their explanatory potential with regard to clinical action. The legislative dimension comprises the legislative regulations, while the organizational dimension includes the hierarchy and organization of work. The professional dimension covers clinical experience, education, professional specializations and general clinical norms.

This study is based on two sources of empirical data. The first is the RTIP itself as it is described by the law, alongside its interpretations in the guidelines. The characteristics of the guidelines provide a basis for the analysis of the clinicians' assessments, obtained from the interviews with the clinicians. These interviews are presented in the main empirical part of the thesis and constitute the second source of the empirical data.

This study has shown that the combination of the three analytical dimensions mentioned above provide a more extensive, although not exhaustive, explanation of the findings than each of the dimensions separately. Certain properties of the dimensions, such as the wording of regulations, the length of experience of the practitioners, and the ways their work is organized, are analyzed in various combinations, called constellations, in the final part of the thesis in order to synthesize the findings. The constellations capture both the relatively clear tendencies in the clinicians' assessments, as well as those outcomes of the regulations that may be seen as ambiguous or unclear.

I find that juridification is a highly complex and diverse process. The guidelines are neither consequent nor in agreement with each other. These extensive variations make it reasonable to suggest that ambiguity is the main characteristic of the regulations. On one hand, this leaves much room for interpretation, which, in its turn, makes the achievement of the legislator's goals rather challenging. On the other hand, ambiguous regulations may result in a wide range of flexible practices.

Specifically, this study suggests that local practices, organization of work, and



hierarchical relations influence the outcomes of regulations and clinical reasoning. Collegial decision-making seems to have a unifying effect on the team participants. The professionals who work alone seem to hold perceptions that could differ and sometimes contrast strongly with the understandings of specialists working in teams. Furthermore, the leaders' understandings may differ significantly from non-leaders. Local practices tend to influence the clinicians' preferences with regard to, for example, specific methods of treatment, such as medical or therapy-based procedures. These preferences seem to affect the way clinicians interpret the regulations. The differences in the profession between psychologists and psychiatrists have, on the contrary, not necessarily been shown to affect the clinicians' assessments, for a variety of reasons. The study has also shown that the longer the experience, the stronger is the influence of clinicians' own authority and judgment upon their practice, rather than that of the written rules and recommendations for best practice. It is reasonable to suggest that experienced practitioners can keep the large degree of their discretionary power in spite of legal changes. Furthermore, institutionalization of clinical norms in legislative regulations may to some extent contribute to the discretionary evaluations embedded in the clinical autonomy. Clinicians with little experience tend to reject traditional thinking and follow the legal goals.

The case of this study shows that weak procedural rights may both enlarge and limit the patients' possibilities to influence their treatment, depending on the clinical context. The regulations are followed differently, with some patients being allowed to decide upon their treatment while others are expected to accept the standard offer with much less possibility to participate in the choice of treatments.

This work has shown that it is possible to influence clinical practice through legislative regulations. The outcomes of such influence, however, may vary and seem to differ from clear to more ambiguous ones.

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## Terminology employed in this work

Term	A short explanation	Chapter(s) providing a detailed explanation
The APR	The Act on Patients' Rights. The law adopted by the Norwegian Parliament in 2001.	1.2; 2.5
The RTIP	The Right to Information and Participation. Regulated by the APR.	1.2; 2.6
Legislator's goals with the RTIP	Legal goals include increased possibilities to self-determinate and gain information as well as influence decisions regarding patients' own treatment.	1.4
Clinical norms/professional norms	Traditional ways of thinking institutionalized in clinical practice.	Chapter 2
Juridification	Regulation of clinical practice through RTIP.	Chapter 2
Co-determination	Involvement of the weaker part in decisions about treatment by the stronger part.	Chapter 3
Self-determination	Individual choices about one's own health	Chapter 3
Subject anomaly perspective	Refers to any situation where the decisions are made by the practitioners alone.	Chapter 3
Subject perspective	The process of decision-making between the two equal subjects.	Chapter 3
Ambiguity	Captures unclear outcomes of the regulations.	Chapter 7

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# 1. Introduction

## 1.1 Regulation through individual rights

This thesis explores how Norwegian clinical practitioners and health care authorities assess and interpret individual rights. It provides an analysis of how and why certain clinical practices and legislative regulations are developed. The Right to Information and Participation (the RTIP) was introduced in 1999 as part of the Act on Patients' Rights (the APR). It was the first time that the legislators in Norway have regulated the aspects of information and participation in treatment in the form of an individual right. As part of its implementation, the RTIP has to be interpreted within various institutions. Such interpretations may lead to a variety of understandings, which may have different implications for clinical practice.

I set out to study how the RTIP is interpreted in recommendatory guidelines for clinical practice and how clinicians assess their practice framed by these guidelines and by the RTIP. The intention with this work is to provide insights into how the regulation through the RTIP has affected the process of informing the patients (the right to information) and involving them in decisions about treatment (the right to participation).

Actors subjected to legislation may find themselves at an intersection of various rules, which may influence the interpretations of the law differently. Such developments may have implications for clinical judgment. These developments may be viewed as part of the democratic process, as they could stimulate new opportunities

for formerly disempowered individuals. The change in the balance between law and professional practice in favor of the former has become a subject of studies exploring the phenomenon. In academic discussions, it has earned the specific title of “juridification” (Aasen et al. 2014; Magnussen & Nilssen 2015).

Scholars mostly agree that the relationship between law and professional practice in Norway has changed and that current social development is characterized by juridification (Aasen et al. 2014; Magnussen & Nilssen 2015).

This work explores the implications of juridification, in this study understood as regulation through the RTIP, in the provision of health services. Juridification is a notion that has been given slightly different meanings in different contexts; it has no clear-cut, unequivocal definition. Generally, juridification is understood to be the tendency towards expanded and more detailed legal regulations, legal regulation of new areas, the spread of actions guided by legal rules or increasing expectations of lawful conduct in any, especially a public, setting (Blichner & Molander 2006; Blichner & Molander 2008). The “actors” involved in the process of juridification may be governments, legislators, administrations, the judiciary, professional experts, and others, including individuals as well as institutional and corporate organs (Blichner & Molander 2006; Blichner & Molander 2008).

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## 1.2 The expansion of legal regulations in the form of rights within health care

The expansion of individual rights in the area of health care is relatively new for Norway<sup>1</sup>. Various parts of the health care legislation embrace a wide range of institutional obligations, professional obligations, and individual rights (Aasen et al. 2014). The expansion of these rights began with the introduction of the APR. This expansion has been in accordance with the international developments in the last century. In the European Union, in particular, the institution of human rights stimulates development in the area of individual autonomy.

Rights may be regarded as fundamental resources that allow us to make well-informed and conscious choices (Knudsen & Rothstein 1994). The legal regulation of information and self-determination in health care is one example of regulation using rights as an expression of social support to counteract discretionary powers. Individual rights may be an important tool for expanding the patients' possibilities to self-determine<sup>2</sup> in treatment. They also may influence professional decisions that should be based on clinical reliability. Individual rights may also contribute to increased trust between users and service providers by limiting differences in the distribution of services (Magnussen & Banasiak 2013). It could potentially increase predictability and strengthen the transparency of discretionary reasoning. The enforcement of the right

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<sup>1</sup> The judicial revolution of rights began in the United States, where the debate on the possible implications of the battle between group or individual interests on society has progressed further than in Norway (Østerud 2000; Hirschl 2004).

<sup>2</sup> Self-determination is associated with the general principle of autonomy and is defined as the respect for individual choices and autonomous decisions. It is one of the core principles of the Norwegian health care system stated by the Norwegian government and parliament (Storting 2007).

according to the legislators' goals would lead to increasing the patients' autonomy in the choice of treatment.

Regulation through rights might gradually reduce the space in which the questions concerning patients' self-determination could be debated. As a consequence, the individual's motivation to participate in collective actions might decrease. One example would be the patients increasingly seeking individual problem-solving strategies to influence their situation (Lundeberg 2008), instead of being motivated to involve themselves in patients' interest groups (Janoski 1998) or to participate in hospital councils where collective decision-making takes place. Furthermore, the legal enforcement of rights might also reduce the space in which clinical discretion is practiced, which could lead to an increased consideration of any legal obligations. For example, this enforcement could result in more time being devoted to the requirements for transparency rather than to the choice of treatment methodology, or in more attention given to the patients' role in decision-making. As a consequence, patients may be given a larger responsibility for deciding upon the course of their treatment, which could lead to a shift from traditional clinical obligations towards an increased focus on the patients' own possibilities to shape the outcome of their treatment.

Legal enforcement of self-determination through individual rights may depend on individual capacity as well as on the administration of the rights in clinical practice. The latter is explored in this work and implicates discretionary powers as an important factor in the process of implementation of these rights.

In general, the Norwegian health care sector may be characterized by significant changes that have taken place during the last 15 to 20 years with the introduction of a more comprehensive level of legal regulation than before. This includes the national and international regulation of health care services, comprising the regulation of health service organizations, clinical practices, professionals, and patients. There has been an increasing tendency for the legal regulations to become more detailed in their specification of health standards and to change the patients' status from passive recipients to active, self-aware, and self-responsible subjects of treatment (Skålevåg 2005; Nilssen & Kildal 2009).

Strengthening an active approach to treatment has been associated with the idea of information and participation, as well as self-help strategies in treatment. The APR and the RTIP, as explored in this thesis, are an example of the active approach. When the APR was adopted, it covered a broad package of rights. The APR was partly a simplification and consolidation of already existing legislation and partly an implementation of new rights (Magnussen & Nilssen 2015). The objective of the APR was to give the population equal access to high quality health care by granting patient rights in their relations with the health service and to promote health services based on a respect for human dignity and the fair distribution of rights and duties (St. Meld. nr. 25 (1996–97); Ot.prp.nr. 12, 1999).

### 1.3 The right to information and participation as the legal basis for clinical practice in psychiatry

The principle of self-determination is the core of patients' rights in Norway (Aasen 2000). The particular right to information and participation, further called the RTIP, is defined in the APR. It outlines professional obligations and individual rights and constitutes clinical practice in the area of information and participation. The RTIP addresses the asymmetrical relationship between the patient and the professional. During treatment, the patient depends on the knowledge, skills, and support of others. The aim of the RTIP is to ensure that health professionals treat patients with "respect" and "dignity," as described in §3 of the APR:

*The patient is entitled to **participate** in the implementation of his medical treatment. This includes the patient's right to choose between available and medically sound methods of examination and treatment. The form of participation shall be adjusted according to the individual patient's ability to give and receive information. (The Act of 2 July 1999, No. 63)*

There is an agreement regarding the fact that the rights introduced in the APR are weak due to the low precision used in specifying how informing the patients and their participation are to take place in practice (Syse 2009). The RTIP may cause disagreement in its interpretations (Kjønstad 2007). On one hand, it entitles patients to information and to participation in the choice of treatment, while on the other hand it limits this choice to prudent and available methods of treatment. Evaluation of these criteria is a matter of professional discretionary judgment. Furthermore, the RTIP

allows discretion in information delivery by stating the obligation to adjust the information to the capabilities of individual patients to receive it. This suggests that the RTIP builds upon the consideration of individual autonomy and self-determination, as well as professional reliability and discretion.

I explore how the Directorate of Health and clinical specialists interpret the appropriate application of the RTIP in the specific organizational context of DPC<sup>3</sup>. I also focus on the balance between the legal goals of increased patient involvement and well-informed self-determination, and on the professional background including profession, clinical norms and experience. I ask the open question of how the Directorate of Health interprets what is the best clinical practice in the area of informing and involving patients. Furthermore, I explore the practitioners' assessments of how the practice in these areas is performed.

I chose a specific area of clinical practice, psychiatry, as the case of juridification to explore. There are several reasons for choosing this field. First of all, it has had a long history of holistic approaches to treatment, often based on the assumption that psychiatric patients are not capable of making decisions about their treatment and need to be protected (Rynning & Hartlev 2012; Skålevåg 2005; Hofmann 2007). Thus, traditional practices may be a barrier for enforcing the logic of patients' rights. This

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<sup>3</sup> DPC (district psychiatry center) is quite a new way to organize specialist health care services in the field of psychiatry. The centers are placed between hospitals and municipalities. The primary functions of DPCs include follow-up and rehabilitation of people with chronic conditions as well as stabilization of acute conditions and serious diagnosis. Patients are supposed to receive health help at the centers before being referred to the hospitals.



field has also been characterized by a shortage of information given in treatment (Jensen & Froestad 1988; Meland 2007). Furthermore, it has been shown that psychiatric patients are seldom satisfied with either the information they receive or the possibilities for real participation (Ruud 2006, p. 5). A number of studies has concluded that cases where the patients' autonomy was overpowered and they were provided with little to no information regarding their condition or treatment have occurred in psychiatric treatment even after the RTIP came into force (Blesvik et al. 2006; Norvoll 2006; Hillestad 2008). These reports may suggest that the practice may to a large extent be dominated by a traditional, paternalistic approach to treatment. Furthermore, psychiatric patients have not been on equal footing with somatic patients with regard to individual rights for a long time (see section 2.3). All in all, it is possible that the RTIP and the values it promotes may be largely different from the paternalistic approach to treatment in psychiatry (Skålevåg 2005). Justification of the choice of the case study in this work is further presented in chapter 3.

Finally, the scarcity of knowledge about the practice of legal regulations in voluntary psychiatry also served as a motivation for this study.

#### **1.4 Juridification as regulation through the RTIP in clinical practice**

The starting point of this study was that juridification is at work in various parts of Norwegian society, including clinical practice (Aasen et al. 2011; Aasen et al. 2014). I assumed that an expansion of power through the RTIP has taken place in Norway and

influences individual action. Among others, this process concerns the relationship between citizens and public administration employees with treatment expertise.

Traditionally, the legal regulation of health services has been characterized by broad object clauses and legal standards that have determined societal objectives and the general principles of the regulation with regard to access to information in health care and participation in the development of services. Since 2001, this regulation has gradually become more individualistic and right-oriented. At the same time, health service is more professionalized, leaving more space for professional decision-making and discretion. This aspect of the regulation may lead to a variety of implications, ranging from increased transparency of services delivered by professionals to bound professional discretion or reinforced paternalistic control over vulnerable groups who might benefit to a lesser or larger extent from formal and concise rather than vague and discretionary rights (Aasen et al. 2014, p. 3).

An important aspect of this development is the connection between clinical discretion and the expansion of regulation through the RTIP. Reaching legal goals behind the RTIP in health care and treatment is among others dependent on the clinical administration of it in practice. Clinicians have long hoped to gain control of certain lines of work, such as in the form of what has been called “jurisdiction” (Abbott 1988) or “self-regulation” (Johnson 1972). Hence, the welfare state and regulations of health services through the RTIP form a strong potential foundation for administrative and clinical power. This solid foundation may oppose the idea of self-determination and well-informed consent in treatment, since it may imply other kinds of reasoning based on, for example, compliance.

It has been argued that clinical practitioners in the welfare state have had a meaningful influence on the development of laws. The development of legal regulations has often been left to experts (Magnussen & Nilssen 2015). Hence, the regulations in the area regarding informing and involving patients in practice may themselves be based on professional compliance, as well as the legislators' goal of autonomous influence from the recipient of the health services (Stang Dahl 1994).

Furthermore, if the RTIP is seen as being formulated in a general and abstract manner, it may leave more space for substantial discretion and may thus cause extensive variations in practice. The implications of juridification in this context would then be that the RTIP is determined and administered by the clinical practitioners with a large degree of freedom. At the same time, specific regulation through the RTIP may reduce the scope for discretion and therefore bind the ability to base decisions on sound clinical judgment.

The question of which evaluations should be made by specialists and which ones may be influenced by the recipients of health services is critical in the debate regarding the balance between discretion and its regulation by the authorities. Discussions regarding an expansion or a limitation of societal control of discretionary power tend to be triggered by issues of equality or quality of provided services (Aasen et al. 2014, p. 149). Clinicians have been given a mandate to apply discretionary power in their practice in accordance with the society's best interest (Aasen et al. 2014, p. 149). Thus, social trust is a critical argument in support of clinical judgment in service provision. Furthermore, based on the logic of clinical reasoning, only the clinician may make an

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intuitive judgment based on the overall profile of individual patients (Schwartz & Griffin 2012).

### **1.5 The purpose of the study**

The overall focus of this work is on the relationship between clinical practice and its regulation by the RTIP. The question posed here is as follows: how may regulations of the RTIP influence clinical practice? All of the following detailed discussion in this work was conducted in an attempt to find an answer to the research question. In order to answer it, I address the specific setting of mental health services in DPCs where the process of regulation through the RTIP takes place.

I explore how the RTIP is understood within the particular context of institutionalized adherence to professional expertise.<sup>4</sup> To appreciate the outcome of juridification, the general characteristics of the explored regulations are discussed, as they describe the setting in which health care is provided.

Law and its interpretations may have different forms and may be general or specific. The smaller the possibility of free interpretation left to those who administer these regulations, the more specific they are. Regulations<sup>5</sup> that are worded in a vague

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<sup>4</sup> For a broader discussion of juridification and various dimensions of social and political life, see Aasen et al. 2014.

<sup>5</sup> At this point regulations may comprise both law and its interpretations.

way may be denoted as general. They require the consideration of contextual factors during their practice.

There is a relationship between the precision of regulations and the space of the individual judgment left up to clinical practitioners. The more specific the regulations, the less free room the practitioners have when they are applied. Regulations may be expressed as rights, obligations, and recommendations; rights and obligations restrict the room for action more than recommendations. There is a corresponding relationship between patient rights and professional obligations. The stronger the rights expressed, the stronger the corresponding obligations of the health providers (Magnussen & Nilssen 2015).

Guidelines for practice may be an example of regulations that aim at standardizing practices using a set of predefined understandings of best practice, despite the necessity to consider the individual characteristics of health care recipients in practice. Guidelines, including standard recommendations for what information to provide and prescriptions of how to involve the recipients of services, can be seen as an example of regulations that are embedded in the tension between standardization and individual adjustment. Legislative regulations may be built on the assumption that standardization and individual judgment are critical to clinical practice. Specifying the obligation of information delivery by defining its precise content may represent an attempt to implement the right to information. This right exemplifies the expectation to standardize practice to the point when it is beneficial to individual patients. Guidelines introducing the standardized expectations of clinical practices bind

discretionary powers, while those that allow individual adjustment may encourage discretion.

The general objective of legal regulations through the RTIP is to increase patients' participation in making decisions about their treatment and to expand the information background for such decisions. These goals may be understood in clinical practice in various ways. This study aims at capturing various understandings of the RTIP in the clinical practice.

## **1.6 State of the art**

### ***1.6.1 Juridification and individual rights***

In recent years, there has been a wide debate among social scientists (legal scholars, sociologists, and political scientists) about various forms of juridification processes in different fields and their possible consequences (Fimreite 2003; Østerud et al. 2003; Blichner & Molander 2006; Blichner & Molander 2008; Feiring & Nese 2005; Lundeberg 2008; Hatland & Nilsen 2009; Magnussen & Banasiak 2013; Aasen et al. 2014). There have been various approaches to grasping the phenomenon of juridification, and different forms of it have been studied, resulting in a certain lack of coherency in the existing body of knowledge. Furthermore, even though the phenomenon and the extent of juridification and its consequences have been the subject of public debate and scholarly work both in Norway and abroad, the discussions have been mainly dominated by theoretical arguments and ideological positions.

One important debate has particularly focused on juridification within the framework of the welfare state. Various possible consequences of increased exercise for individual legal rights in welfare policy are of particular interest. For instance, a number of scholars have argued that individual rights may enable political action and individual autonomy (Lundeberg 2008; Magnussen & Nilssen 2015).

From a Scandinavian perspective, more extensive studies in this area have been carried out in Sweden than in Norway (Gustafsson 2002). The dimensions explored empirically with regard to the implications of juridification in Norway include the relationship between juridification and local democracy (e.g., Baldersheim 1997; Fimreite 2003), juridification and the practice of courts (e.g., Olsen 2000; Gloppen 2003; Ohnstad 2003), juridification and users (e.g., Kjellevold 2006; Rosén et al. 2001; Næss 2003), juridification and service providers (e.g., Bjørngaard 2000; Carlsen & Norheim 2003; Næss 2003).

Thus, the existing empirical studies comprise different approaches, conceptualizations, contexts, and areas of juridification processes. The following examples appear to be the more significant ones in the context of this study.

In the area of judicialization, Gargarella (2014) explored the increasing role of international courts. He argued that powerful actors tend to dominate democratic processes (Gargarella 2014). He further showed that the court challenges the possibility to contest violations of rights by disadvantaged social groups (Gargarella 2014).<sup>6</sup>

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<sup>6</sup> Similar conclusions have been reached by Fallberg (2000) and Lundeberg (2008).

Magnussen (2006) investigated how the Norwegian Supreme Court creates and applies the rules. She argued that the Supreme Court projects the image of being a stable and robust institution, while at the same time appearing as a flexible system of decision-making (Magnussen 2006). Hers is a study of how and why legal reasoning is established and developed, based on the case of the rule of strict liability. Bothfeld and Kremer (2014) focus on reflexive labor laws in Germany and show that decentralization of decision-making creates space for participation and democratic legitimacy of resulting regulations.

It has been studied how the proceduralization of welfare state law affects the democratic dimension of social citizenship (Aasen et al. 2014). According to these studies, equal opportunity and a democratic change of traditional welfare provision are unlikely to occur in the field of welfare, which is dominated by considerations other than clients' influence (Aasen et al. 2014). Magnussen and Brandt (2014) came to a similar conclusion concerning the increase of professional discretion. They analyzed the right to health care in Norway and found that the legal construction of the right to necessary health care seems to enhance the professional scope of discretion rather than strengthen the individuals' position against the welfare state.

Ferraz et al. (2014) investigated the democratic implications of judicialization in a Latin American context. The authors argue that judges reject *a priori* arguments related to costs of treatment when faced with individual patients (Ferraz et al. 2014). Another study that explored the courts' decisions in the Netherlands and in Norway found that in many cases, legal professionals failed to consider and to include the legal consciousness of people who have legal connections across borders (Van Rossum &



Fredriksen 2014). An analysis of Norwegian prisons illustrated that the autonomy of those who are somehow different from the others (i.e., those with a minority background) was stronger than that of the others (Bygnes 2014). Another empirical analysis that reached a similar conclusion was the recent study of drug rehabilitation (Mjåland & Lundeberg 2014).

These studies address the question of the implications of juridification and individual rights in different ways, which suggests that the implications of juridification depend on the context, the administration, and the legal construction of the regulations. There is a need for more systematic knowledge of the implications of regulation through rights, which could contribute to drawing clear-cut conclusions about them.

### ***1.6.2 Studies of juridification in health care sector***

Juridification, which is understood as the instrumentalization of public law in the form of individual rights, has recently received political attention in the area of health (Kjønstad & Syse 1992; Magnussen & Nilssen 2015, p. 237). Significant legal changes have taken place during the last 15 to 20 years due to the health sector's exposure to more comprehensive legal regulation than before, including the regulation of the treatment relationship between specialists and patients. The new legal regulations embrace health service institutions, health care workers, and patients. However, there is little knowledge regarding these processes in the health care sector. The academic literature is rather fragmented and is characterized by deficient empirical

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analyses, as pointed out elsewhere (Magnussen & Banasiak 2013). An overview of the empirical evidence in this area, which was presented by the Ministry of Health and Care Services, emphasized the following:

*The knowledge about the implications of the health rights in the area of health care in Norway is fragmented and insufficient... Very few empirical studies explore this topic... It means that we know very little about if the implications of regulation through rights bring about the consequences designed by the legislator... (Feiring & Nese 2005, p. 5)*

Scarcity of empirical evidence also concerns welfare rights, including patients' rights. In the existing studies, there has been a strong focus on rights as a counterbalance to professional discretion, as well as on the disagreement between legal regulations and the actual implementation of rights. Discretion has been argued to provide a strong foundation for clinical practices, as opposed to legal rules. Thus, Bærøe and Bringedal (2014) discussed the individuals' capacity to exercise rights discretion. They explored whether the stricter regulation of the clinical profession diminishes health equality (Bærøe & Bringedal 2014). They argued that the relationship between juridification and professional discretion is not antagonistic but instead presents the question of which type of regulations is the right type for enabling the necessary amount of discretion while restricting unwanted professional autonomy (Bærøe & Bringedal 2014). Bringedal and Tufte (2012) suggested that a health care system may contribute to both maintaining and reducing inequality in the distribution of health care.

Magnussen and Brandt (2014) explored how assessments of patients' needs for health services are evaluated by specialists. They concluded that the weak wording of patients' rights to health care leads to heterogeneity in clinical action among the medical professionals who implement the law. This conclusion suggests that legal concepts of rights may lead to various understandings and different practices. Halvorsen (2004) argued that the manner in which practitioners relate to rights is rather accidental.

Magnussen and Brandt (2014) further find that prioritization guidelines are used differently. There are also variations in how patients with the same diagnoses are treated (Magnussen & Brandt 2014). It is emphasized that there are indications of significant variations among the practice of legal rights. It is, however, also underscored that individual rights are perceived to be vague and that they do not necessarily result in a decrease in professional discretion (Magnussen & Brandt 2014).

Another study, which was carried out in Latin America, revealed that judicialization of health care may lead to the transfer of discretion from health providers to judges, expanding their discretion in the area of social policy (Ferraz et al. 2014). At the same time, the authors argue that in other countries, such as South Africa, the judiciary has used its discretion in health cases to decrease the scope of professional discretion in health care (Ferraz et al. 2014). In addition, the study of Bygnes (2014) shows that rights to rehabilitation broaden the discretion of prison personnel.

As mentioned above, much of the discussion of the implications of regulations on rights concerns the balance between individuals' autonomy and their dependence

on professional expertise. Furthermore, the debate regarding the effects of regulation through individual rights comprises speculations about the revolutionary outcomes for patients' possibility to influence their own treatment (Skålevåg 2005). However, these discussions have not been based on empirical studies.

The existing empirical evidence suggests that legal regulation through rights involves a possible disagreement between the values of public administration, the recipients of health services, and the law. With the expansion of legal regulation into new areas, the legal way of thinking and acting is now penetrating various areas of health services. Based on the discussion above it could be anticipated that the legal rights may influence professional decision-making in very different ways.

The scarcity of empirical approaches, which hallmarks the field of health services, leaves a gap in understanding the role and implications of increasing regulations. This work contributes to the empirical and normative analysis of juridification processes as they play out in the form of regulation through the RTIP in the field of psychiatry. The relationship between clinical discretion and the legal regulations is important in this context. It is explored in the next section.

### **1.7 Defining the boundaries of clinical discretion**

The discretionary power of professionals in the context of this study may be influenced by variety of possible rules and situational factors that might lead to different outcomes of professional evaluations. Thus, actors' understandings of the

context must be included in the analysis in order to capture different implications of the RTIP. The context may form the action to some extent but the creative judgment of the actors who reason may lead to great differences of the outcomes in the reasoning process. The regulation through the RTIP of discretionary power is intended to find the optimum balance between allowing the necessary individual judgment and reducing groundless professional autonomy. The process of looking for the right balance between regulation through the RTIP and clinical discretion may, for example, take place by adjusting the wording of the regulations, which may be more or less vague or precise. The legislative delegation of discretionary power to clinicians via legal rules is founded on the assumption of the capability to make reasonable judgments based on practical or theoretical professional knowledge (Bærøe 2011; Molander et al. 2012).

Legal regulation granting a profession the space for discretion to make overall individual judgments creates a structural framework for the practice of discretion based on, for example, scientific knowledge (Bærøe 2011). The same regulations' primary aim may be to control discretion (Molander et al. 2012). Structural discretion may set limits on the professionals' possibility to create their own regulations for practice. Rights can restrict the discretion of health professionals by specifying their duties and the patients' rights, and also by articulating the aims of health care services, as well as the principles for their distribution. Rights are further interpreted and implemented in procedures and practices within organizational contexts and thus also can regulate health professionals' discretion through the legal goals they are expected to follow (Bærøe & Norheim 2011).

When considering a patient's individual needs for health and also when applying their general knowledge of diseases, conditions, available treatments, etc., the professionals inform and involve the patients based on their best judgment. The manner in which the legal goals and clinical norms are expressed in this process is one of the crucial points of this study.

Legal regulations may influence which information is distributed or how the patients are involved. They may enable the professionals to make clinically sound decisions or allow an individual adjustment of the information and the form of involvement. This argument lies at the core of the dichotomy between two potentially antagonistic concerns expressed through legal goals and clinical norms. On the one hand, health authorities are responsible for regulation in order to achieve some degree of common for the practitioners and legislators understandings. On the other hand, legal goals are not always in accordance with the professional interests of the individual practitioners. Politically defined goals enforced through the law may counteract individual perceptions of best practice. The detailed regulations associated with following the legal goals could counteract the discretionary powers necessary to adjust individual situations to existing regulative framework and to the requirements of reliable practices.

Legal regulation through the RTIP may be viewed as being based upon the combinations of various interests. On the one hand, for example, it may be used as a tool to increase the power of the patients. On the other hand, it may strengthen professional discretionary powers. Allowing the adjustment of services to individual circumstances is the rationale for granting discretion to the professionals.

## 1.8 Possible outcomes of the regulation through rights

There is disagreement among scholars as to which extent individual rights can contribute to solving social and welfare problems (Fimreite & Larvik 2005; Magnussen & Nilssen 2015). The implications of legal regulations have been debated in Norway, and one of the academic debates followed the Norwegian Power Report (Kinander 2005). The members of the “Power and Democracy” research group could not reach a unanimous conclusion. One of the major discussions was related to an increase in individual rights as a problem for democracy (Østerud et al. 2003, p. 21). An expansion of rights was argued to extend the competence of the courts, where struggles between interests are more frequently framed as legal claims. The increasing use of legal instruments to solve social problems has also been argued to endanger democracy. Rights were characterized as possible triggers for legal activism, which could be used in order to enforce the individuals’ will.

One of the report’s conclusions was that the relationship between law and politics had changed in the sense that more power and authority have been transferred to the individuals through processes such as anchoring national regulations in international human rights conventions. This process has been characterized differently, both as juridification but also as democratization across national borders. The United Nations Convention on Women’s Rights is worth mentioning in this context<sup>7</sup>. The substance of the argument discussed in regard to the Convention focuses on the question of the circumstances in which human rights doctrines could contribute

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<sup>7</sup> For more extensive discussion see the contribution from Hege Skjeie (Kinander 2005, p. 74).

to enforcing democratic responsibility, self-determination, and the participation of weak social groups.

This line of arguments focused on the tyranny of the majority in cases when weak social groups do not get to exercise much influence on social developments as opposed to the self-determination of these weak groups. Rights were argued to constitute a legal safeguard of the individuals' autonomy and interests. They have an important function in a democratic society, enabling the subjection of private and public exercises of power to judicial controls. Regulation through rights could allow access to information about different opportunities to act, procedural requirements, advantages, and risks that accompany individual choices. An insight into the opportunities to act might furthermore enable individuals to hold authorities accountable and increase the feeling of self-respect and integrity. Furthermore, rights may counteract closed professional cultures (Magnussen & Banasiak 2013).

Due to the lack of empirical knowledge on the outcome of regulation through rights, it is impossible to make well-grounded assumptions on the effect of the RTIP upon the subjects of this regulative right. Until further empirical work has been done, one may only speculate on the possible implications of the RTIP.

The different nature and the extent of the implications of the RTIP could be in different ways contested by and restricted to the professional cultures. Rights regulating professional action that are driven by clinical codes of ethics and established norms may have different implications for specialists' assessments of their actions. Consequently, they may influence the patients' possibilities to gain information and



influence treatment in various ways. This may range from increased access for deciding upon a treatment to an expanded professional control over vulnerable groups who may thus not benefit from formal and vaguely formulated individual rights (Kjønstad 2007).

The observations made in the literature with regard to the possible implications of juridification processes suggest a variety of possible outcomes of regulation through the RTIP. There is a complex interplay between different legal regulations, which might have different implications. Based on the complexity of the outcomes of juridification discussed in the literature, it is expected that the expansion of individual rights and regulation through the RTIP may not have straightforward implications for clinical practice.

Furthermore, the RTIP regulates an intersection point between clinical and legal institutions. As defined in the APR, it is expressed in a rather general and abstract manner. It may thus leave substantial space for discretion, the extent of which is unknown, assuming that it may be understood differently when it comes to the definitions of individual rights and duties, procedural rules, and clinical competencies. In this study, I attempt to explore the possible variations in the implications of the recent development in legal regulation within the specific field of clinical practice.

As previously suggested, the clinical practice is certainly affected by the existence of established practices, legal rights, and alterations in legal rights may affect the process of distributing health care. Therefore, the outcomes of the RTIP in clinical practice cannot be discussed in isolation from well-established traditional practice, in which regulated clinical action was introduced before the RTIP. A development in

which the RTIP is practiced may be viewed as being trapped between new legal regulations and clinical discretion. Both may affect the individuals' capacity to make autonomous decisions, which may equip clinicians with the tools to make discretion-based judgments, thus enlarging their autonomous room for clinical decision-making. This situation might also challenge the practitioners' ability to base reliable decisions on medically justifiable judgment. The goal of this thesis is to elucidate the variety of implications of the RTIP and to discuss the mechanisms that may contribute to the complexity of the outcomes of regulation through the RTIP.

Enhancing the patients' influence on the formation of their treatment through regulations could strengthen treatment practices founded on principles of autonomy and self-determination. At the same time, the relationship between specialists and their patients is based on an asymmetric power relationship that may be perceived as the instrument for controlling patients' behavior. Regulation of the patient-expert relationship through the RTIP and the strong connection between clinical practice and professional norms may increase and also limit specialists' opportunities to base their actions on discretionary judgments. For instance, the implementation of the RTIP might influence the process of matching diagnoses to treatment methods. The outcome of the RTIP might be that the patients' preferences concerning treatment are considered as an important factor for making the decisions. The theoretical approach chosen to study the outcomes of regulation through the RTIP in clinical action is discussed in the following section.

## **1.9 The theoretical framework of the study**

### **1.9.1 *The institutional approach***

The theoretical framework proposed in this study provides guidance for explaining and analyzing the interpretations of the RTIP as they are expressed in the legislative regulations and assessed by clinicians in light of the clinical treatment.

I suggest that the institutional characteristics embedded in clinical practice, organizational context, professional background and in the legislative regulations can to some extent contribute to explaining the clinicians' assessment of their actions and their interpretations of the RTIP. This explanation is possible because the practice in this study is structured to some extent by the clinical norms, organizational context and the regulation through the RTIP.

Based on the institutional approach, the focus of the analysis is on the clinicians' de facto assessments of clinical action and the interpretations of the RTIP made in the regulations.

The appropriate rules for action embedded in regulation through the RTIP, organizational context and professional background, may provide different criteria to evaluate questions regarding information and participation by practitioners. These different criteria may lead to variations in clinicians' understandings.

The professional background in a democratic society can be characterized by the obligation to provide a service to those who need it. The legislative regulations employ the RTIP as a tool for achieving the goals of the legislator. The organizational

structures give room for the coexistence of the legislative regulations and professional practices. This issue, along with further advantages and limitations of the theoretical approach, is discussed in chapter 3.

### **1.9.2 The interpretations of the legislative regulations**

To investigate and explain how the regulations through the RTIP influence clinical practice, it is necessary to explore the following:

- The content, uniformity and the variations of statements in the regulations,
- The *de facto* clinical practice.

Consequently, I begin with an analysis of statements in the regulations. The Directorate is the only legitimate actor in Norway allowed to interpret the letter of law in the field of health care. The content of Directorates' interpretations is, except for the law, the main source that guides practitioners in doubt regarding the best practices concerning rights and obligations with regard to informing and involving patients.

Starting with an analysis of the RTIP and Directorate's guidelines, termed legislative regulations, I further focus on how clinical specialists interpret the RTIP and assess the practice of informing and involving patients in treatment. The analysis comprises regulations interpreting the RTIP that were issued from 2001 to 2011. Further, interviews with 30 clinicians were analyzed.

In order to explore the relationship between clinical action and legislative regulations, I suggest how the institutional framework can be put to use in the empirical analyses. Aiming at capturing different outcomes of the RTIP I especially focus on the three analytical dimensions. The explanatory dimensions, that are anticipated to influence understanding of the clinical action in this study are the legal, organizational and professional dimensions. All of them are introduced at the same analytical level. The major anticipation is that each dimension influences clinical action. These anticipations represent three different normative platforms to understand the clinical action in the context of DPCs.

This work will thus contribute to the knowledge of the mechanisms through which institutionalization of the law within professionalized practice takes place. Law, organizational structures and professional practice may give rise to different perceptions of reality. Assuming this is the case, a legislators' attempt to regulate clinical practice might result in disagreements between the law and the interpretations of the law. Capturing and understanding these possible disagreements is the point of this work. The particular characteristics of each dimension are described in chapter 4. Specific hypotheses are attached to each dimension (see chapter 3) and guide the presentation of data in chapter 5 and 6.

### **1.10 Thesis outline**

This work is structured as follows:

**Chapter Two** first gives a brief account of the history of psychiatry in Norway and the common features that characterize the field of psychiatric practices. Secondly, it presents the development of the legal regulations in the health care sector that took place in 2001.

In **chapter Three**, the goal is to develop a theoretical framework in order to explore and explain the implications of regulation through the RTIP for clinical practice in the organizational setting. I chose to base my theoretical reasoning on the institutional approach in a broad sense.

Clinicians can be faced with a variety of possible treatment situations and their choices among action alternatives according to the consequences and goal achievement are likely to entail other factors than rules. These situational factors may influence the implications that the RTIP has on the clinical practice, and must therefore be described. This is particularly important in the situations when the rules are not being followed. I assume that the specific outcomes of clinical reasoning can be the result of, for example, pragmatic reasoning, consequence-oriented action or rule following.

In **chapter Four**, the goal is to present the principles which relate the data sources and the theoretical approach. I justify the choice of the case study research design. The aim is to operationalize the case and establish analytical dimensions that could contribute to the explanation of findings. Furthermore, the purpose is to operationalize these dimensions and develop the hypotheses within them.

Having the clinicians' subjective understandings as a starting point, I assume that they are active, interpretative and creative actors making their autonomous

judgments who may not always follow the specific legislative regulations or accepted professional conventions. Through their individual adjustments to the regulations, actors may have their own goals and interests as well as perceptions of the organizational context, specific situations, and understandings of the best practices. Furthermore, I discuss the generalization potential of this study.

Two types of empirical material, the guidelines for practice issued by the Directorate and the interviews with clinicians, are presented in the two empirical chapters, chapter Five and chapter Six. In **chapter Five**, I analyze the content and the precision of the statements regarding the RTIP made in the guidelines. Based on the empirical material, I discuss to what extent the regulations vary and how it may influence the clinical action. The analysis of the legislative regulations given in chapter Five (characteristics of the legislative regulations) serves as a starting point for the analysis of the data obtained from the interviews with clinical specialists, which is presented in chapter Six.

The data material in **chapter Six** consists of interviews with 27 clinical practitioners. The presentation of data is driven by the hypotheses developed in relation to the explanatory dimensions in chapter Three. I ask an open question about the practitioners' assessments of their actions and the RTIP.

Furthermore, the interpretations of the RTIP made in the guidelines and discussed in chapter Five are analyzed against the interview data with regard to the extent to which they explain the clinicians' assessments.

In the last chapter, **chapter Seven**, I present a final discussion of the most important findings, the answers to the research question, and a description of this work's contribution to the understanding of juridification processes, both in general and with regard to regulation through patients' rights and its implications for patients' possibilities to act.





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## 2. Psychiatry as a legally regulated field of practice

### 2.1 Introduction

In this chapter, the aim is to provide an overview of psychiatry as a clinical field of practice. A short review of psychiatry's historical development in Norway will be given, leading to its current form of unified practice based on well-established professional knowledge. This review is necessary since psychiatric practice is the context for the study of the implications of the RTIP. Additionally, the institutional characteristics of professional thinking and acting for applying the institutional perspective in the analysis of the empirical data must be discussed. One of the assumptions in this study is that the established traditional clinical norms in psychiatry will influence the understanding of the RTIP.

Another goal of this chapter is to focus on the law regulations that frame the field of clinical practice. I will introduce the legal and ethical backgrounds for clinical, voluntary psychiatry that regulated the practice before the expansion of individual rights in 2001. I also describe the Directorate, which develops the guidelines for clinical practice based on the law. Finally, it is necessary to present the changes in the legal regulations of the health care system that took place in 2001. It is important to emphasize that patients' rights were just one aspect of these comprehensive legal changes.

## **2.2 A rationale for choosing psychiatry as the empirical area of the study**

### **2.2.1 Psychiatry – legal developments**

Psychiatry has been one of the more controversial fields of science. Throughout history, it has shifted from advocating wild practices of segregation and repression of anyone considered as deviant from regular societal norms, to the first attempts at scientific treatment of mental illness, like the now largely abandoned and condemned practices of electric shock therapy and lobotomy (or leucotomy, for which a Nobel prize was awarded in 1949, and which was still practiced in Norway as late as 1974), to the full-blown medical science of today. This development reflects not only the progress of science as a better understanding of natural processes but also the moral progress of human society with its norms and understandings of ethics. An important component of this progress is the development of the very idea of human rights and its gradual spread to various parts of society, eventually including the rights of medical patients and, in particular, the rights of psychiatric patients—something not immediately obvious as a rational option to a person of the not-so-distant past.

Since these developments are so recent, efforts to find the proper place of psychiatry within human society still continues, and the legal framework of today reflects achievements in societal moral judgments of the last decade or so. It is therefore most important to be able to cast a look on the most recent changes that have occurred to the field, with the aim of exploring the outcomes of regulation through laws in clinical practice. This may be done from several standpoints: judicial (legal), medical (scientific), or administrative and organizational (social science). This work is an

attempt at such an overview from the latter prospective, and it considers Norway to be the subject of a detailed study.

The particular developments in Norway in the last decade or so with regard to social positioning of psychiatric practices have been influenced by the new law, the Act on Patient Rights (the APR) of 2001, which signalled a cardinal change in the way psychiatric service is regulated. Since 2001, the legal regulation of clinical practice has become strengthened and individualistically oriented (Kjønstad & Syse 1992, p. 189; Kjønstad 2007, p. 36). The new legal regulations concern health service institutions as well as health care workers and patients. The APR, earlier legal acts, and governmental white papers<sup>8</sup> make up the background for this study of the implications of patient rights for clinical practice.

### ***2.2.2 User participation in mental health on the political agenda***

The issue of participation and information for psychiatric patients has been on the political agenda and has been debated for more than one decade now (Magnussen et al. 2009, p. 11). The relationship between specialists and patients in psychiatry has traditionally been characterized by a particularly great degree of paternalism (e.g., Jensen 1980; Froestad & Jensen 1985). The first breakthrough with regard to patients' possibilities to influence their own treatment in psychiatry was the introduction of the

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<sup>8</sup> White papers are used as a means of presenting government policy preferences prior to the introduction of legislation.

National Action Program for Mental Health in 1998. One of the debates that took place then also considered the strong paternalistic tradition in the relationship between specialists and patients, the professionals taking all the power to decide about the treatment (Kolstad 2006; Orefellen, 2008). Psychiatry is, therefore, in itself a highly relevant field for exploring the implications of the RTIP for the patients' possibilities to influence their own treatment.

The major goal of the Program was to “strengthen user-oriented measures...” by introducing the concept of patient participation in decision-making in treatment (Helse- og Omsorgsdepartementet 2005). User participation became defined as one of the major areas in carrying out the national health care policy for psychiatry. In the strategy goals for 2007, user participation was placed under the special areas of emphasis: “Users’ participation within specialized health care service has to be strengthened by establishing good practice... it concerns respect for users’ preferences and experiences when decisions about treatment are taken...” (Helse- og Omsorgsdepartementet 2005, p. 434).

The traditional professional norms for clinical practice in the field do not support such aspects of patient involvement in treatment as do the ones regulated by the RTIP. These norms have been singled out as a true obstacle in the introduction of patients’ rights into clinical practice: “There is a need for change in the present situation concerning culture, attitudes and values that mental health service represents. It is a barrier that prevents the implementation of the national action plan...” (Sosial- og Helsedirektoratet 2003, p. 11–12).

Professional culture, norms, and values were not only the main barrier for the implementation of the goals related to user participation defined in the Program but also were the main reason for the introduction of the Program (Statens Helsetilsyn 2001, p. 28). Apart from changing the traditional values, the chief political goal was to achieve an equality between psychiatric patients and somatic ones with regard to the possibilities to exercise influence on the choice among the available treatment services (St. Prp. Nr. 63 (1997-98) 1998; Hammerstad, 2006).

Psychiatric patients have not been on equal footing with somatic patients with regard to individual rights for a long time (as described in section 2.3). Indeed, the relationship between psychiatry clients and clinicians has been regulated by clinical discretion longer than has been the case in other fields of medicine. However, knowledge regarding how the complete incorporation of an individual rights framework into the field has influenced clinical action is still scarce.

### **2.2.3 Earlier studies of clinical practice**

#### *2.2.3.1. Clinical practice before and after introducing the rights*

Another reason for choosing psychiatry in this study due to the existing knowledge regarding the outcomes of empirical examinations that explored the clinical practice before the right was enforced for psychiatric patients. These works show that psychiatric patients in particular were disadvantaged with regard to information

provision and exercising influence on their own treatment (e.g., Bleiklie et al. 1980; Froestad & Jensen 1983; Froestad & Jensen 1984; Bomann-Larsen & Jensen 1985).

Coercive treatment has been the predominant subject of studies of psychiatry since the introduction of the APR in 2001. Coercion in the form of shielding, restraints, and involuntary medication has been the subject of a heated debate in the Norwegian public sphere, as it conflicts with legal and human rights and evokes debates on autonomy, paternalism, and the patient's right to the most efficacious treatment (Diseth & Høglend 2014). A number of these studies concluded that cases where patients' autonomy was overpowered and they were provided with little information have occurred in psychiatric treatment even after the APR came into force (Blesvik et al. 2006; Pedersen 2006; Norvoll 2006; Hillestad 2008).

Some authors argue that there has been a shift in psychiatry towards an autonomy-oriented legal culture. This change was especially true concerning the provision of information to those patients whose are unable to make their own choices independently (Rynning & Hartlev 2012; Vrangbæk & Østergren 2004). In addition, patients have the right to choose the service provider, participate in and complain about the received treatment, or ask for a second opinion. Patients also must provide their consent to treatment that is based on the available information and involves patients' awareness of what is going to take place and how. Specialists are obliged to deliver this information (Mech 2010). At the same time, since 2001, services have been developed based on the cooperation of users and the number of information sources for patients (Hammerstad 2006). This focus on users' experiences and knowledge in the

development of services has been increasing, and it calls for user participation at the system level.

These studies provide an overview of the legal developments within psychiatry and speculations as well as general conclusions about their outcomes. However, to the best of my knowledge, there are no empirical studies that have explored the implications of the RTIP in psychiatry after the aforementioned legal changes were introduced.

#### *2.2.3.2. Government reports and evaluations*

The final point of the last subsection (2.2.3.1.) seems to be confirmed by some general evaluations of psychiatric services. The Evaluation Report conducted by the Research Council of Norway concluded that the amount of patient participation in and influence on their treatment is low, and any information that may be provided to them is deficient (Brofoss & Larsen 2009). This is also one of the conclusions drawn from the evaluation report of District Psychiatry Centers (DPCs, Gråwe et al. 2008). Their evaluation, which was carried out in 2006, revealed that patients were not satisfied with either the information they received at the DCPs or the possibilities for actual client participation. In the report from 2008, SINTEF emphasized that most of the interviewed patients were not satisfied with the information they received about their rights to access to their own medical records. Many patients claimed that they also were not allowed to influence the development of their treatment. In addition, individuals pointed out that information about complaint instances and complaint procedures was



missing. The report shows that there was a deterioration between 2002 and 2007 of the time devoted to professional consultations, follow-up, understanding, and respect for the patients' points of view.

At the same time, an evaluation made by the Norwegian Research Council for the years 2001–2009 suggested that most of the goals related to user participation have been achieved, according to the aims of the National Action Plan (Helse- og Omsorgsdepartementet 2012). These conclusions imply a discrepancy between the implementation outcomes of the plan and its primary goals. There are also variations between the conclusions drawn by SINTEF and the Norwegian Research Council. Finally, the evaluation reports focus mainly on feedback from the patients and their families, while the opinions of clinical practitioners have not been investigated previously.

#### **2.2.4 *Voluntary vs. coercive psychiatry***

In this study, I chose to focus on voluntary psychiatric treatment rather than coercive methods. The relationship between the law and the profession with regard to this type of treatment has a much shorter history of regulation of practice through the law than in coercive psychiatry. However, patients who are subjected to coercive treatment generally have more severe diagnoses that may decrease the possibility for the clinical contact as well as the exchange of information between specialists and patients. In these cases, any analysis of the implications of the studied right becomes problematic.

Another important argument for not choosing coercive treatment is that it is regulated through the Law on the Establishment and Implementation of the Mental Health Act (my translation) (Helse- og Omsorgsdepartementet 1999). This law includes similar regulations with regard to patients' decision autonomy as the RTIP. In § 4-2 of the law, *Protection of personal identity*, it is stated that restrictions and the use of coercion shall be limited to an absolute minimum and that the patients' views are to be considered. Interventions may be carried out only when their positive effects clearly outweigh any negative ones. It is also stated that when treated in an institution, patients should make their own decisions regarding admission, whenever possible.

Since the APR must be applied in cases of coercive treatment in accordance with the Mental Health Act, the latter being higher in the legal hierarchy than the regulations of the APR, it would be difficult to differentiate between the implications of these two regulations in clinical treatment. At the same time, an exploration of the implications of regulation through the RTIP in voluntary practice is sufficient to answer the research question posed in this work concerning the way regulation through the RTIP influences practice.

### **2.3 Psychiatry as a professional discipline in Norway – a historical background**

General background knowledge about the historical development of psychiatric services in Norway provides an important background for the context of this study. In order to explore and explain how clinical practitioners implement legal regulations of information and participation in their day-to-day practice, it is necessary to understand

how the psychiatric service is constructed. Psychiatric services are not only established through common organizational structures but are also standardized through the body of professional knowledge and skills, which is relevant to this study (Rosenvinge et al. 2004).

### **2.3.1 *Psychiatry until the 1960-s***

Psychiatry as a professional discipline developed in Norway in the middle of the 19th century (Kringlen 1997; Kringlen 2004; Kringlen 2012). Beginning in the 1870s, private institutions for psychiatric care were established (Malt 2012). During the middle of the 19th century, the field was influenced by the so-called “moral treatment”<sup>9</sup>. However, during the end of that century, the ideas of somatic medicine began to prevail (Kringlen 2012). The first systematic classification of psychiatric diagnoses was published at the end of the 19th century (Malt 2012). The main forms of treatment at this time were psychoanalysis and electroconvulsive treatment. Until the 1950s, Norwegian psychiatry could be considered almost exclusively hospital psychiatry, as it was engaged in the treatment of severely ill patients (Kringlen 2012).

The breakthrough in psychiatric treatment was the introduction of psychoactive drugs in the 1950s (Malt 2012, p. 35). These drugs did not cure the patients, but they

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<sup>9</sup> A therapeutic and preventive philosophy for managing mental disorders, which was popular in the early 19th century. The treatment consisted of removing the afflicted from their homes and placing them in a surrogate “family” of 250 members or less, often under the guidance of a physician. This philosophy emphasized religious morals, benevolence, and “clean living,” in contrast to the somatic therapies of the day (such as bloodletting or purging) (Gill 2013).

did produce a distinctive effect, particularly in the acute phase of the illness. The patients' symptoms were partly removed, and many patients were able to be rehabilitated (Kringlen 2012).

After World War II, Norway was significantly affected by psychoanalytic and social psychiatric theory and practice (Kringlen 2012). At the end of the 1950s and during the 1960s, a number of psychiatric units was established at somatic central hospitals. Patients with acute psychosis, severe depression, and suicidal attempts were treated at these facilities (Kringlen 2012).

### ***2.3.2 Public criticism of psychiatry in the 1970-s***

In the 1960-s and 1970-s, critics of mental institutions gained a strong force in the public debate in Norway. Criticism was directed at treatment conditions in "asylums." Critics cited such arguments as scarce personnel, a focus on the preservation of patients rather than their improvement, and a strong orientation towards medical treatment. Treatment in asylums was described as toxic even in small doses and not therapeutic (Sagabråten et al. 2007).

The criticism of institutionalized psychiatry was not a solely Norwegian phenomenon but rather a part of the international debate on the inhuman situation of psychiatric patients and the poor variety of accessible forms of treatment in Europe (Schönfelder 2008, p. 16). The stigmatizing aspect of treatment in psychiatric institutions and the difficulties of adjustment to life after the treatment was complete

were emphasized as the main arguments against treatment procedures carried out in institutions (Geller 2000).

New goals for psychiatric treatment were developed and became directed at the decentralization of psychiatric institutions, a reduction of coercive and electroshock treatment, and a stronger focus on medical treatment through psycho-social interventions that took place within patients' local environments. The aim was to reduce long treatment periods at institutions and encourage fast reintegration into the local communities. Since then, community-based services have become the cornerstone of mental health treatment systems. The role of central hospitals changed towards offering a more time-limited back-up service in periods of crises for patients and providing services for patients with special needs (Hansson et al. 2002).

During the 1960s and 1970s, the recruitment of professionals into the field of psychiatry expanded. In addition to psychiatrists, the field saw an increase in psychologists, psychiatric nurses, milieu therapists, and social workers, who became involved with psychiatric patients (Malt 2012).

### ***2.3.3 Deinstitutionalization of psychiatric services***

During the last 30 years, a central idea promoted by psychiatric services has been that it is better for the patients to stay in and receive treatment in their community (Schönfelder 2008, p. 17). Community settings are thought to make it easier for patients to access services, which leads to increased cooperation between service levels and

reduces the stigma associated with psychiatric treatment (Bjorbekkmo et al. 2009). The treatment group has also changed to users with milder mental disorders, such as moderate depression, anxiety, eating disorders, and other nervous symptoms, for which more individually adjusted treatment has been offered (Malt 2012, p. 35).

The number of patients at central psychiatric institutions was dramatically reduced between 1970 and 1995 from 8405 to 1645 (80%) (Malt et al. 2003, p. 31). However, mental hospitals in Norway have not been closed down as they have been in other countries like England, but they have been modernized to accommodate fewer patients (Kringlen 2004). The decentralized services represent an alternative to central mental hospitals, so that patient care mainly occurs locally. Specialized outpatient and inpatient services have been transferred to Community Mental Health Centers (CMHCs) and are also often integrated in local general hospitals (Orefellen 2008).

The role of CMHCs was described by the Norwegian Directorate of Health and Social Welfare as a specialist health service cooperating with municipal organizations and supported by specialized hospital services (Helse- og Omsorgsdepartementet 2004; Sosial- og Helsedirektoratet 2006a). It is the so-called second level of psychiatric services placed in between primary and specialized care (Malt et al. 2003, 32). Initially, there were no strong recommendations from the Norwegian health authorities as to how the decentralized specialist services (CMHCs) should be organized, which led to a variety of organizational models, which often expressed the treatment philosophy of local professionals (Bjorbekkmo et al. 2009).

CMHCs were further introduced in the National Action Plan for Mental Health in 1996 (St. Meld. nr. 25 (1996-1997)). The primary goal was to expand the number of CMHCs. Correspondingly, an expansion of primary mental health services has taken place. Since the 1970s, the municipalities have been responsible for securing patients' fundamental needs with regard to psychiatric services. Patients were granted the right to receive treatment at the lowest level of existing services and as close as possible to their homes (the so-called LEON-principle).

With the decentralization of psychiatric services, increased attention has been given to users' autonomy and the independence of mental health services. A critical aspect of decentralized mental health services includes the development of housing services and individually adjusted social services for the mentally ill. The primary goal was to enable users to take individual responsibility for decisions independently of specialized psychiatric services (Hammerstad 2006). The patients were given the chance to become active participants in their own life and take a more active role in their own treatment. This change has been one component of the legal and ethical developments taking place in society, as described below.

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## **2.4 The legal and ethical basis for information and participation before the APR**

### ***2.4.1 Regulations regarding psychiatric patients prior to 1961. The Control Commissions***

Until the last few decades, the main regulation guiding the relationship between patients and their doctors was professional discretion, which had roots in Hippocrates's tradition:

Perform (these duties) calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and sincerity, turning his attention away from what is being done to him; sometimes reprove sharply and empathically, and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present condition. (Aasen 2000, p. 86)

The relationship between law and psychiatry in Norwegian clinical practice is, however, not a new phenomenon. One particular aspect of psychiatric services has had a long history of interaction with legal rules and the practice of law: involuntary hospitalization. This area has long been supervised by state organizations named Control Commissions. Control Commissions have been considered by the legislators to be an important control or surveillance organizations for the way psychiatry specialists carry out coercive procedures (Høyer 1986). The first Control Commissions were established in Norway in 1848, in accordance with the first Norwegian Mental Health Act. The authorities perceived them to be the most important safeguard against violations of patients' legal rights in psychiatry (Høyer 1988). The structure of the



Commissions differed through the years. Currently, the chairman must be a lawyer or a judge, and one of the members must be a medical doctor; otherwise, two other members are required to participate (NOU 2011).

#### **2.4.2 The ethical code of 1961**

The first Norwegian Mental Health Act was revised in 1961, when ethical rules for doctors were introduced for the first time by the Norwegian Medical Association. Until then, there had been no regulations for clinical practitioners with regard to participation or information in treatment, apart from the recommendations to conceal as much information as possible from the patients. When clinical specialists treated their patients, the legal point of view allowed them to make evaluations and decisions about the treatment without revealing any information to the patients or involving them in such decisions. The ethical code elaborated somewhat on specialists' obligation to inform patients<sup>10</sup>: "A doctor should give a patient information about his condition, but has in accordance with his conscientious evaluation, the right not to reveal the information that he thinks can be harmful to the patient," (Aasen 2000 p. 89).

Thus, according to the ethical rules from 1961, specialists were not obliged to but were only recommended to inform the patients about their conditions and treatment. From an ethical point of view, it was acceptable not to inform patients about their health conditions, and such a decision was a matter of professional discretionary evaluation.

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<sup>10</sup> Ethical rules for doctors, developed by The Norwegian Association of Medical Doctors, were published for the first time in 1960 (Legeforeningen 2016).

It was up to each specialist to evaluate the potential harmfulness of any information before sharing it with the patient.

When the Mental Health Act of 1848 was revised in 1961, the Control Commissions were retained in much the same fashion as before. The number of Commissions in 1986 was 55, which is roughly similar to the amount remaining in 2011 when 57 working commissions were appointed by county governors in Norway (Helse-og omsorgsdepartementet, 2011). The main assignment of the Control Commissions has been to evaluate decisions regarding coercive treatment and to give patients the possibility of a faster legal evaluation of administrative discretionary decisions for free (Kjønstad 2007, p. 63).

Control Commissions have combined the legal regulations of the Mental Health Act and the professional administration of the law in psychiatric practice for decades now. This relationship is, however, related to the strongest form of intervention into patients' freedom which is legal in Norway: coercive treatment<sup>11</sup> (Kjønstad 2007, p. 323).

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<sup>11</sup> In the international literature, the term "coercive measures" usually refers to coercive interventions recurring during hospitalization in psychiatric wards (Raboch et al. 2010). This includes seclusion, restraint, and involuntary medication.

### **2.4.3 The Medical Practitioners Act of 1980**

The first legal regulation of clinical practice with regard to informing patients was introduced in 1980 by the Medical Practitioners Act. According to its provisions, patients “should have information about the health care condition and treatment...” (Lov om leger, chapter 3, § 25, art. 3).

The legal definition concerning informing patients described above was in line with the earlier professional ethical code. As stated in the white paper on APR, “...it was initially depending on the doctors’ discretion as to which information that was provided to the patients...” (Ot. prp. nr. 12 1999, p. 67). This recommendation to inform did not guide practice directly.

Also for the first time, the Medical Practitioners Act regulated the professionals’ obligations with regard to patients’ participation. In § 25, art. 3 of the Act, participation was vaguely defined and clinical discretion played an important role in the interpretation of the right (Ot.prp. Nr 12, 1998–1999, s. 67): “To the degree it is possible, the specialists will allow the patient himself to participate in treatment.” (Lov om leger chapter 3, § 25, art. 3).

Specialists were obliged to provide patients with the opportunity to participate in the treatment. However, it was up to the discretionary evaluation of each specialist to decide the form and the aspects of treatment that the patients were allowed to participate in.

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#### **2.4.4 The reforms of the 1990-s**

In the Supreme Court decision of 1993 (Rt. 1993, p. 1169), it was emphasized that when health care is provided, information has to be given so that patients may express their conscious consent. However, the amount of information that is to be provided was still unclear.

In the ethical rules for doctors introduced in 1996, it was specified that patients are to be informed to the degree and extent that they desire to be informed: “The patient will be informed to the extent he/she wishes to be informed... information that could be a burden for a patient will be given with carefulness” (Etiske regler for leger 1996, §3).

According to these changes in the ethical code, professionals were to provide the information that patients asked for. It was for the first time that it was left up to the patients to decide which types of information could be a burden to them and that they were allowed to influence the information that was given to them. These were, however, not legally binding rules but recommendations for good practice that were developed by the professionals themselves.

The few legal rules and ethical principles mentioned here were the formal basis for the information and participation in clinical practice before the introduction of the APR. It has been argued by law scholars that such scarce and vague regulations gave professionals extensive possibility to practice discretion (Berg 1991). It has been implied that decisions regarding the content and form of health care services, such as the choice of treatment and information that is provided, have been governed by health

personnel based on their specialist knowledge, ethical premises, and personal judgments (Kjønstad & Syse 1992, p. 197; Syse 2009, p. 31). Thus, even though the areas of patient participation and information were legally regulated before the APR was introduced, this change has still been characterized as being driven mainly by professional autonomy and discretion in clinical decisions (Berg 1991, p. 170).

In the next section, I explore the legal expansion of regulations that were introduced in 1999 and that changed the legal framework for health care practitioners in general and psychiatric practice in particular.

## **2.5 Juridification in psychiatry – the legal revolution of 2001**

An increase in legal regulations has been taking place in Norway within different areas. This is partly due to an increase in public legal regulation in general and also partly due to an increase in individual rights (Magnussen & Banasiak 2013). It would not be possible to study the implications of the regulation through the RTIP in psychiatric practice without relating to the extensive legal changes that took place in the health care sector and culminated with the introduction of the APR and the RTIP.

### **2.5.1 Health Act package**

In 1999, four new Acts on health services and care were passed by the Norwegian Parliament. These Acts were called the Health Act Package and consisted of the Specialized Health Services Act, the Mental Health Care Act, the Health Care

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Personnel Act, and the APR. These laws went into effect in 2001 (Befring et al. 2002, p. 56; Syse 2004). It is important to mention that all of these acts reflect and complement each other (Befring et al. 2002). The first patients' rights were developed as a "mirror reflection" of the legal rules that imposed obligations on health care personnel (Syse 2009, p. 89).

The Specialized Health Services Act (Law of 2<sup>nd</sup> July 1999 nr.61) was introduced as a replacement for the Hospitals Act of 1969. It sets the requirements on the individual organizations for the provision of health care services.

The Health Care Personnel Act (Law of 2<sup>nd</sup> July 1999 nr. 64) describes the requirements related to the appropriateness of professional conduct as well as sanctions if these are not fulfilled. One of the major legal changes introduced with this law was that specialists have been assigned the responsibility for decisions concerning the choice of methods of examination and treatment. These decisions must be based on the criterion of professional reliability (see §4: Law of 2<sup>nd</sup> July 1999 nr. 64). The principle of reliability was described as the basic rule defining the responsibility of health care personnel that always must be applied when health care assistance is provided (Syse 2009, p. 245).

The Mental Health Care Act (Law of 2<sup>nd</sup> July 1999 nr. 62) stipulates that psychiatric treatment and services are, from an organizational and administrative point of view, part of the specialized health services (Kringlen 2008, p. 560). However, certain aspects of mental health services (for instance, coercive or mandatory treatment) are regulated by the Mental Health Act. The main objective of this act is to

ensure that mental health care, both voluntary and coercive, is carried out in a proper fashion and thereby emphasizes the importance of the patient's autonomy and the right to choose for him- or herself (Syse 2009).

The Mental Health Act has a section that relates to the APR (see §1-5). Originally, it presented a reservation against applying the APR to the mentally ill "as long as it suits." In April 2006, this regulation was changed to the following: "When psychiatric health care services are provided, the APR must be implemented" (Syse 2009, p. 92 (my translation)). The regulation came into force in January 2007 and includes both coercive and mandatory treatment.

This change of relation between the two acts (i.e., the inclusion of a paragraph specifying a stronger relationship with the APR in the Mental Health Act) is most meaningful for psychiatric patients. According to the priority rules in the law, "*lex specialis*" (in this case, the Mental Health Act) is assigned a greater importance than "*lex generalis*" (in this case, the APR) (Syse 2009, p. 132). Therefore, after the legal change, the regulations of the APR must always be applied in psychiatric practice.

The legal developments that took place in 2001 have been characterized as juridification of the health sector, but they also were a significant, flourishing period for patient rights in Norway (Kjønstad & Syse 1992, p. 189; Kjønstad 2007, p. 36). The Norwegian Public Health Service had traditionally operated under the assumption that patients were sufficiently protected by the duties and role prescriptions that were imposed on health care personnel and units (Kjønstad 2004a; Kjønstad 2004b;

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Magnussen & Nilssen 2015). The legislative aim with these acts was to introduce a shift in the relationship between patients and health care specialists (Skålevåg 2005).

### **2.5.2 The development of the APR**

When the APR (Law of 2<sup>nd</sup> July 1999 nr. 63) was adopted, it covered a broad package of rights. The main objectives were to base health services on respect for human dignity, the fair distribution of rights and duties, and equal access to health care (Ot. prp. nr. 12 1999). It was the first unified legislative act that referred to patients as subjects of the law (Fryjordet 2004). The legislation of individual patient rights intended to narrow down the possibilities of exercising professional discretion. The goal was to increase the patients' chances to hold the thousand-years-old paternalistic medical practice to account (Kjønstad & Syse 1992, p. 197).

The development of the Act has been influenced and encouraged by various actors. For example, the Supreme Court precedents were binding for all future applications of the Norwegian law (Kjønstad 2004b). Some of the critical Supreme Court decisions that affected Norwegian patients are presented in Table 2.1.



Table 2.1. Supreme Court decisions prior to 2001 that set precedents for patients' rights  
(Adapted from Syse 1999, p. 45).

Decision	Effect
Rt. 1977 s. 1035	A patient was granted access to a medical journal.
Rt. 1981 s. 771	The chances for discharge from a psychiatric hospital were expanded, giving patients with serious mental disorders more freedom.
Rt. 1987 s. 1495	The Court stated that there was a right to compensation on an objective basis in case of illegal detention at a psychiatric hospital
Rt. 1989 s. 674	The omission of the information provided in a medical record became strong enough reason to rule professional "negligence" followed by compensation.
Rt. 1990 s. 874 (Fusa-conviction)	A strongly disabled woman was declared to be entitled to essential health care at home in spite of the financial constrains it caused the municipality. This sentence substantially strengthened patient rights in health care services.
Rt. 1993 s. 1169	It was declared that when health care is provided, information has to be given so that patients may express their conscious consent. However, the amount of information that was to be provided was still unclear.

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However, other factors than the Supreme Court's activity have also contributed to the development of patients' rights in Norway. An important role was played by patient organizations and specialists employed in the National Health System (Kjønstad & Syse 1992, p. 189). The influence from these professionals may be illustrated by the example of the rejection of the proposed APR draft, which was presented in NOU<sup>12</sup> (NOU 1992, p. 8).

Municipalities and their trade union KS<sup>13</sup> were critical to the proposition presented in NOU (1992, p. 8), claiming that it would lead to a greater use of resources for administrative work rather than the treatment of patients (Syse 2009, p. 50). It would also decrease the local democracy of municipalities with regard to distributing their own resources. The Ministry of Health and Care Services criticized the NOU (NOU 1992, p. 8), claiming that, according to this proposition, a lot of medical and judicial resources would have to be devoted to evaluating people who are in a so-called "unregulated zone," those who do not fall under clear-cut prioritizing criteria. As a result, they argued that in such cases, it would be necessary to use time resources to evaluate complaint cases concerning the unjustified rejection of service provisions (Syse 2009, p. 51). It was therefore concluded that it is not reasonable to regulate the deadlines as patients' rights.

Another example of influencing proposition NOU 1992 was by the Norwegian Patient Association (Syse 2009, p. 56). Their suggestions were related to the more

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<sup>12</sup> NOU- (Norges offentlige utredninger) Official Norwegian Reports

<sup>13</sup> KS – (kommunesektorens interesse- og arbeidsgiverorganisasjon i Norge) Norwegian Association of Local and Regional Authorities

extensive regulation of health services through legal rights and included the expansion of patients' opportunities to access information and medical records and exercise influence on treatment decisions/co-determination. The introduction of a permanent office of a patient ombudsman in all counties was also proposed (Innst. S.nr. 165, 1994–1995). It was suggested during the hearing proceedings that procedural patients' rights should be included as respective duties of health personnel, so that potential lawsuits could also be based on the Health Care Personnel Act (Ot. prp. nr. 12, 1999, part 1). Furthermore, the Patient Association suggested incorporating the notions of respect for the patient, informed consent, and the right to complain into the APR. At the same time, it was emphasized that many of the decisions made in health care systems cannot be regulated by precise legal rules.

In the final account, the rights that were legislated in the APR concerned participation when receiving medical help, access to medical records, and informational insight into the patients' health condition and treatment. The main legislated rule concerned the patients' informed consent, which was to be given priority before the right to medical treatment.

### ***2.5.3 Individual rights for patients***

Apart from the few examples given above, the strengthening of the individual rights of patients in APR referred to several other aspects. Firstly, patients were gaining a greater influence on the logistical matters in their treatment (e.g., selecting physicians and hospitals). Secondly, they also were given influence in clinical matters, such as

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increased opportunities to participate in decision-making concerning medical examinations and treatment. Furthermore, the Act provided patients with the rights to necessary health care, an evaluation and re-evaluation of their condition, the ability to choose a hospital, to receive an individual plan of treatment, to transportation, to participation and information, to protection against the dissemination of information, to consent to medical treatment, to access to their medical record, and to complain (Syse 2009).

Kjønstad & Syse (1992, p. 194) have categorized patient rights into three broad categories of rules:

- 1) Those regulating the right to become a patient
- 2) Those regulating the rights patients have when they have attained the status of patients
- 3) Those providing patients with procedural rights.

The last category includes the rights based on the principle of self-determination and autonomy<sup>14</sup> (Magnussen et al. 2009; Aasen & Kjellevoid 2012). In this case, it refers to information and participation that have been given legislator's attention in the APR. These aspects of treatment were legislated in the form of the RTIP (i.e., an individual right one has as a patient that is classified under the category of procedural rights). The

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<sup>14</sup> The principle of autonomy, which was understood as respect for individual choices and autonomous decisions, was one of the core principles of the Norwegian Health Care System stated by the Norwegian government and Parliament (Storting 2007).

next section provides a closer look at regulations through the RTIP provided by the APR (Molven & Feriks 2011).

## **2.6 The right to information and participation in the APR**

### **2.6.1 *The contents of the RTIP***

This thesis explores how Norwegian clinical practitioners and health care authorities assess and interpret the RTIP. The RTIP is described in chapter three of the APR and consists of two elements: participation and information. This description of the participation in the RTIP as defined by the APR is as follows:

The patient is entitled to participate in the implementation of his medical treatment. This includes the patient's right to choose between available and medically sound methods of examination and treatment. The form of participation shall be adjusted according to the individual patient's ability to give and receive information. (Molven & Feriks 2011, § 3-1).<sup>15</sup>

This description of the information in the RTIP as defined by the APR is as follows:

The patient shall have the information that is required in order for him to gain insight into his health condition and the contents of the treatment given to him.

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<sup>15</sup> I am using Molven's translation of the Act on Patients' Rights into English.

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The patient shall also be informed of possible risks and side effects involved. (Molven & Feriks 2011, §3-2).

The information shall be adjusted according to the individual capabilities of the recipient such as age, maturity and experience as well as well as cultural and lingual background. The information shall be given in a kind, caring manner. Health personnel shall as far as possible ensure that the patient has understood the contents and meaning of the information that has been passed on to him (APR § 3-5, my translation)<sup>16</sup>

According to the Ot. prp. nr. 12 (1998–1999), the patient should receive information automatically without having to ask for it (p. 70).

The right to participation is further mentioned with regard to the right to an individual plan in §2-5, which states that patients have the right to “participate... in the work with individual plan,” (Kjellevoid 2013). This right was enforced with the law change in 2007<sup>17</sup>.

Specialists’ obligations corresponding to the RTIP are regulated by the Health Care Personnel Act (Law of 2<sup>nd</sup> July 1999 nr. 64) (Syse 2009, p. 246) as follows: “The health care provider shall give information to persons entitled thereto pursuant to the

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<sup>16</sup> There were changes in the content of chapter three in 2011 and 2012. These changes in the law’s text are not considered here since the empirical data were gathered before the changes were introduced.

<sup>17</sup> An individual plan has been defined by various legal acts as suggested in the APR (Syse 2009, p. 235). It entitles patients “that are in the need of long-term, coordinated health care services... to get developed an Individual Plan in accordance with the Municipal Health Services Act; the Specialized Health Services Act; the Mental Health Services Act” (§ 2-5. Rett til individuell plan: lovdata.no) (*my translation - AS*).

APR section 3-2 to section 3-4...” (APR § 10 ) (translation of the Ministry of Health and Care Services).

With regard to patients’ right to participation, there are no directly corresponding regulations in the Health Care Personnel Act. However, particular principles regulating the overall and reliable professional conduct are incorporated into the act (Syse 2009, p. 246):

Health personnel shall conduct their work in accordance with the requirements to professional responsibility and diligent care that can be expected based on their qualifications, the nature of their work and the situation in general. Health personnel shall act in accordance with their professional qualifications. Medical practitioner shall make decisions in matters concerning medicine... in relation to examinations or treatment of the individual patient.” (The Medical Practitioners Act of 2 July 1999 nr. 64 2010, § 4) (translation of the Ministry of Health and Care Services).

### ***2.6.2 The RTIP, the right to self-determination, and access to the medical record***

From a legal perspective, the right to consent to health help is embedded in a respect for patients and their self-determination in treatment, based on the necessary information required to evaluate a health care situation. As a general rule, health care can only be provided when the patient’s consent is given “unless legal authority exists

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or there are other valid legal grounds for providing health care without consent” (Molven & Feriks 2011).

Consent can also be withdrawn at any time, and health care providers have to provide patients with information regarding the consequences of not obtaining health help. In the Mental Health Care Act (Law of 2<sup>nd</sup> July 1999 nr. 62), art. 2.1, the right to informed consent (APR Ch. 4) is made directly applicable for the voluntary treatment of psychiatric patients. It is also demanded in the same act that as long as it is possible, self-determination has to be applied to all patients subjected to mental health care.

In 2006, the Mental Health Care Act was supplemented with article 4.3, which stated that the psychiatric treatment of patients who do not have the ability to consent and are considered to have serious diagnoses can take place only pursuant to the regulations of coercive treatment.

According to article 4.3, the health care provider decides whether the patient lacks the competence to give consent. This decision is based on the patient’s age, mental state, maturity, and experience. A decision concerning the lack of patient ability to give consent should state the reasons for it and should be given in writing. According to art. 4.3, “Competence to give consent may cease to apply wholly or partly if the patient, on account of a physical or mental disorder, senile dementia or mental retardation, is clearly incapable of understanding what the consent entails” (Molven & Feriks 2011).

Furthermore, in cases when other regulations do not comprise the right to information or they do it in a weaker form than the RTIP, priority has to be given to



the APR (les posterior) (Syse 2009, p. 248). The RTIP and the legal goals that make up its background must have regard for patients' integrity and self-determination (Syse 2009, p. 264; Molven & Feriks 2011).

The right to information has to be viewed from a legal perspective as an integral part of the right to self-determination. Information is a pre-condition of the validity of the right to informed consent (Aasen 2000, p. 281). The right to participation can be perceived as a continuity of the right to informed consent or a pre-condition for it. In the first case, participation encompasses a greater degree of active participation, especially in the choice of treatment when it has the possibility to develop preferences as to which treatment to apply. Similarly to information, the second case is a way to secure the quality of informed consent. The right to informed consent is then to be based on sufficient knowledge and the patient's evaluation of the situation.

Chapter 5 of the APR regulates the right of access to medical records, which is an important component of the right to information. The medical record encompasses descriptions of health conditions, diagnosis, treatment methods, complications, recommendations, etc. (Aasen 2000, p. 454). In Norway, this right was established by a decision of the Supreme Court (Rt. 1977, p. 1035). Before that, it was regulated by the Medical Practitioners Act of 1980 (art.46). One justification of the Supreme Court in Rt. 1977 (p. 1035) concerned the aspect of better communication between specialists and patients. The right was further expanded to "correction and erasure of medical records" (patients may demand that the information in their medical records is to be corrected or erased) and "transfer and loan of medical records" (the patient is entitled to object to the disclosure of his or her medical records or information in the records).

According to the right, the patient is also entitled to a brief and simple explanation of medical terms. While the right to information in art. 3-2, point 1, gives patients the right to oral information, art. 5-1, point 1, ensures the right to written information (Aasen 2000, p. 454).

In some circumstances, the patient may be denied access to information in his or her medical records if this is absolutely necessary in order to avoid endangering the patient's life, causing serious damage to the patient's health, or if access is clearly inadvisable out of consideration for persons close to the patient. The expanded regulation of access to medical records has been granted to patients since 1 January 2001 (Syse 2009, p. 388).

The aforementioned rights must be viewed in a close relationship as pre-conditioning and complementing each other.

### **2.6.3 Executive power in interpreting patient rights**

#### *2.6.3.1. The Directorate of Health*

The legislators have not defined health rights precisely (Kjønstad 2003). The Directorate is the only legitimate unit that can develop interpretations of the content of the RTIP. The starting point for the analysis of clinical practice in this study is the guidelines developed by the Directorate.

When the Directorate interprets the health law, it may be done in the form of written recommendations or online information sources. With regard to online sources,

there are two websites that are authorized by the Directorate. The written and online recommendations published by the Directorate may be formed in two ways, either as a code of conduct or as guidelines for practice (IS-1870). The focus of this study is on the online and written guidelines for best practices. In order to explain the outcomes of regulation through the RTIP, it is necessary to gain insight into the development process of the national recommendations for clinical action. These recommendations create the standards for examination, treatment, and following-up on patients. These standards have the purpose of securing the best interpretations of the RTIP and eliminating variations in its implementation in practice.

When guidelines concerning the RTIP are developed, international standards for establishing such regulations are followed. As a result, the professional environments within the areas of health care, law, and user representatives are actively involved in this process. The assignment of developing national guidelines most often comes from the Ministry of Health and Care Services. However, it may also be the Directorate itself that initiates this process, as well as external professional environments. The work proposed for each legislative regulation has to be approved by the leadership of the Directorate before it can begin. The Directorate states that the regulations are recommendatory. It emphasizes that an individual evaluation of these sources has to always be made before a choice of action is taken. The space for discretionary interpretation may, therefore, be seen as built in and legitimized within the national regulations. In order to be published under the authority of the Directorate, all of the sources must be accepted by the representatives of patient organizations.

The guidelines published by Directorate expand the content of the RTIP in the field of psychiatry and health care in general. These sources represent advice and descriptions of the best practices for specialists who work clinically with patients. The development of the guidelines is intended to increase the predictability of services provided for the patients. The Directorate emphasizes that if an interpretation of the RTIP strongly deviates from the recommendations, it should be well documented and justified in case of legal claims, state control, or complaints (e.g., IS-1315). The recommendations are developed as a result of an agreement between health care specialists in various fields, central administration, and patient organizations (e.g., IS-1388). The regulations are advisory for practitioners and informatory for various other target groups, such as patients and their relatives.

#### *2.6.3.2. Guidelines for clinical practice*

When issuing the guidelines for clinical practice, the Directorate acts as a juridification agent or law interpreter that gives advice on how practitioners should relate to the aspects of information and participation in their clinical work. It is, however, important to emphasize that the Directorate is not a judicial organization, as are the courts. Thus, its interpretations of patient rights are not neutral reflections upon the will of the legislators.

One of the institutional characteristics of the Directorate is that it has been dominated by professionals in the field of medicine rather than specialists in the field of law since the beginning of its existence (Byrkjeflot 2005). Furthermore, the

Directorate must combine its role as a law interpreter with the interpretations introduced by the actors involved in the development of these regulations on its behalf. Clinical specialists and patient organizations have been the main actors involved in the development of all the recommendations concerning the RTIP.

The Directorate as a formal administrative provider of standards may be expected to create a rather consistent set of interpretations of the RTIP. At the same time, the guidelines address various target groups and should be adjusted accordingly in each case. The guidelines may have various aims and forms and emphasize various aspects of the RTIP. From an administrative point of view, the guidelines have the same advisory status as the basic grounding source of the RTIP.

The RTIP and its guidelines make up the legislative framework for clinical practice and may be interpreted differently by various specialists. This framework may be rather heterogenic, as the various sources can have different contents and various degrees of precision. To a larger or lesser degree, they may also provide the possibility for autonomous practice. The more extensive and precise regulations may bind professional discretion. Clear and specific regulations could result in different implications for clinical practice than the vague ones.

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## **2.7 The relationship between specialists and patients**

### ***2.7.1 Professional reasoning in psychiatric treatment***

Psychiatry as a discipline is at the crossroads of social and natural science. It is therefore important to have objective diagnostic methods and systems of classification (Malt et al. 2003, p. 14). These two factors are the basis for the reliable choice of appropriate method of treatment. When making this choice, contact with patients is a permanent element (Malt et al., 2003). The ability to establish a good relationship with patients is an important trait of a skillful psychiatrist. A critical aspect of psychiatric treatment is the so-called “cooperation alliance” between specialists and their patients (Krupnick et al. 1996). This is a phase when the trust between patients and specialists is established. The professional goal is to make patients feel that the specialist is on their side and expresses an accepting and securing attitude (Malt et al. 2003, p. 777). Various strategies for how to develop and maintain a good relationship with patients over time exist (Horvath & Luborsky 1993; Krupnick et al. 1996; Safran & Muran 2000).

A professional motivation to develop a good cooperation alliance may be strong for many reasons. One of them is that it is an important tool for gaining patients’ compliance with the treatment (Martin et al. 2000; Duncan et al. 2004), such as accepting an undesired drug<sup>18</sup> or being persuaded not to insist on an unreliable

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<sup>18</sup> Perhaps of most interest was the finding of a strong association between alliance and outcome in pharmacotherapy, in both the medication (imipramine) and placebo conditions. What this finding suggests is that the therapeutic alliance may strongly influence the placebo response embedded in pharmacotherapy as an

treatment (Malt et al. 2003, p. 902; Krupnick et al. 1996). Furthermore, a well-established therapeutic alliance is considered to have a positive influence on patients' motivation in psychotherapies (Martin et al. 2000; Johansson & Jansson 2010).

When developing an alliance relationship with the patient, a good professional practice is not to reveal any information that may endanger the patient's trust (Malt et al. 2003). Any information that may be difficult for patients to accept and could cause them to reject the treatment is typically withheld until a good alliance relationship is established. Such information may, for example, include the prognosis related to certain diagnoses (Malt et al. 2003, p. 109).

The regular course of action is that specialists recommend a plan for treatment and gain patients' acceptance of it through dialogue (Malt et al. 2003, p. 106). This plan is based on treatment methods that are reliable. In case of any doubts, a good professional practice is to refer to the experience, either one's own or that of more experienced colleagues. Experience is a valid knowledge basis for reliably appropriate action.

Educational background, experience, and standard tools of examination are critical elements of professionally reliable evaluation that are understood to be the most objective (Malt et al. 2003, p. 18). If two experienced professionals come to the same conclusion regarding the same patient, the reliability of that evaluation is perceived to be strengthened (Malt et al. 2003, p. 18). At the same time, the more objective the tools

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imprecise factor above and beyond the specific pharmacologic action of the drug. The variability of the doctor-patient relationship may account for the considerable variability in placebo and active drug responses.

for gathering data, the more reliable the results of a specialist's evaluation are considered to be. Another validity principle for making a reliable diagnosis is the cause-effect relationship in the development of illness supported by its long observation (Kukar 2003; Malt et al. 2003, p. 17).

### **2.7.2 *The traditional approach to patient-specialist relationship***

When professional discretion alone regulated health care services, the patient traditionally lost the opportunity to make decisions (Bleiklie et al. 1985, p. 202). During the time when patients had no legislated rights, there was an underlying assumption that the specialists made all the decisions in the context of treatment. The patient had to accept being subjected to the treatment in order to receive any health services. In fact, one of the treatment strategies in psychiatry has traditionally been to withhold information from the patient (Bleiklie et al. 1985; Bomann-Larsen & Jensen 1985).

Being the subject to professional authority has been called a surrender of private judgment (Friedman 1973, p. 129; Starr 1984, p. 10). When one enters an authority relationship as a subject, one surrenders one's judgment regarding a certain range of matters to someone else (Archer 1995, p. 30). What then becomes the subject of surrender is individual action (Raz 1987, p. 39). In an authority relationship, one becomes bound by decisions made by someone else (Green 1990, p. 40).

It has been documented that patients, as a rule, historically did not have control of the information necessary to influence decisions in their treatment (Froestad &



Jensen 1985). Professional control of the information was used as a measure to influence and persuade the patients in treatment (Bleiklie 1992). Even though the accessibility to various information sources has been increasing lately, the level of specialist knowledge necessary for insight into the process of professional evaluation has also been increasing (Starr 1984, p. 391).

Professionals in the health care sector in general and in psychiatry in particular have traditionally not been receptive to any influences over their discretionary space for making autonomous decisions. Evaluations have been based on patient's independent observations (Fischer & Brodsky 1978). In medicine, patient compliance has for a long time been a central concept.

Thus, recent changes in the legal framework, introducing novel factors of the RTIP that have been implemented into psychiatric practice, have made strides against the traditional logic of the field, although they may not always be easily accepted by practitioners.

### ***2.7.3 The RTIP-based approach to patient-specialist relationship***

The RTIP may be seen as an alternative way to regulate the relationship between clinicians and patients than professional autonomy, reliability, and discretion. Specialists may be more or less open to letting the RTIP influence their discretionary autonomy in treatment (Bomann-Larsen & Jensen 1985).

It remains to be seen whether the new type of regulations will function according to the legislators' intent. The obstacles in providing efficient and reliable treatment based on the RTIP may be numerous, and the RTIP and its guidelines might therefore not be followed by all practitioners.

In voluntary psychiatry, it is the patient who looks for assistance from the specialist. This process comprises individual responsibility to admit to a problem, the ability to obtain information on available services, and the courage to seek help (Bomann-Larsen & Jensen 1985, p. 196). These requirements, together with possible problems regarding accessibility and the long waiting lists to get in, may attract patients who are capable of making use of the RTIP. At the same time, an increasing level of specialization of professional knowledge in psychiatry, which requires extensive education and experience-based training, might also be a factor that contributes to a misbalance between specialists and patients (Hunink & Glasziou 2001).

Health rights in general and the RTIP in particular have been characterized as weak rights with limited possibilities to make legal claims on their violation. There have not been any legal claims based on the RTIP in Norway thus far (Bernt 2001, pp. 169–70; Syse 2009). It may be speculated that the reason for this lack of claims is that health rights are often vaguely formulated, and the discretionary space for their interpretation has been characterized as large (Skålevåg 2005). It may, therefore, be difficult for their interpreters to decide if the rights have been fulfilled. These challenges in the interpretation of health rights in legal practice might also be found in clinical practice.

There can be variations in professionals' perceptions of their obligations towards patients. Such individual interpretations have been considered a necessary aspect of clinical practice. Examples of these variations may be the kind of information that should be provided or the type of diagnostic methods to be applied (Malt et al. 2003, p. 113). Skills to make such evaluations have been called "professional art" (Malt et al. 2003, p. 898). The degrees of the variation in professional interpretations of the specialists' obligations towards patients that results from recent legal changes will be further discussed in this work.

## **2.8 Summary**

The aims of this chapter were to describe psychiatry as a unified and institutionalized field of clinical practice and to focus on the development of the law regulations that have framed the field of clinical practice.

The implications of the regulation through the RTIP for clinical, voluntary psychiatry are the subject of study in this work. A historical overview of the regulations of psychiatric practice before and during the expansion of individual rights has been given. The APR signaled a cardinal change in the way psychiatric service is regulated in Norway. As a result of introducing the APR, the legal regulation of psychiatry has been strengthened and become individualistically oriented. Historically, the relationship between psychiatry patients and clinicians has been regulated by clinical discretion longer than has been the case in other fields of medicine. Before the RTIP

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was enforced for psychiatric patients, they were disadvantaged with regard to information provision, which carried the possibility of influencing the treatment.

The current legal expansion of individual rights has led some authors to argue that there has been a change in psychiatry towards an autonomy-oriented legal culture (Skålevåg 2005). This was especially true for clinical practice; until the last few decades, the main regulation guiding the relationship between the patients and their doctors was professional discretion, which had roots in Hippocrates's tradition. According to the ethical rules of 1961, specialists were not obliged to but were only recommended to inform their patients. The first legal regulation of clinical practice with regard to informing patients was introduced in 1980 by the Medical Practitioners Act. For the first time, this act regulated professionals' obligations in regard to patient participation. Furthermore, the ethical rules for doctors that were introduced in 1996 specified that patients were to be informed with as much information as they desired. The few legal rules and ethical principles mentioned here provided a formal basis for patient information and participation in clinical practice before the introduction of the APR.

It has been argued by law scholars that such scarce and vague regulations gave professionals the extensive possibility to practice discretion (Berg 1991). In 1999, four new acts on health services and care were passed by the Norwegian Parliament. These acts were called the Health Act Package, which consisted of the Specialized Health Services Act, the Mental Health Care Act, the Health Care Personnel Act, and the APR. These laws came into effect in 2001 (Befring et al. 2002, p. 56; Syse 2004). It is important to mention that all of these acts reflect and complement each other. The

first patients' rights were developed as a "mirror reflection" of legal rules that imposed obligations on health care personnel (Syse 2009, p. 89).

Legal developments that have taken place in 2001 have been characterized as juridification of the health sector, but they also significantly signify a flourishing period for patient rights in Norway. The Norwegian Public Health Service had traditionally been based on the assumption that patients are sufficiently protected by the duty and role prescriptions that were imposed on health care personnel and units. The Supreme Court's activity contributed to the development of patients' rights in Norway (Table 2.1.). An important role was also played by patient organizations and the specialists employed in the National Health System.

The RTIP, the right to informed consent/self-determination, and the right to access one's own medical record, all of which were legislated in the APR, must be viewed as having a close relationship and corresponding, pre-conditioning, and complementing each other.

The Directorate is the only legitimate authority that may develop interpretations of the content of patients' rights for clinical practice. The Directorate has published supplementary legislative regulations that expand the content of the RTIP in the field of psychiatry and health care in general. These sources represent advice and descriptions of good practice for specialists who work with patients in a clinical setting. The development of these regulations was intended to standardize practice among professionals and increase the predictability of services provided for patients.

One of the institutional characteristics of the Directorate is that it has been dominated by professionals in the field of medicine rather than specialists in the field of law since the beginning of its existence (Byrkjeflot 2005). When interpreting the RTIP, the Directorate must combine its role as a law interpreter with the interpretations introduced by the actors involved in the development of the guidelines. Clinical specialists and patient organizations have been the main actors involved in the development of all the recommendations concerning the RTIP. These target groups represent different interests, which leads to many question regarding the content of these understandings.

The RTIP may be seen as a way to regulate the relationship between clinicians and psychiatry as an alternative to professional autonomy and discretion. Since the introduction of the RTIP, specialists may be willing to accept some influence from patients regarding their discretionary autonomy in treatment to various degrees.



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## 3. The theoretical perspective upon the implications of the RTIP

### 3.1 Introduction

The question of what can explain the relationship between law and human action is one of the basic issues in social sciences. It is also the question that different theoretical perspectives provide various answers to.

The goal of this chapter is to develop a theoretical framework in order to explore and explain the implications of regulation through the RTIP for clinical practice in the organizational setting. I chose to base my theoretical reasoning on the institutional approach in a broad sense. This approach consists of different perspectives, developed in various fields and consists of different elements having in common general assumptions about the nature of human action (Alexander 1982). Within the scope of institutional approach two logics of action are discussed below, the logic of appropriateness and the logic of consequence. There are several justifications for this choice. The institutional approach enables the analysis of the professional practice<sup>19</sup> perceived as an outcome of rule following (such as clinical norms and legislative regulations). It therefore allows capturing the outcomes of regulation through the RTIP for clinical action that may either deviate from or comply with the legislator's goals. The perspective comprising rule following is not sufficient to capture the clinical practices explored in this work. Therefore, the rational choice element is added. It takes

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<sup>19</sup> Professional practice relates to the context of clinical treatment situation in which RTIP is interpreted. Professional practice is further called clinical practice.



its point of departure in the clinical assessments of action alternatives, based upon their consequences. In this study, *athelt* gives insight into how clinicians assess the value of the consequences following from each alternative, and how the choice is made based on this.

Clinicians can be faced with a variety of possible treatment situations and their choices among the action alternatives according to the consequences and goal achievement is likely to entail other factors than rules. These situational factors may influence the implications that the RTIP has on the clinical practice, and must therefore be included in the analysis, as they could provide insight into situations when the rules are not followed. I assume that the specific outcomes of clinical reasoning can be the result of, for example, pragmatic reasoning, consequence-oriented action or rule following.

The interpretations of the RTIP are presented in the guidelines<sup>20</sup> that frame *de facto* clinical action when the questions concerning information and patient's participation in clinical treatment are being evaluated. The analysis of the guidelines is aimed at exploring the characteristics of the guidelines and the variations in the content of their interpretations of the RTIP. While the characteristics of the guidelines may to some extent explain the assessments made by the clinicians, their content is the basis of the analysis of the clinical assessments. At the level of clinical practice, the content of the assessments is explored and explained. The general assumptions of institutional theory frame the analytical concepts applied to explore clinical reasoning. These

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<sup>20</sup> The guidelines for clinical action include both online sources and published written documents, as described in more detail chapter 4.

comprise the general assumptions on human action as well as context-related explanatory dimensions (the organizational one and the professional one).

The concept of juridification is based on the assumption that the RTIP regulates clinical practice and is interpreted in clinical practice. Applying the institutional perspective, I explore how the space for discretion is structured and how clinicians evaluate and choose the best treatment for individual patients.

The analytical concept of co-determination draws a line between the traditional practices and the new understandings introduced by the RTIP. Professionals within public services, such as psychiatry, are simultaneously subjected both to regulations through clinical norms and to the requirement of rational, practical reasoning, and to compliance with the law. As such, they not only have to demonstrate legitimacy by following professional prescriptions and rationality of clinical judgment, but also to be responsive to public moral pressure (Scott 2008).

In this chapter I first discuss general theoretical anticipations about the nature of human action. I introduce the dimensions of the analysis (the legal one, the professional one, the organizational one and the relationships between them), which may contribute to explaining how the legislative regulations influence the clinical action. I suggest that the legislative regulations (the legal dimension) may influence clinical action directly.

### **3.2 The institutional approach**

Generally speaking, institution can be understood as a relatively stable collection of practices with roots in pre-defined patterns of thought and action and established regimes of knowledge that are exemplary for particular actors in precise

situations (March & Olsen 1998, p. 2). Institutions are embedded in the structures of meaning, the institutional dimension that legitimizes identities and rules. Rules and identities prescribe more or less precisely what exemplary action is and what the appropriate interpretations of different situations are (March & Olsen 2004, p. 7). The institutional approach is not unified and coherent. It has been applied within a variety of other perspectives, such as the discourse theory or ethnographic studies (Goodin & Tilly 2006, p. 150). It has also been employed within different disciplines, such as sociology, political and organizational science, law, and economy.

Scholars make a distinction between sociological institutionalism (DiMaggio & Powell 1991), historical institutionalism, new economic institutionalism, and rational choice institutionalism (Hall & Taylor 1996; Rueschemeyer 2009, p. 207). According to Blaikie, a variety of contexts and disciplines have also contributed to a number of existing conceptualizations of the notion of “institution” as such (as cited in Magnussen 2006, p. 35). The process of putting these rules into action, such as following the rules in the interpretations of the RTIP in the case of this study, is called institutionalization.

In this work, the main understanding of institutional approach is adopted from work of March and Olsen as it has been recognized in political and organizational science (March & Olsen 1995; March & Olsen 1996, p. 139). Their concept of the institutional approach as an institution embedded in identity and action driven by rules of appropriateness is based on the assumption that institutionalized informal norms are the sources of homogeneity and stability (Goodin & Tilly 2006 p. 159). In this study, I anticipate that clinical practice is driven by norms. It has been shown previously that

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traditional norms can be strong drivers for clinical practices (e.g. Tversky & Kahneman 1981).

Once an identity with practice is established, individuals will not only follow but also aspire to sustain any informal rules (March & Olsen 1998, p. 2). Thus, one may expect that the legal goals institutionalized in clinical practice will then to some extent continue to be institutionalized in the form of established practices.

In this study, the aim is to explore de facto practices, and not only the case of rule following. For this reason, Scott's (1995) understanding of institutional perspective is important to consider. He addresses three pillars of this perspective, regulative (legal systems comprising policies and rules), normative (moral and ethical systems including work roles and norms) and cognitive (cultural systems including values and assumptions), the first two being especially relevant in this context (Palthe 2014). A similar distinction is made by March and Olsen, who furthermore emphasize that the institutional settings in practice are likely to prompt individuals to evoke different logics in de facto action (March & Olsen 1998). They perceive human action to be embedded in the "logic of consequentiality" (LoC) and the "logic of appropriateness" (LoA).

As argued in the following sections, a combination of these two logics allows capturing the situations when different sets of rules (clinical or legal) are followed, as well as not following the rules (consequence-based considerations), which may all together explain clinical action. It also allows exploring which settings in practice enable the dominance of one logic over the other, for example, under what conditions

rules of appropriateness may overpower or redefine clinicians' self-interest (March & Olsen 1998; Olsen 2001).

In the next sections I first present the main assumptions about the two logics assumed to drive clinical action, the possible relations between them, and proceed to the description of action driven by norms, external rules and consequence-based reasoning.

### **3.2.1 The logic of appropriateness**

#### *3.2.1.1. Matching the norms and the regulations to concrete situations*

Within institutional theory, one way to interpret action is the logic of appropriateness (LoA) (March & Olsen 1989; March & Olsen 2004). LoA is a general understanding in which the starting point for explaining individual action is that actors follow rules when they evaluate a present situation. The basic assumption is that existing rules are the fundament of present action (March & Heath 1994; March & Olsen 1989). To be used for the purposes of this study, the concept of rule-driven action has to be operationalized to the context of clinical practice as follows.

Establishing appropriateness is done by asking questions of what is appropriate to do when participation and information are practiced in treatment. The answers to these questions depend on how the professionals identify themselves. The process of identification takes place through answering the following questions: "Who am I?",

“What is the situation?”, and “What does a person like me do in this particular situation?” (March & Olsen 1989; March & Heath 1994; March & Olsen 2004).

Further, the professionals have to determine what kind of specific rules to apply. In this study, legislative regulations and professional norms are considered the basis for the practice of participation and information. According to LoA, this way of matching norms or legislative regulations to situations will still take place regardless of the situations being recognized as new or reoccurring (March & Olsen 1989).

In this matching process, experience and intuitive judgment of the situation are influential factors. The established patterns of how to recognize situations are anticipated to be the critical point in the interpretation of the RTIP. Such recognition is possible after classifying the situation based on the criterion of similarity with previously encountered situations (March & Olsen 2004, p. 4).

In this study, I anticipate that specialists try to match new situations with the ones they already know and apply existing rules to both new and routine situations (March & Olsen 2004, p. 4). A situation may be more or less inconsistent, which could cause variations in the specialists’ perceptions of it, affecting the choice of rules applied to it (March & Heath 1994, p. 61).

### *3.2.1.2. Role identities and self-awareness*

In LoA, legislative regulations and professional norms may be equivocal, and individual interpretations of the same rules and norms may vary. Therefore, searching

for appropriateness is a process that is characterized by uncertainty and cannot be easily predicted. It requires individual thought, judgment, imagination, and care (March & Heath 1994, p. 61). When specialists match rules to situations, the outcome will depend on their interpretations of the role expectations attached to them (Goodin & Tilly 2006). Such expectations are related to critical aspects, without which one cannot claim to be a proper expert (Goodin & Tilly 2006, p. 479). In the case of clinical practitioners, they must perform according to particular standards of reliability accepted in practice, as well as to be in compliance with the legal framework for the practice.

LoA thus establishes the concept of role identity. Identification with social roles, such as a clinical specialist, assumes knowing, following, maintaining, and accepting the rules assigned to them. Thus, identities become a type of moral guidance for what is good and true for the actors that identify with them (March & Heath 1994, p. 64).

Individuals clarify their identities by means of self-awareness (March & Heath 1994, p. 61). An identity will always be related to how actors describe themselves in terms of their professional obligations. Accepting an identity is a motivational and cognitive process that is related to learning the rules of how to act in a particular way and how to interpret physical and social environments (March & Heath 1994, p. 63). For example, clinical practitioners must learn the existing regulations guiding clinical conduct that clarify an understanding of it in practice.

LoA combines the normative aspect of regulations and order with the spontaneity of individual actors. LoA connects the impact of regulations upon defining actions with the possibility of individual actors to influence actions through their

interpretations of regulations, situations, and identities. It is thus possible to analyze action and situations by exploring the rules, together with other factors that influence actors' perception of what is natural to do and to unravel the nuances of individual interpretations in specific situations.

### *3.2.1.3. Clinical action as norm following*

In general, norms guide action and shape peoples' attitudes and beliefs (Rueschemeyer 2009, p. 64). In the context of this study, I limit the concept of norms to professional, clinical norms. Clinical practitioners may be expected first of all to follow the rules accepted in their practice, which may thus be seen as sources of stability and homogeneity in understanding a clinical situation.

Professional norms are considered to be a strong source of guidance for action (Brunsson 1989, p. 228; Molander & Terum 2008, p. 182). Through years of professional training, individuals learn what the appropriate norms of action are, when to invoke them, and how.

Legal rules originate from various legal sources, of which the law is the most important one. Legislative history is supplementary to law, while advisory legislative regulations based on law and legal practice (particularly the Supreme Court's practice) may also be mentioned.

Existing legal rules and professional norms have values and principles embedded in them that guide the individuals' interpretations of reality. They might give



rise to different understandings when the practitioners have to recognize the symptoms, match the diagnoses to the method of treatment, relieve or prevent the symptoms and, importantly, ensure patient compliance with the treatment (Martin et al. 2000; Malt et al. 2003, p. 39).

Although the concept of institution may be related to stability and order in social life, the institutional approach concerns not only consensus and conformity but also conflict in following the rules (Ritzer 2004, p. 14). Institutional theory sees formal legal rules as insufficient for explaining de facto institutionalized practices (Ritzer 2004, p. 395). Through the application of LoA, this study addresses the deeper and more resilient aspects of clinical practices and investigates how different types of legal rules may be adopted or fall into decline in de facto clinical practice. The logic of consequentiality (LoC) is also applied in order to explore when and how legislative regulations are not followed. It may be seen as more outcome-oriented premise for action related to the evaluation of clinical situation embedded in discretion and practical reasoning of what is appropriate. In this case, norm following may be justified by the expected outcome of action.

The rule-following perspective does not, however, capture all of the clinical practices studied in this work. It is therefore expanded by the rational choice approach to the human action.

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### 3.2.2 *The rational choice*

Within institutional context, rational choice derives from the assumption of structurally conditioned rationality, utility, and profit maximization. Thus, actions are the product of strategic, utility-maximizing individuals (Austen-Smith & Fryer 2005).

Within the field of clinical practice, rational choice comprises the idea of practice as an instrument of clarifying the goals of the treatment procedures, i.e. which choice of action the practitioners follow, and whether and how the result of an action accords with what was desired.

Following the rational LoC implies treating possible rules and interpretations as alternatives in a rational choice problem. I follow J.March and suggest that to act on the basis of the logic of consequentiality or anticipatory action includes answering the following questions (March & Heath 1994, p. 102):

*a. What are my alternatives?*

*b. What are the consequences which follow from each alternative? How likely is each possible consequence assuming that the alternative is chosen?*

*c. How valuable for me are the consequences associated with each alternative? How is a choice to be made among the alternatives in terms of the values of the consequences?*

From the rational choice perspective, the actor chooses the alternative that has the best-expected consequences. It is based on a means–end rationality, where one tries to predict the future effects of an action. From this perspective, to act in conformity

with the rules that constrain conduct is based on rational calculation and contracts, and is motivated by incentives and personal advantage.

In the organizational context of this study the clinician has the responsibility to the organization to fulfil certain set of tasks. Clinicians may as well pursue their own interest and engage in opportunistic behavior at the cost of implementing the legislative goals or clinical norms. The institutional, consequence-based approach suggests an explanation of how the institutional setting may influence individual behavior and stresses how/when strategic interaction determines treatment outcomes.

### ***3.2.3 Pragmatism and consequence-oriented reasoning***

Clinical reasoning is also characterized by pragmatic thinking. The application of knowledge, skills, autonomy and expertise may to a large extent depend on specific clinical situations. According to LoA-oriented action, the reasoner is obliged to distinguish, the better choice from the worse in a situation that will always to some degree be uncertain or unique.

Good clinical practice includes the ability to choose treatment, and diagnostics in the most efficient order so as to minimize pain, financial cost, and time elapsed to improvement (Graver 1988). This is an oversimplification, but useful at this point. Based on the literature on professions, I assume that clinical specialists are not trained to follow rules, but rather to apply discretionary judgment and achieve clinical goals. They are first of all rational and pragmatic thinkers, which means that deviations from

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the consequent pragmatic reasoning can be treated as deviations from reason (Graver 1988). Pragmatism can be seen as a philosophical tradition which inspired a broad spectrum of theoretical approaches ([Stanford Encyclopedia of Philosophy 2008](#)). The most common approach in the clinical tradition has been the logic of practical valuation based on empirical observation (Miller 1996). This approach to pragmatism stresses the priority of action over doctrine, of experience over fixed principles.

In case of assessing the patient's influence on decision-making, clinical pragmatism is focused on helping to clarify, not to prescribe, the patient's choices based on the situation at hand (Tryon et al. 2008). Clinical action is then determined by the need to respond to the immediate necessity or to achieve a particular practical result. In this way pragmatism may be seen as being consequence-oriented. In pragmatism it is the situation that sets premises for patients' involvement and information in treatment. Thus, the best solution is the outcome that seems best in this situation (Whitford 2002). The rational choice is more strongly oriented towards the future than pragmatism (Rosenfeld 1996). Based on the logic of rationality, the practices are structured to promote clinicians' individual interests, which may in practice overlap with patients' influence and information in treatment. In the context of clinical practice, the goals and means which depend upon the norms and regulations are not blindly determinative for action.

This difference between the rational choice and the pragmatic approach may be easy to establish theoretically, while in the context of clinical practice it may be difficult to differentiate between them. For example, convincing patients to comply with the treatment suggested by clinician may be seen as experience-driven action as

well as the outcome of the goal to fulfil treatment as fast as possible reducing the costs to a minimum. Pragmatism rejects the maximizing assumption as dependent on a knowledge of ends, that have yet to be discovered in particular situation, and posits in its place an actor who hypothesizes solutions related to the specific treatment, adjusting it to experience. In the pragmatist construal, desires/interests form only in reference to specific problem situations. Utility is not a reason for actions (Feilzer 2010). The difference between the rational choice and the pragmatic approach depends on the motives clinicians have while carrying out the treatment. In order to understand their motives, we need to have information about the clinical goals behind their decisions.

In the following section I discuss the clinical norms, LoC and legislative regulations as the basis of clinical action. I anticipate that each of them may lead to different perceptions of clinical autonomy and may result in different interpretations of the RTIP.

#### **3.2.4 *The relationship between LoA and LoC***

Clinical practice involves balancing the enduring tensions between different logics of action, for instance between the demands and obligations of legislative regulations and individual calculated self-interests. March and Olsen suggest four different relationships between the logics which are important in the context of studying de facto clinical practices (March & Olsen 1998).

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One approach is to subsume one logic as a special case of the other. Within the LoA perspective, consequential reasoning is seen as one of many possible rules that clinicians may come to believe are exemplary for their professional roles in treatment situations. From the LoC perspective, rules of appropriateness may be seen as the result of utility calculations. In this case, rules and identities are "...simply devices that minimize transaction costs in the implementation of consequential action" (March & Olsen 1998 p. 953).

Another understanding is that all action involves rule following when one perceives "...consequential logic and personal interest calculations simply as rules of particular form that are associated with specific identities and situations" (March & Olsen 1998, p. 953). Thus, "...consequential choice is simply one of many possible rules that may be evoked and followed when deemed appropriate" (March & Heath 1994, p. 102).

Another perception comprises the relationship between logics as constantly changing. At this point, the rules are developed when the actor takes new roles, relations, forms new identities. Thus, action based on LoA and LoC can be both self-reinforcing and self-limiting.

An alternative is to assume a hierarchy between logics. LoA may be used subject to constraints of consequences, or rules of appropriateness are seen as constraints within which LoC operates. One version of the hierarchy notion is that one logic is used for major decisions and the other for refinements of those decisions. Alternatively, one logic may govern the behavior of leaders and the other the behavior of clinicians.

Logics of action may also be differentiated in terms of clarity. Thus, it may be hypothesized that a clear logic will dominate a less clear logic. This is based on the assumption that the rules of appropriateness can be defined with varying precision and provide unclear prescriptions in different settings and situations. For instance, legislative regulations may vary with regard to how precise, consistent and obligatory they are. Likewise, the clarity of (self-)interests, preferences, choice alternatives and their consequences may vary. Clinicians, for example, may be influenced by the rules and structural settings in the organizations, yet they may face ambiguous rules as well as situations where no direct personal interest is involved. Thus, rules and interests give actors more or less clear behavioral guidance and make it more or less likely that LoA or LoC will dominate.

Time pressure is likely to promote rule following rather than the more time- and resource-demanding calculation of expected utility (March & Simon 1993). Furthermore, in case when a policy prescribes following the rule of law, LoA is likely to be used to justify decisions also when it is not used to make them. LoC may be preferred when clinicians consider rule following to be unsatisfactory in terms of established goals (March & Olsen 2009).

In this study I pose a question about the relationship between LoA and LoC. The aim is to explore how de facto action takes place, how and when LoA or LoC may dominate clinical action. At this point, the question will also be under which circumstances the well-established ways to think (clinical pragmatism) may be driven by LoC or LoA. Rules of appropriateness include routines, organizational structures, clinical norms and established practices and legislative regulations. In the following

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section I discuss action driven by LoA (clinical norms, legislative regulations) and LoC (self-interest).

### **3.2.5 Action driven by norms, consequence and regulations**

It has been argued in the literature that the consequence-oriented professions such as psychiatrists/psychologists in welfare states have been ineffectively subjected to public accountability. It has led to strengthening clinicians' obligations to report and the arguments for subjecting them to increased legal regulations (Goodin 2009).

The idea that norms of action are developed in order to justify and guide action as opposed to purely consequence-driven action has been widely acknowledged in the social sciences (Elias 1982). The concept of norms has been one of the basic tools for analyzing the components of action (March & Olsen 1989, p. 22; Rueschemeyer 2009, p. 65). The acknowledgement of the fact that informal rules guide administrative practices has a long theoretical tradition in organizational science (Zhou 1993). This is especially true with regard to the capacity of external rules to influence well-established institutionalized traditions (Feldman 2000; Feldman & Pentland 2003).

An alternative to guiding through norms is regulation using a scope of external rules. Regulations may thus be expressed in the form of routines or procedures (March & Olsen 1989, p. 22). An example is the RTIP, which regulates professional practice through written guidelines developed by the Directorate. The concept of external rules is broad and incorporates various types of rules that may define appropriate behavior.



On one hand, rules make it possible to coordinate complex situations by, for example, reducing the uncertainty of treatment procedures. On the other hand, they may appear as rigid and constrain action, including setting certain boundaries on clinical discretion (Neunreither & Wiener 2000).

The evaluations of the RTIP may be based on various principles, such as legal security, expected outcome, professional discretion, and reliability. Thus, apart from legal and norm based framework for treatment, clinical decision-making relies heavily on the rational consequence based logic in respect of evaluating treatment alternatives.

In the literature on how the clinical professionals reason, it is emphasized that real professionals such as clinicians perform mental labor, which is highly specialized and complex requiring overall judgment (Noordegraaf 2007). It needs evaluation of the relationships, roles, and objects, by relying on expert knowledge and by continuous interpretation of the situation (Sutherland & Dawson 2002, p. 53; see also Noordegraaf 2000; Rhodes 2005; Tannenbaum 1994; White and Stancombe 2003). Furthermore, the complexity of clinical situation comprises not only expert knowledge but also includes structural and organizational factors.

Patients may become more critical and better informed, which may increase pressures on the professional authority (e.g., Stehr 1994). The assumption of well-informed patient is based on the anticipation that patients are able to make conscious choices. In this case the clinical challenge may be framed as how to convey evaluation of different treatment options in a way that supports informed patient choice (Edwards & Elwyn 2009).

Clinical decision-making is a complex process which may be influenced by a number of situational factors. Apart from the need to evaluate treatment goals, methods and their effectiveness, the patients' preferences for involvement in decision-making may also affect the decision (Say et al. 2006). Furthermore, the large number of available treatment options may increase patients' opportunity to decide which treatment fits his or her needs best.

Empirical studies have shown that when the evaluation of the choice of treatment takes place, such factors as perceived and actual quality of care, compliance, accessibility, cost of treatment, socio-economic status of the patients, availability of services, patients' mental capacity etc., are important (Owumi & Raji 2013). Thus, clinical decisions might be to a large extent influenced by the clinical goals. The best treatment is not necessarily the one shown to be most efficacious in randomized controlled trials, but the one that fits a particular set of individual circumstances and aligns with the clinical goals.

Empirical studies have also shown that compliance is an important clinical goal. It has been argued that clinicians may manipulate information in order to achieve compliance. Convincing involves the ability to reach compliance and other goals that are logically consistent with the starting premises (Appelbaum & Grisso 1988). Furthermore, patients' mental capacity can influence the practice of the RTIP as well. The construct of understanding generally relates to an ability to comprehend information related to diagnosis and recommended treatment (Lamont et al. 2013). I assume that social structures do not always determine individual actions and that actors' intentional action can to some extent explain social structures (Nielsen 2005, p.

50). Future goals may also be achieved by the goal-mean rationality. It would be difficult in the clinical context to imagine action purely based on rationality where the situational factors and rules are not considered. Similarly, action based only on rules where the clinicians' intentions, the evaluation of consequences and situational factors would not be considered in clinical, rational decision process. Thus, in this study the goal is to capture various combinations of intentional, practical reasoning and rule-based action.

Theoretical anticipations regarding clinical action discussed in this section are just the one aspect of the general explanations concerning implications of the RTIP in this study. The second one comprises anticipations regarding the three dimensions that can interact in different ways and may influence practices of the RTIP. These anticipations represent three different set of hypotheses about the factors which may affect the regulation through the RTIP as described below. I suggest that both the legislative regulations, profession and organization, as well as the relationship between them could influence the outcomes of regulation through the guidelines.

### **3.3 The legal, the professional and the organizational dimensions**

In this section the focus is on the factors which may to some extent contribute to framing and explaining clinical action. I introduce the two dimensions that supplement the major legal dimension, i.e. the professional and the organizational dimension. The goal is to establish a set of hypotheses related to each dimension. The overall assumption is that they will influence how the clinical discretion is

administered. Thus, each of the dimensions is expected to have some explanatory power of de facto practices. Furthermore, the legislative regulations may influence the practice directly.

### **3.3.1 *The legal dimension***

The legal dimension comprises first of all the RTIP, the legal goals of the RTIP (expansion of the information and the possibility to influence the outcomes of decisions about treatment), the guidelines for clinical practice (either written documents or online websites), as well as theoretical anticipations of the character the process of juridification might have. The guidelines expand and supplement the content of the RTIP defined by the law.

The concept of juridification covers the core aspect of the legal dimension, i.e. de facto outcomes of regulation through the RTIP for clinical action. It sets focus on the analysis of the interaction between the actors and legal rules for action. It involves exploring the character of legislative regulations and to what extent the clinical action can be explained by them and why. For this purpose, the understandings of the RTIP by the clinicians and by the Directorate are to be explored and compared. The goal is to capture how effective is the regulation in clinical practice. The focus is on variations and similarities in the interpretations. It has to be possible to understand which of the Directorate's interpretations guide discretionary decisions of the practitioners and why.

Finally, the purpose of the analysis is to explore to which extent the understandings legitimated in practice fulfil the legislator's aim of giving the patients a new status in clinical decision-making.

### *3.3.1.1. Vague and precise interpretations of the Directorate*

Scholars in the field of law distinguish between stable rights and those allowing discretionary interpretations (Kjønstad & Syse 2008, p. 103; Rynning & Hartlev 2012; Aasen and Magnussen 2013, p. 8). Regulations establishing these rights may be worded in a general or less general way. In this manner, some of them allow a great degree of discretion while others leave little space for it. In this study, I call the first kind of regulations vague and the second type precise.

The RTIP is a right that is vaguely defined. Inconsistent words, general concepts, and non-specific wording tend to characterize vague regulations. The vaguer the wording, the greater space for discretion is anticipated (Molander et al. 2012, p.216).

Contrary to that, precise regulations are characterized by specific, clear, and concise concepts (Magnussen & Nilssen 2011, p.6). They leave practitioners little chance to re-define them in practice (Kjønstad & Syse 2008). Precise regulations bind clinical discretion stronger than vague ones.

The RTIP as a vague right allows certain freedom in developing particular interpretations. This could threaten the principles of predictability and the legality of treatment (Syse 2009).

Thus, the balance between precise and vague formulations is characterized by the disagreement between the space for professional discretion and the goals set by the rules of law. This may suggest disagreement between democratic authority and clinical reality. The precision of legal regulations is assumed to be an important aspect in exploring the implications of the RTIP since the assumption is that the legislative regulations may connect and unify practices, but also lead to variations in clinical reasoning.

The legal dimension in general comprises not only de facto given legislation (the law, guidelines and the legal goals), but also the core values of the legal system. The fundamental legal value with regard to the expansion of legal tools, such as individual rights, is the principle of the Rechtsstaat that influenced the classical formation of legal security, discussed below (Nilssen 2007).

### *3.3.1.2. Administration of the RTIP and the principle of legal security*

According to the principle of legal security, rights such as the RTIP are the individuals' guarantee against the arbitrariness of public authority. Legal goals derived from the RTIP are concerned with individuals' possibilities to influence decisions regarding their own treatment. The ideal of legal security with regard to the RTIP will

be achieved when the individuals have the opportunity to exercise influence upon professional evaluations of treatment.

In this study, legal security is related to the expectation of following the legal goals of the RTIP in practice. The universal requirement of equal treatment for all patients means that individuals must receive the same services as others in the same situation or that they have to be related and alike (Molven 2002, p. 37). An unreasonable or biased variation in treatment or treatment that contradicts the requirements of the RTIP is against the legislators' demands posed to health care services (Aasen & Magnussen 2013).

With regard to the fulfilment of the RTIP, legal security presupposes an existence of predictable rules regulating patients' decision autonomy and the provision of information. Such rules must comply with existing laws. Another aspect of legal security is the similar practice of legal rules concerning all patients (Aasen & Magnussen 2013). Furthermore, in order to ensure the use of the principle of legal security, three legal principles must always be complied with when legal rules are implemented:

- One may not choose solutions that violate the goal of the legal regulation in question.
- Similar cases cannot be evaluated differently.
- One may not introduce interpretations of legal rules that are obviously unreasonable.

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These principles create a general legal framework for discretionary interpretations that can be used by the administrators of the rights (Molven & Feriks 2011, p. 37).

These legal principles and values may lead to the formation of certain criteria to evaluate questions related to patient information and participation. Thus, in particular, instrumental premises specific for the level of legislative regulations may be established to evaluate such questions. These premises will be different from the corresponding premises within the other dimensions (see sections below). Legal principles and values will thus set boundaries upon interpreting the rights and assigned obligations that must be followed in order for the RTIP to be implemented (Aasen & Magnussen 2013).

The demarcation line between the traditional clinical practice (see chapter 2) and the new understanding introduced by the RTIP is drawn by the introduction of the concept of co-determination. It covers the area of clinical practice regulated by the RTIP. The conceptualization of it is presented in the following section.

### *3.3.1.3. The concept of co-determination. The “expert-patient” relationship*

In clinical field of practice, professionalism becomes apparent when the tensions inherent in the “expert-patient” relationship are controlled by means of professional authority (Johnson 1972, p. 51). Professionalism may thus be seen as a way to regulate and control the clinical reality and degree of patients’ involvement in treatment.



One of the major disagreements that occurs in clinical professions and threatens their stability is the one between professional discretion, reliability, patients' protection, and compliance on the one hand and the patients' autonomy and influence on their treatment on the other hand (Johnson 1972, p. 59). This has been called "the asymmetry of expertise" (Abbott 1988, p. 5). There has been an increasing debate regarding how professionals can protect their discretionary judgments and moral values against the patients' preferences with regard to their treatment.

In social science, co-determination is a broad concept that generally refers to some form of exercising influence on decisions made by others (Michel 2007, p. 5), in particular by a weaker party on a more powerful party. It has been defined in a variety of contexts, such as political and organizational ones, in which it may take the form of involvement through councils or some type of supervisory boards. At the individual level, the concept has been related to the possibilities for influencing one's own situation, such as using complaint channels or individual political rights, co-defining the treatment. While participation may rather be related to equal parts, co-determination relates to patients' influence on decisions concerning their own treatment made by the professionals. Participation can be direct or indirect, such as by representing others through representative boards (Harwick & Barki 1994). Co-determination represents a direct form of involvement of the less powerful part.

This concept has been applied in studies of the various forms of employee co-determination. These studies have been inspired by the so-called democratization processes, which began in Norway within various organizations in the private and public sector in the 1960s (Bergh 1983; Bleiklie et al. 1985, p. 99; Kalleberg 1983). As

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an extension of these processes, co-determination in the form of influence on the employee's own working situation, as well as on the general development of the employee's organization, became a subject of interest for many scholars (Falkum et al. 2009, p. 6). Similarly, co-determination has been studied in the social services for the elderly (Wærness & Gough 1985, p. 265) and in relation to children's involvement in kindergartens (Søbstad 2002). It has also been associated with the literature on empowerment and is perceived to be close to the concept of co-responsibility and self-responsibility (Madsen 2010).

The concept of co-determination is used here to illuminate the understanding of the RTIP by the Directorate and by the clinical practitioners, as opposed to self-determination, which is set out as a legal goal based on the principle of respect to individual choices and autonomy in general. In the clinical context, co-determination presupposes involving the patient within the scope of reliable treatment, excluding the possibility of the patient manipulating the doctor.

I chose the concept in order to study the implications of the RTIP, because, in the context of clinical work, it encompasses two aspects explored in this study. The first is the variety of forms of patient involvement in making decisions about treatment. The second one is related to the information about the treatment provided in the clinical situation.

A further justification for using the concept of co-determination is that it was used in the preliminary works on APR, where the RTIP was defined as the right to 'co-determination and co-responsibility' in treatment (Ot. prp. nr. 12 (1998–1999), p.64).

A focus on these two concepts may suggest the importance of patients' influence and taking responsibility for one's own treatment in the legal understanding of the RTIP. Co-determination may also be perceived as a concept capturing the core of all the clinical interactions with patients regulated through the RTIP.

#### *3.3.1.4. Distinguishing co-determination from subject anomaly and subject perspective*

The concept of co-determination may be placed between the two opposite ends of the influence scale in a decision-making relationship, in which both parts actually take part in decision-making but one of the sides has more influence than the other on making a decision. The two ends of the scale represent two extreme situations called the subject anomaly perspective and the subject perspective, described below. While real-life situations normally fall somewhere between the two extremes (i.e. co-determination takes place), it is usually possible to tell which of the ends dominates the decision process. In the clinical context, it is the professionals who will always set the premises for patients' involvement, i.e. be the dominating part in the co-determination process.

The first extreme situation, termed the subject anomaly perspective, refers to any situation in which the decisions about the treatment are made by the practitioners alone (Skjervheim 1996, p. 107). In this case, clinical action seems to be driven by the desired outcome of treatment. Involving patients in decisions may then be seen as an instrument for the practitioner for achieving the goals set for the treatment (Skjervheim 1996, p. 111). This may be seen as the more traditional, authoritarian way to make

decisions embedded in the norm of compliance. In this case, the extent to which clinical actions are successful depends on how well specialists manage their calculations (Skjervheim 1996, p. 12).

Therefore, situations when patients are convinced in treatment to do what the practitioners understand to be in the “patients’ best interest” may occur. In this way, patients may become objects and spectators of therapy, rather than subjects and participants in it (Skjervheim 1996, p. 128). Thus, the patients’ preferences are replaced by the choices of the authority figure (Raz 1987, p. 46; Green 1990, p. 38).

An alternative to well-calculated action is called subject perspective (Skjervheim 1996, p. 111). This alternative concerns the process of decision-making between the two equal subjects. The core aspect of this perspective is that the outcome of the interaction between the two parts is a result of the active engagement of both parts in deciding upon the course of events (Skjervheim 1996, p. 135). Individual autonomy and an awareness of one’s choices on both sides are central to this perspective (Skjervheim 1996, p. 140; Knutagård 2003). This is the decision-making framework for equal parts rather than for the unbalanced interaction between the weaker and the stronger part as it takes place in the clinical context. The two situations of subject perspective and subject anomaly perspective may be seen as being beyond the legal goals, i.e. giving the patients a stronger possibility to influence the course of action in treatment.

The aim of applying the co-determination concept in the analysis is to explore the relationship between the specialists’ assessments of de facto professional practice,

the guidelines and the RTIP. Co-determination comprises cases when patients could influence professional reasoning within the scope of reliable treatment. The concept provides a common platform for comparing the understandings of the RTIP by the Directorate and by the clinicians.

### **3.3.2 *The professional dimension***

The professional dimension is defined by the fact that the clinicians are professionals who work in the specific professional context. This dimension is closely associated with clinical action. Clinicians are persons qualified in clinical professions but are also research scholars. It also includes the professionals' autonomy and the theoretical knowledge in the professional dimension as the basic characteristics of professional practice (Johnson 1972, p. 28). Professional practice regulates which factors are crucial and are to be taken into account in professional reasoning (or clinical reasoning). Clinical reasoning takes place in a particular situation. According to Schön, '...the practitioner allows himself to experience surprise, puzzlement, or confusion in a situation which is uncertain or unique. He reflects on the phenomena before him, and on the prior understandings which have been implicit in his behavior...' (Schön 1983, p.68).

In clinical practice, problems are to be solved according to the rules and statutes that are formed by professional expertise and discretion (Malt et al. 2003). These institutionalized rules are embedded in professionally endorsed formal structures (Park et al. 2011).

The professional dimension also includes the process of socialization into the clinical profession. Socialization comprises both education- and experience-based training which can be seen as a means of controlling the entry to the profession (Grey 1997). Socialization of new workers through experience aims at preservation and predictability of normative social order in work and occupations (Evetts 2006). Once education is finished, experience can be seen as the most developed and complex form of legitimation, resting upon combination of time, ideologies of integrity, independence, service and expertise.

The professional dimension guides the overall clinical reasoning and comprises the general rules for practice. Thus, in this study one of the assumptions is that clinical practice may have some common characteristics institutionalized in clinical norms for practice. This hypothesis is further discussed in the next section.

### *3.3.2.1. Criteria for perceiving clinical practice as homogenous*

In this section I focus on clinical practice as unifying for the ways to apply clinical discretion. As such, practice may be seen as having common professional characteristics of clinical decision-making.

Professional training embedded in homogenous professional norms in the field of psychiatry may be viewed as contributing to the stability of practices. Clinical professions depend on education and require a particular set of occupational skills related to the clinical field, with "...institutional and ideological traits more or less in

common...” (Freidson 1994, p. 16). Socialization into the profession, which is often understood as training, contributes to the homogenous professional knowledge and identity (Halvorsen & Michelsen 2002, p. 19). This establishes a clear distinction between those within and outside the field of practice (i.e., professionals and nonprofessionals). Professional norms legitimize and to some extent unify practices based on professional autonomy and discretion in clinical action.

Furthermore, professional values in clinical practice are based on universality<sup>21</sup>, functional particularity, neutrality, and collective orientation (Parsons 1991). The criteria of formal training and the application of institutionalized characteristics of a professional field are critical for the professional dimension of clinical practice (Parsons 1968).

### *3.3.2.2. Unifying norms in clinical practice*

Professional behavior may be characterized to some extent by a high degree of generalized and systematic knowledge which is based on the codified set of tools and instruments (Noordegraaf et al. 2014). Individuals who possess specialized knowledge gained through education and experience acquire the skills necessary for the execution of central tasks in their field of practice (Park et al. 2011). Due to the fact that they are representing professional practice, practitioners within a particular field are obliged both to follow and to endorse the institutionalized norms embedded in formal structures

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<sup>21</sup> - called reliability and objectivity by Malt et al. (2003)

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(e.g., Læg Reid & Olsen 1978; March & Olsen 1989). This can suggest that psychiatrists and psychologists, sharing the field of work, may have rather similar understandings of the RTIP in clinical treatment. Thus, professions may share the underlying logic of decision-making based on logical, clinical reasoning.

The concept of shared cultural jurisdiction (Abbott 1988) underlines the shared tasks, expertise and duties among the professions. It may also comprise shared training activities and knowledge background, responsibilities and power within, for example, organizational structures. Different professions then share the authority and each profession is authorized to decide cases dealing with the same subject matter.

In this study I chose to focus both on common institutional characteristics of psychiatry as a discipline as well as on the differences within it. This approach is justified by the question of if/how common norms and professional differences could explain the practice. In clinical practice, clinicians may have various professional identities and career paths, but they may still share similar points of view, definitions of methods, diagnostics, and interests at the overall general level (Halvorsen & Michelsen 2002, p. 20). Therefore, clinical practice may to some extent be considered as a united, homogenous professional field. Furthermore, social norms, which allow clinicians to practice discretion, are based on the common expectation of treating patients with dignity and respect regardless of the profession.

However, there are also mechanisms which may lead to differences in clinical practices that have to be considered. These mechanisms are discussed below using the concept of jurisdiction.



### 3.3.2.3. *Jurisdiction*

A phenomenon worthy of mentioning within the scope of the professional dimension is jurisdiction. It has been defined, among others, as the power of different professional groups to influence the regulations of their conduct (Abbott 1988, p. 20). The traditional monopoly approach suggests that the profession has reserved working tasks for individuals within the profession. By having control over the working field it has the power to decide upon the offered services as well (Molander & Terum 2008, p. 18).

While such exercise of power by professionals may aim to unify and control the body of professional knowledge, it may also result in attempts to expand the power for the purpose of achieving formal control of defining the tasks of the professions, and offering free choice of professional training (Abbott 1988, p. 67).

Classifications of diagnoses and methods of treatment will always leave some considerable areas that are not covered by standard professional knowledge. Discretionary reasoning in clinical practices is difficult to codify (e.g., Gray & Harrison 2004; Sternberg & Horvath 1999; White & Stancombe 2003). Professions will therefore always have only subjective jurisdiction over cases that require discretionary evaluations. The field of practice may therefore be seen as the arena for competition among different professional groups.

If this is the case, each profession may also aim at possessing, defending, and expanding their jurisdiction (Abbott 1988, p. 251). It is therefore reasonable to suggest that members of different professions may be preoccupied with underlining the differences among them. Professional practice may then be seen as consisting of

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various occupations organized in social groups and characterized by numerous types of knowledge (Freidson 1994, p. 79). Different occupations may be perceived as being in conflict with each other over jurisdiction in certain areas, such as training or work placement (Freidson 1994, p. 84). Specialization within the same professional field may also be in continuous conflict regarding enforcement of their knowledge and perception of the professional reality. In such a case, there is no space for discussion among professional environments, and differences between professional groups could be seen as potential battlefields.

Furthermore, different groups, wings and factions organized around different points of view may exist within the same specialization. This idea challenges the classical perception of homogenous practice within professional theory. Members of the same professional groups may see the organization, specialization, and any plans for the future development of their profession differently. However, it is not only jurisdiction that might lead to variations in the practices which are regulated by the clinical guidelines and the RTIP. The education and experience might be important factors contributing to the variations among the practices.

#### *3.3.2.4. Action embedded in experience*

Variou empirical studies have shown that traditional norm-based practices may play a particularly important role in the interpretations of law. In the clinical context it has often resulted in the logic of reforms being subjected to professional logic (Sahlin-Andersson 1999, p. 306).

Assuming that some professionals have less experience with the job than others, it has been argued that they tend to have different occupational ideas, identities, and dedications (e.g., Noordegraaf 2011a). It is reasonable to anticipate that this may influence their ideas about the relations between the RTIP, the guidelines and the practice.

A legislative framework that regulates the way of clinical work, limiting “limitless” professional discretion, may resonate with work desires of clinical specialists (Heiliger & Hingstman 2000). This means that professionals might have to organize their work more explicitly and perform it based on a principle of transparency. However, more experienced doctors might find it difficult, particularly with regard to less experienced clinicians or patients (Noordegraaf & Van der Meulen 2008).

Following Durkheim, professional specialization can be seen to be inferred from and assigned to work roles, in which culture and social norms play a major part (as cited in Freidson 1994, p. 52). I consider socialization into profession as an important regulatory mechanism of clinical practice, which includes identification with institutionalized skills and solidarity with established norms, both of which come from a long and thorough training (Freidson 1994, p. 99). Such training may encourage individuals to identify with others who have received similar training (Freidson 1994, p. 99–100).

It has been argued that the longer the professional experience, the stronger the tendency to rely on discretionary evaluations (Dreyfus 1992; Dreyfus & Dreyfus 2005). According to this argument, an experienced expert could recognize reoccurring

situations and act intuitively based on the previously gained experience, which cannot be codified in written rules. Thus, it is reasonable to assume that experts may rely more heavily on discretionary judgment and established ways to act when interpreting the RTIP than their less experienced colleagues.

Clinical discretion embedded in training may explain the variations in the interpretations of the RTIP, and therefore has to be considered as a possible explanation of the diversity in the interpretations of the RTIP. This is especially important when clinical reasoning takes place.

#### *3.3.2.5. Action embedded in education*

It has been shown that rules learned by the professionals during their educational training tend to be strong mechanisms regulating their action. As the sociology of professional groups and professional education has shown, education is at the heart of forming professionalism and building professional powers (e.g. Shuval 1980; Torres & Mitchell 1998). Professional education is a resource for producing content (knowledge, skills, norms, rituals, subjectivities, etc.) and an actor in socialization processes (e.g. Faulconbridge & Muzio 2009).

According to previous research, a novice would rigidly apply written rules and manuals learned in education (Dreyfus & Dreyfus 2005). Thus, it is reasonable to assume that a specialist with fewer years of experience could have better knowledge of written legislative regulations than an experienced one.

Thus, experience and education are the two sources of knowledge that could to some extent explain variations in professional action in clinical practice. This perspective on action could be related to the institutional approach, in which norms would be expected to guide reasoning within the specific professions.

### *3.3.2.6. Clinical discretion and practical judgment*

It is not only experience and profession that structure clinical reasoning. Whereas the objective dimension of clinical practice is typically tightly defined in terms of adherence to best evidence, the subjective dimension is rather vague (Heath & Palenchar 2008). It depends on a form of knowledge that is tacit and difficult to codify (Polanyi 1958). The judgments made by virtuous clinicians entail ethical and practical considerations not just as to what to do in relation to the particular circumstances of the patient, but also, in a resource-limited healthcare system, how to balance the competing demands of advocacy (addressing the needs of the individual patient) and distributive justice (balancing this patient's needs or wants against the wider needs of the population) (Polanyi 1958). These considerations play out, for example, in relation to questions of whether to prescribe, whether to refer etc. (Heath & Palenchar 2008).

When evaluating individual needs, clinical professionals have to make their best rational judgment based upon the knowledge of diseases, conditions, and available resources. These factors are expected to be evaluated first of all by the criterion of reliability, which means problem-solving and result-oriented approach (Bleiklie 1992,

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p. 3). Based on this point of view, the question of the RTIP could be perceived as a question of the best, professionally justifiable solution under the particular circumstances.

The judgment of the best treatment does not necessarily have to agree with the care that is actually offered. There may be several reasons for this. One of them may be the legal framework enabling the patients to influence the choice of treatment. The patients might ask for a particular treatment, and such a request could weigh heavier than the rational judgment. Balancing between such considerations may be seen as manoeuvring between the rules and an evaluation of the specific situation, which may result in a variety of outcomes.

Discretion has been described using the metaphor of a doughnut with a hole in it, since it concerns decisions that are usually structurally limited by other factors than the actors who make them (Bærøe 2011). At the same time, it also represents a relative freedom to decide how to evaluate the situation using one's own independent standards for justification (Bærøe 2011). This individual autonomy is represented by the doughnut hole. As such, discretionary judgment may differ and lead to various outcomes of the same diagnostics, evaluations and treatment procedures (Whooley 2010).

In practice, specialists are confronted with practical questions of how to inform and involve patients in treatment. The components of the practical decisions include a description of the situation (patient-specific), the course of action (the specialist's assessment of the de facto situation), and the structure for it (clinical norms, guidelines

and the RTIP). This structure of professional reasoning justifies action in a specific situation (Degenholtz et al. 1999; Wallander & Blomqvist 2005; Wallander & Blomqvist 2008). In practicing clinical authority, there is an expectation of doing it in a reasonable way that will be accepted by others who have similar experiences.

In the context of this study, clinical reasoning is bounded by the specific organizational structures, i.e. DPC (see chapter 4.1.) It is therefore important to anticipate that the organizational structures, for example, different DPCs, may have explanatory value in understanding the way clinicians reason when involving and informing patients.

### **3.3.3 *The organizational dimension***

The organizational dimension in this study concerns professional work taking place within organizational structures. It may be expected that the organizational structures will influence the way how the clinical practice is carried out. Organizations may endow individuals with goals and interests (Egeberg 2007). From the rational perspective it may be assumed that organizations are instruments which may shape the goals the individuals want to achieve (Christensen et al. 2007, p. 29). Based on this assumption, it may be argued that if you affect organizational structures, you may influence individual action as well. From this perspective, discretionary reasoning can be designed through the organizational control over the structures and work arrangements. Thus, from this perspective, organizations may be perceived as setting preconditions for individual action.

Furthermore, public organizations are often characterized by conflicting goals and heterogeneity. They do not necessarily function as uniform framework for individual action but may lead to tensions and disagreements. Decision-makers may therefore find themselves in a context where expectations may remain diffuse and demand ongoing interpretation, and where actors, problems and solutions can be selected and linked to decisions in different and partly unpredictable ways. Based on this, conflicting or various interpretations of the RTIP may be expected among teams within the same organizational units as well as between them.

#### *3.3.3.1. The concept of local rationality*

Handling conflicts of goals by setting common standards for action is often called local rationality. Rationality is defined locally when strategies are developed in a given situation by an organization (or a team) to pursue their goals. Local rationalities may then be developed within the same organization, as well as among different organizations. Health care services in general, especially psychiatry, have been characterized by local variations in, for example, service offers, understandings of patient rights, accessibility, provision of information, involvement of users or service level (Jensen et al. 1992; Johnsen et al. 2014).

Local rationality does not guarantee comprehensive or collective goals; on the contrary, there may be differences among teams, organizations and individuals working on their own. This may lead to a difference between actual professional practices and original organizational strategies. In this case there may arise tensions



between the legal, the professional and the organizational dimensions. It is then necessary to explore the relationship between them. I elaborate upon the relationships between the legal, the professional and the organizational dimension in the following sections.

### **3.4 Combining the organizational and the professional dimensions**

Within the scope of the organizational and the professional dimensions, the important question is how to link the professional practice with the organizational structures. Mintzberg suggests that the relationship between the organizational structures and individual action is not necessarily characterized by tension (Lunenburg 2012). One of Mintzberg's suggestions is that organizations are the prime coordinating mechanisms. He furthermore argues that the strategy an organization adopts and the extent to which it practices that strategy result in a variety of structural configurations, including the one called professional bureaucracy. This configuration is especially relevant in this study, since the relationship between the organization and profession are critical to explore in order to understand the outcomes of regulation through the RTIP. According to it, professions can both be influenced through the organizational structures and keep some degree of their autonomy (Mintzberg & Quinn 1992; Lunenburg 2012).

A professional bureaucracy uses standardization of professional skills as its prime coordinating mechanism within professions. Professionals tend to work independent of their colleagues, and work division among the professions is assumed.

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Based on it, differences between the professionals can be anticipated. The professional expertise is emphasized and has the highest authority. According to it, the organization is relatively formalized but provides space for practice of autonomy to the professionals. Organizational strategies may be strongly influenced by the individual professionals. Based on this perspective, standardized understandings of the RTIP which are not based on the individual judgments may therefore be rejected. Highly trained professionals provide nonroutine specialized services. New, external rules may be adapted to rather slowly. Professional bureaucracy, particularly its aspects of professionalism, autonomy, and structural looseness may lead to rather common coordination problems. Formal organizations, which provide complex services through highly trained professionals in an atmosphere of structural looseness, tend to broaden the limits of individual discretion and performance. This is especially true in case when professionals perform in relative isolation from colleagues and superiors, while remaining in close contact with the patients. It has been argued that clinicians tend to identify more with their professions than with the organization (Bentsen et al. 1999).

An alternative way to perceive the relationship between professional practice and organizational structures is that it may be characterized by tensions between professional and organizational dimensions.

Assuming that organizations do adjust to demands posed by the RTIP, they may do it by incorporating it through obliging the leaders to develop new internal routines and strategies. Such adjustment may influence clinical traditions, established rules and conventions, and put restraints on the decisions made within the organizations. Thus, in line with the institutional approach I suggest that the institutional context of

organizational structures may influence the hierarchical relations and individual clinical reasoning. Following this argument I assume that organizational structures may have implications on professional practice through setting a framework for hierarchical relations, the way to organize work, cost control (related to e.g. available treatment resources per patient/diagnosis) and targets. For example, team leaders may, to some degree, define the team's strategy for action. Furthermore, working in teams may affect education-based or institutionalized ways of thinking. The goals defined by leaders are not always in line with individually defined practices.

Institutional factors may be a result of organizations gradually having grown more complex through the development of informal norms and practices. In addition to solving tasks in an instrumental sense, they have become value-bearing institutions with their own distinct identities and opinions about what the relevant problems and appropriate solutions are. A large number of specialized practices may in fact mean that each unit has limited goals and problems that may be addressed independently of what other organizations do. The specific structure of DPCs may therefore play an important explanatory role in understanding implications of the RTIP. The structure of DPCs is simple and has no strictly defined division of work among the professions. Clinicians cooperate within the same organization but are also divided into teams. There is no strict division of work between the administration and the leadership. All of these factors together may influence clinical work.

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### **3.4.1 *Hierarchy structures combining clinical work with leader positions***

It has been argued that medical doctors have to combine the clinical role with that of leader particularly often (Noordegraaf 2011a). In this way, treatment may be seen to be under professional, organizational and collective control (e.g., Foster & Wilding 2000; Freidson 2001; Hwang & Powell 2009).

Clinical specialists sharing the roles of managers and clinicians have to consider factors at the different organizational levels when making clinical decisions (Noordegraaf 2011a). Therefore, they might make an attempt, to a larger degree than other professionals, to align clinical actions with the organizational strategies. In this way loyalties to the professional fields may be to some extent constrained by the organizational context (e.g., Evetts 2011; Suddaby et al. 2009). This is due to the fact that the responsibility for implementation of legal goals, spreading the information to other employees and compliance with the law are delegated first of all to the managers (Noordegraaf 2011a). From this perspective, organizational structures may set up managers against professionals, but also managers may be seen as having a connecting role between law and professionals in order to generate services that are viable and accepted. The role of managers may, therefore, in some cases be seen as seeking connective forms for practice and organizations, which might enable participants to link professional practices to broader strategies, as well as to legal and economic developments.

An alternative perception may be based on the decoupling hypothesis. It has been broadly argued that, especially in the clinical context, clinical managers may

buffer external influence on clinical practice (Meyer & Rowan 1977). This has been called a decoupled organization structure. In this case, clinical units such as DPS and clinical practice in general, in spite of legal changes, continue more or less unchanged. The concept of loosely coupled systems has been used to explain this separation of internal operations from the organizational form.

It has been shown that leaders tend not only to face organizational dependencies, but also many kinds of work-related expectations from the colleagues, as to, for example, decision autonomy (e.g. Grant 2003; Rothstein & Downer 2012). This may influence organizational strategies for clinical treatment. Thus, organizational structure may exert a determining influence on the technical core of clinical work and vice versa (Hafferty & Light 1995, p. 141).

Leadership interventions in professional fields cannot completely escape institutional constraints and power relations. As clinical professionals are strongly socialized, it is reasonable to anticipate that they will not easily redefine their own images of how to involve and inform patients in treatment. If they do, they might perceive it as a loss of their distinctiveness and weakening of their positions (McGivern et al. 2015).

### ***3.4.2 Organization of clinical work in cross-disciplinary centers and teams***

By the mid-1960s, a development of horizontal linkages among organizations characterized the health care sector in many Western countries (May 1967; Ermann &

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Gabel 1984; Ruef & Scott 1998). Professional practice became fragmented, and health services broke away from the profession-dominated control of the medical system (Scott 2000). Organizational systems became highly diverse, combining a variety of organizational units, financing mechanisms, and different professional groups (Scott 2000, p. 15). The new model was claimed to be related to cross-occupational teamwork and collective information processing (Westberg & Jason 1992; Seifer 1998; Vyt 2008).

Professionals with a variety of specializations were placed within the same organizational framework, in which the organizational structure does not support a single professional dominance (Bentsen et al. 1999, p. 308). Given these changes, it is important to investigate not only individual clinical practice but also how work is performed in cross-occupational teams. As argued elsewhere, working as a member of a team is about 'sharing information' and 'listening to and taking into account the views of other health professionals ...' (Parsell & Bligh 1998).

As described in chapter 4, mental health services have also been reorganized in Norway into loosely coupled and cross-disciplinary centers (Pedersen et al. 2008; Lorentzen et al. 2010). This organizational form may be characterized by the simple structure, in Mintzberg's terminology (Lunenburg 2012). It uses direct supervision, and employs vertical and horizontal centralization. Examples of it are teams, which are relatively small groups consisting of specialists led by team leaders. Thus, a team consists of the leader and a few workers in the operative core. Workers and leaders perform overlapping tasks, which necessitates adjustments to be made by both parts. For example, leaders work clinically as well as have the responsibility to implement

the RTIP. The distance between the professionals and leaders is therefore relatively small and the hierarchy rather simple. It may also mean that the team collectively makes strategic decisions. Because the organization/team is small, coordination is informal and maintained through direct supervision. Such structure allows flexible division of responsibilities and easy relations within and across teams. Even though the relationship between the team leader and the team is informal, it might be important for local understandings of the RTIP. Moreover, this type of organization can adapt to environmental changes rapidly. This organizational form may diminish the variations in the practices that could be expected among the professions, as tasks and goals have to be commonly known and defined by the group. Thus, comparing team rationality with practices of clinicians working on their own might, therefore, be particularly relevant to the studied problem. Teams as well as leaders might also influence the interpretations of the RTIP made by the clinicians.

In the terminology applied elsewhere, teamwork comprises multiple person decision-making (March & Heath 1994, p.104). In such context the structure of a team may affect the clinical identities. Teams may accentuate problems of communication and coordination, bounded rationality and rule following. Teams may be assumed to be socially adept and create expectations, anticipating reactions they encourage others to anticipate them. Thus, decision structures can create premises for decisions as well.

Team-based practices might suggest an alternative to traditional institutional powers (see chapter 2), and boundaries for clinical decisions, less stratification, and strengthened collective frameworks. I assume in accordance with other work (Parsell & Bligh 1998; Noordegraaf 2015) that organization of professional work can affect

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whether and how clinicians combine evaluation of treatment situation, norm-based judgments and the RTIP.

A number of studies has shown that organizational structures and organization of work form professional action. For example, it has been shown that interprofessional health care teams resent the nucleus of shaping clinical behaviour, especially of the novices (Lingard & Sublet 2002).

Throughout this work it has been argued that clinical norms make to some extent a unified framework for clinical action. At the same time, it is anticipated that the various aspects of the professional dimension such as specific occupations, work experience (its length and specificity), discretion, and situation of individual patients are the modifications within clinical practice which may influence the way the RTIP is put at work.

### ***3.4.3 Combining organizational structures and professional reasoning***

Organizational structures may lay down the framework for action, define the range of available strategies, resources and the sequence of alternatives for clinical reasoning. The actors' behavior may then be highly influenced by an expectation of the organizational environment. Thus, from the organizational perspective, clinical reasoning can be structured and limited through organizational structures and the enforcement of the RTIP in the form of organizational routines and procedures. This assumes a lack of full rationality in clinical reasoning. Thus, clinical reasoning can be



steered through the process of establishing standards for organizing the work as well as setting hierarchy structures.

Organization may function as a system of coordination, i.e. a connecting tool for achieving appropriate planning, goals, decision-making and leadership, so that the means to achieve the goals are deployed with maximum effects (Noordegraaf 2011b). Furthermore, organizational structures might influence the setup of the priorities for day-to-day decision-making (Noordegraaf 2011b). Organizational structures could also be understood as role expectations in clinical situation, i.e. a normative structure which sets framework for clinical action.

An organization might also be seen as a form of professional self-regulation. Informal organizational structures may develop through a complex blend of informal norms from social backgrounds and task-related contexts. Different groups with wide-ranging tasks and backgrounds may influence the dominant and comprehensive organizational norms (Christensen & Lægheid 2005). Clinical professions may, for example, strongly influence the cultural features of a public organization without them having any strong formal influence over them. In such a case, organizational goals and values are related to professional knowledge and organizational decisions and activities are underpinned by strong professional norms. From this perspective, the RTIP may be expected to be institutionalized into professional norms and goals.

Organization structures from a more traditional point of view may also be seen as a form of steering the professional autonomy. In this case, structures may be anticipated to shape individual attitudes and interests and give actors a normative

context to relate to. Organization then provides a framework of shared values, and the emphasis is placed on creating and maintaining common goals. The organizational order is based on collective reasoning, and it is critical to create an awareness of this among the employees. Organizational structures, goals, norms and values are the framework for organizational members and furnish them with a normative and consequence-based guide for actions. From this perspective, the RTIP may be expected to be expressed in the organizational goals.

The variety of ways in which organizations may affect the professions and clinical reasoning within organizations, and vice versa, suggests that the relationship between organizations and professions might be a guarantor for the implementation of the RTIP, but also a potential threat to the legislator's goals with introducing the RTIP.

Furthermore, it has been emphasized that organizational hierarchy may also influence clinical reasoning through, for example, leaders with a good professional knowledge, decision power and the ability to deal with complex information (Noordegraaf 2011a).

In the context of DPC, horizontal specialization may be important to take into account when both psychiatrists and psychologists have the clinical responsibility for treatment of the patients. Vertical hierarchy structures may be important in explaining clinical action as well. An example of organizational structures influencing clinical practice could be when difficult questions and conflicts are pushed up to a higher level in the organizational hierarchy. Furthermore, organizational steering of clinical reasoning could be seen as a more centralized and directive-related enacted indirectly

through formal structures, procedures and routines.

#### **3.4.4 Bounded rationality in clinical practice**

Rational decision-making is highly data-intensive. It requires the decision maker to collect extensive information about all potential choices, outcomes, costs and consequences. In the complex context of clinical decision-making such requirements for different outcomes would not be possible. Many empirical studies of how individuals act show that in complex decision situations the concept of bounded rationality expresses the real context better than full rationality approach. Bounded rationality implies that the goals are diffuse or inconsistent, and that the problems and situations that the individuals face are complex (Christensen et al. 2009, p. 23). This concept is based on the idea that the decision maker has incomplete information about various alternatives and their consequences. In the context of clinical practice this means that specialists only know of a limited set of alternatives because of limited capacity, and must select information and premises for decision-making. Time and resources are required to acquire a better knowledge base, and a complete insight is impossible to achieve. For this reason, the clinician chooses an alternative that yields an acceptable degree of goal achievement. In other words, the practitioner will have a decision-making rule built upon achieving satisfactory rather than optimal results, whereby satisfactory, but not necessarily optimal, solutions are chosen.

Bounded rationality allows suggesting that clinical norms that dominate practice may be critical for explaining the decisions made by the clinicians, while the same

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decisions may still be influenced by a formal organizational framework. Through organization, the ability for calculation increases, as does insight into the connection between means and ends through prognoses, planning and analyses. At the same time, the ability to exercise social or political control through exertion of authority also increases the legislator's ability to influence others to act in a desired manner. How, then, can conflicts of interest between situational factors, the goals behind the RTIP, organizational strategy and clinical norms be dealt with?

This question may be related to formulating and developing clinical goals. First, a clinician, proceeding from rational calculations, could choose between relevant alternatives of action and assert his own goals and interests. Second, the actors can negotiate a compromise between different interests, which in turn provides the basis for rational choice based on knowledge about alternatives and consequences. Third, the competing goals can be addressed one at a time, so as not to come into conflict with one another. Fourth, goals in different areas such as clinical decisions and compliance with organizational requirements, do not always need to be viewed vis-à-vis each other (Christensen et al. 2009).

Quasi-resolution to a conflict of goals can also be dealt with by actors who come to an agreement on means. If a certain alternative is acceptable for everyone, there is no need to come to a decision on how potentially conflicting goals should be assessed in relation to one another (Christensen et al. 2009, p.30).

In the context of clinical action, which can be assumed to be to a large extent goal-oriented, it is reasonable to hypothesize that the logic of consequentiality will

dominate. Furthermore, following March and Olsen, it can be anticipated that it is easier to rationalize behavior in terms of one interest or another, than to interpret behavior as appropriate, simply because rules of appropriateness are collective, publicly known and fairly stable (March & Olsen 2004). Collective rules of appropriateness, which are anticipated to play the role in the interpretations of the RTIP in clinical practices, are embedded in the legal, the organizational and the professional dimensions.

### **3.5 The relationship between the legal and the organizational dimensions**

Based on the assumptions of organization theory, organizations in the public sector may be seen as being involved in enforcing the laws, but they can also function as arenas for professional practice, service provision and distribution of resources. They can be faced with conflicting logics and identities while acting as law-driven providers of health services. Both legislative regulations and organizational structures consist of the rules for how the treatment in the area of informing and involving patients should be done. Meanwhile, neither the structure nor the RTIP say directly how an organization's members should actually behave; they only provide guidelines and a framework. Thus, there might be variations in how the specific organizations relate to the RTIP-based regulation.

Taking a formal decision to adopt popular organizational recipes does not necessarily mean they will be implemented. Different research traditions offer different possible processes and outcomes when organizations attempt to implement recipes

(Røvik 1996). These can be expressed as theories about quick coupling (the popular idea or recipe can be implemented relatively quickly and will render the expected positive effects), rejection (a more sceptical and pessimistic scenario. In this tradition organizations are complex, value-based institutions generally able to successfully resist reforms, especially attempts at rapid adjustments in structures and processes) and decoupling (although popular concepts may be too vague in relation to the complexities of an organization's tasks, or else perceived as out of step with basic norms within an organization). Nevertheless, there may be strong pressure from the institutional environment to incorporate them. One way of tackling this dilemma is to adopt modern concepts, but to deliberately keep them decoupled, so that they have little effect on the organizational activities). While it is expected in this study that the organizational structures will influence the practices of the RTIP, it remains uncertain how the organizations relate to it. As discussed in chapter 4, this is not the main focus of the analysis, but the interviews seem to provide enough data to answer the question of the organizational response to the regulation through the RTIP.

### **3.6 The relationship between the legal and the professional dimensions**

From the legal perspective the difficult question has been how to structure the regulations in order to keep the balance between the social control and clinical autonomy (Aasen et al. 2014). In the clinical setting, the clinical procedure comprises gathering the information, analyzing it, defining the needs and assets, setting an accurate diagnosis and prognosis, choosing an effective treatment of the patients and

subjecting it to ongoing revision. Clinical education exists to foster the development of sound clinical reasoning (Hughes 2008). ‘Clinical reasoning, decision-making, and action are based on thinking critically and clinically’ (Hughes 2008, p. 137).

From this perspective, the goal to exercise influence through legislative regulations may be difficult to achieve. Rule-following has been defined in this tradition as not being automatic and requiring reflection (Hughes 2008). Independence and clinical thought are seen as the basis of clinical reasoning. Thus, it can be expected that clinical professionals would rather not deviate from traditional reasoning for the sake of following the rules which might result in suboptimal consequences.

One might expect that organization could interact in different ways with professional practice, and therefore organizational structures may connect and unify practices, but also lead to variations in clinical reasoning (Christensen et al. 2014, p.20). The interrelation between organizational structures and profession has been broadly discussed within the field of organizational science (May 1967; Ermann & Gabel 1984). It has been argued, for example, that organization of hospital wards can influence clinical reasoning (decisions on coercive treatment) (Blesvik et al. 2006).

Within clinical practice, the response to reforms from outside has often been described as “protection of the traditional values of professions” (Bentsen et al. 1999, p. 299). Various studies have shown that when reorganization of health care organizations takes place, professionals are able to keep their decision autonomy (Bentsen et al. 1999, p. 147). A number of studies have shown that hospitals with well-established traditions do not introduce limitations on professional autonomy

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(Blomgren 1999, p. 194). Thus, in a hospital, economic logic becomes subjected to medical logic so that the latter becomes the "...norm in the meeting with the economic logic..." (Blomgren 1999, p. 197). Another study of organization of professional groups within hospitals has shown that in reaction to external reform, clinicians develop so-called "grey zones" in which professional autonomy is practiced (Sahlin-Andersson 1999, p. 215).

In the studies of various hospital reforms in Denmark and Sweden, it has been concluded that professional groups in many cases had the authority to make their own interpretations of what they considered central in the new reforms. They also received a great deal of influence on how the reforms were implemented locally. Some professional groups used the reforms to strengthen their group's interests or to sustain the old structure that supported professional autonomy (Bentsen 1999, p. 221; Blomgren 1999, p. 171; Lindholm 1999, p. 117; Sahlin-Andersson 1999, p. 304). More generally, education and experience can be said to contribute to 'professional jurisdiction and autonomy' (Waring & Currie 2009), working in some cases against organizational structures.

Organizational reforms, even though not having deterministic influence on the clinical action, can affect the professions, for example, by leading to more transparent and coherent organization of work (Sahlin-Andersson, 1999, p. 307). Furthermore, if a reform is in line with the professionals' goals, its introduction may increase the legislators' capacity to lead the professional practice in the desired direction (Andresen, 2010). Furthermore, some of the authors have shown that structural adjustments which set specific and clear requirements on clinical specialists have stronger influence on



practice than duties defined through organizational routines and guidelines (which must be followed by professionals as members of the organizations) (Sahlin-Andersson, 1999, p. 215). Clinical practice and organizational structures may therefore be seen as being to some extent interweaved.

It may therefore be reasonable to anticipate that adjustments in organizational structure might under some conditions contribute to binding or strengthening professional discretion (Sahlin-Andersson, 1999). However, it is impossible to predict the outcome of introducing new regulations into clinical practice with certainty due to varying results of previous organizational reforms, as described in the studies cited above. Furthermore, a variety of factors which may influence judgment of a complex clinical situation makes predictions of the outcomes of regulation through the RTIP challenging. The following discussion develops the arguments which suggest that the rules, in addition to organizational structures and practical reasoning, may influence the clinicians' evaluations in treatment.

Furthermore, considering the influence of organizational structure on clinical reasoning, the concept of full rationality can be discussed. It refers to a practitioner having clear and consistent goals, a full overview of all the alternatives and full insight into which consequences these alternatives will bring in relation to the clinicians' goals. Even so, many empirical studies of decision-making show that this is realistic only to a certain degree, particularly in the context of complex public organizations (Christensen et al. 2007). This state of affairs is discussed in the following section with regard to the relationship between organizational and professional dimension.

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### 3.7 Summary

Assumptions about human action are presented in this chapter together with the three dimensions anticipated to explain clinical reasoning. The main purpose of this chapter is to develop the theoretical concepts that allow an exploration of how the process of regulation through the RTIP influences the interpretations of the RTIP in the guidelines and assessments of legislative regulations and clinical action in de facto practice. Sets of general presuppositions (based on the institutional approach) about the relationship between clinical action and legislative regulations, profession and organizational structures are developed. The legal, the organizational and the professional dimensions are conceptualized, and the characteristics within them are described. Each dimension represents a different set of hypotheses and the main anticipation is that the legal, the professional and the organizational dimensions, as well as the relationships between them, influence clinical action. An assumption is made that each of the dimensions can lead both to variations in, and a unification of, clinical practice in different ways. Two types of relationships are assumed to influence the outcomes of legislative regulations on clinical action, those between the legal and the organizational dimensions, and the legal and the professional dimensions.

In order to capture the explanations of clinical judgment when information and participation are practiced, I introduce general assumptions about the nature of human action (Alexander 1982). Two logics of action (the logic of appropriateness and the logic of consequence) and the concept of pragmatic thinking are discussed. There are several justifications for this choice. The institutional approach allows the analysis of professional practice perceived as an outcome of different factors, including rule-

following (such as clinical norms and legislative regulations). It therefore allows capturing different outcomes of regulation through the RTIP for clinical action that may both deviate from and comply with the legislator's goals. The perspective comprising rule-following is not sufficient to capture the clinical practices explored in this work. Therefore, the rational choice perspective and the concept of pragmatic thinking are introduced. Rational choice regards clinical assessments of action alternatives, based upon their consequences.

While knowledge of possible consequences can make some actions more likely than others, it does not usually determine actions precisely. The same concerns laws, clinical norms and organizational structures which provide parameters for action rather than dictate a specific action (Olsen 2003). This may therefore lead to variations among the practitioners.

Furthermore, the professional dimension is based on the general assumption of unified clinical norms, while deviations from it are possible. I suggest that it is reasonable to anticipate that education and experience, as well as discretion and professional belongingness, may lead to variations in clinical reasoning.

The organizational dimension introduces a set of assumptions on how organization of work and hierarchy might affect clinical reasoning. From the organizational perspective, organizations may endow individuals with goals and interests.

It is anticipated that organization may stand for system of coordination, professional self-regulation, as a form for steering of professional autonomy or a

mechanism enabling decoupling of legal regulation from clinical practices. Thus, it is to be explored if organization strengthens or weakens the implementation of goals with the RTIP.

The relationship between organizational dimension and the profession are to be explored and its influence on the practice regulated by the RTIP discussed. This is due to the fact that professional practices exist within organizational structures and some of the clinicians have clinical responsibilities and hold leader positions. Thus, the RTIP is implemented at an intersection of the organizational and the professional dimension. Organization can shape individual interests and goals.

In case of tensions between the legal, the professional and the organizational dimensions, it may be necessary to explore the relationship between them. The legal dimension incorporates the assumption of legal security, i.e. the expectation of following the legal goals of the RTIP in clinical reasoning. The goal is to explore how the level of legislative regulations influences the organizational and professional dimensions and the relationship between them.

The concept of juridification concerns the aspect of regulation and institutionalized by the Directorate and by the clinicians interpretations of the RTIP. Furthermore, the organizational structure (hierarchy and organization of work) is conceptualized in order to explore the influence of organizational structures on clinical practice of the RTIP.

Clinical discretion is introduced since it is perceived as being critical for answering the question of how vague and precise guidelines may influence practices.

Furthermore, the concept of the logic of appropriateness offers the possibility to explore which rules are considered normatively correct to follow and under which circumstances.

The concept of co-determination is seen as capturing the core of the legislators' formulation of the RTIP. In the context of this study, this concept encompasses two aspects regulated by the RTIP. The first is the variety of forms of involvement in decisions about treatment. The second one is related to the information provided to the patients. At the same time, this concept draws a clear line between the new, the RTIP-based form of involving patients and the traditional one based on compliance.

Making a theoretical distinction between the law, the profession and the organization allows a thorough analysis of different outcomes of regulation through the RTIP. It gives a possibility to explore the relationship between clinical action, legislative regulations (the RTIP and the guidelines), organizational structures and professional norms. Furthermore, this theoretical approach allows exploring how the rules and clinical reasoning may influence the regulation through the RTIP.

**The following hypotheses have been developed:**

The legal dimension:

*Regulations establishing the RTIP may be worded in a precise or vague way.*

*Furthermore, the content of the guidelines may vary from strong to weak.*

*Weak wording may allow deviation from the main principle in practice to a*

*larger extent than the strong ones.*

*Precise regulations are characterized by specific, clear, and concise concepts. They leave practitioners little chance to re-define them in practice.*

The professional dimension:

*The main hypothesis within the professional dimension is that clinical practice may have common characteristics institutionalized in the clinical norms for practice. Thus, professional norms in the field of psychiatry may be viewed as contributing to the stability and unification of practices.*

While this main hypothesis is based on the stability of unified clinical practice, other hypotheses presuppose variations in clinical practice:

*The psychiatrists and the psychologists may engage in emphasising the differences between them.*

*Experience is a source of knowledge that could to some extent explain variations in professional action in clinical practice.*

The organizational dimension:

*The organization of work and hierarchy can furnish organizational members with a normative and consequence-based guide for actions.*

Organization of work may be further operationalized as follows:

*Members of teams may institutionalize the RTIP in a different way than the specialists working on their own.*

The hierarchy hypothesis can be specified as follows:

*Leaders may align clinical actions with the organizational strategies to a larger degree than other professionals.*

*Leaders may buffer an external influence on clinical practice (decoupled organization structure).*

Another aspect of the organizational structures concerns the concept of local rationality:

*Clinical reasoning can be steered and, in a way, also enabled through the process of establishing local standards for treatment, i.e. by the structures and established practices within the scope of specific organizations (local rationality).*

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## 4. Research design. Exploring the case of regulation through the RTIP

### 4.1 Introduction

The goal in this chapter is to present the principles which relate the data sources and the theoretical approach. Case study design was chosen in this work since it allows making some generalizations based on a single case. Thus, one case may be central to the theoretical development. Case study research design was also chosen as it produces context-dependent knowledge. It is necessary in order to explore the complexity of the clinical context.

The major theoretical approach chosen for analyzing the case is institutional perspective. The main reason justifying this choice is that the general assumptions of this approach allow exploring different motives behind human action. The complexity of the context in this work requires an approach that allows capturing different outcomes. This study is based upon de facto clinical assessments that are not defined a priori. The theoretical approach is applied in order to give an overall guidance for how to understand the relationship between clinical action and the specific regulations. The goal is to explore various choices of action made by the professionals and explain the different outcomes of juridification.

Having as a starting point for the analysis the clinicians' subjective understandings, I assume that they are active, interpretative and creative actors making their autonomous judgments who may not always follow the specific legislative



regulations or accepted professional conventions. Actors may have their own goals and interests as well as perceptions of the organizational context, specific situations, and understandings of the best practices, which may all lead to individual adjustments to the regulations.

Within the general approach of institutional theory, the choice was made to focus on three particular dimensions that seem to be relevant within the context of this study, the legislative one, the organizational one and the professional one, and their explanatory power with regard to clinical action. The legislative dimension comprises the legislative regulations, the organizational one includes the hierarchy and the organization of work, while the professional one covers clinical experience, profession and general clinical norms.

The goal in this chapter is to operationalize the three dimensions, introduce certain hypotheses within them and define specific indicators with regard to the characteristics and the content of each dimension. The aim is to discuss each of the dimensions separately.

The structure of this chapter is based on the logic of proceeding from the theory-based concepts to their operationalizations and then towards the specific data sources. From the most general level of theory I gradually proceed to the operationalized lower levels and at the end to the very specific sources of data, procedure of the analysis and the potential to generalize from this study.

This chapter starts with justifying the choice of the case study design. There is a number of reasons for it described in chapter 4.2. The next step is to define the case

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of juridification. The aim is to operationalize the case and suggest the possible explanatory dimensions. Furthermore, the purpose is to operationalize the hypotheses within and the legislative, organizational and the professional dimensions separately. I first introduce the precision and strength of the legislative regulations. The goal is to incorporate the characteristics of the regulations in order to explore their explanatory potential for clinical action.

The characteristics of the guidelines and organizational structures as well as professional background are seen as having a potential to explain clinical action. Therefore, the next stage is to present the data sources within the scope of the legislative, organizational and professional dimensions and describe the procedure of the analysis. The organizational dimension is introduced with the hierarchy and organization of work as well as the concept of local rationality.

Furthermore, the organizational context of the DPCs<sup>22</sup> is presented in this chapter, including the characteristics of the DPCs, their websites and internal

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<sup>22</sup> DPC (district psychiatry center) is quite a new way to organize specialist health care services in the field of psychiatry. The centers are placed between hospitals and municipalities. The primary functions of DPCs include follow-up and rehabilitation of people with chronic conditions as well as stabilization of acute conditions and serious diagnosis. Patients are supposed to receive health help at the centers before being referred to the hospitals.

DPCs cover some form of the following services:

- Outpatient clinics/ambulatory services
- Daytime treatment
- Short-time inpatient treatment
- Long-term treatment and rehabilitation
- Consultation, supervision and support for staff in primary care services
- Acute services and crisis intervention in case of long distance to the mental health hospital (Sosial- og Helsedirektoratet 2006a).

documents. Within the scope of the professional dimension, the professional field with the focus on norms common for clinical practice, different professions and length of experience are anticipated to structure clinical reasoning. Two professional groups (psychologists and psychiatrists) were interviewed for this study. The interviews provide two types of data, i.e. information about the treatment practices and about the structures framing the clinicians practice. The procedure of analysis of the interview data is included in description of it as well with the following procedure of interviews and the interview guide.

Finally, the conclusion of this chapter consists of the description of the relationship between data analysis and the final analytical design. It gives an insight into the process of development of the final research design in this work. The generalization potential from this study follows as it provides knowledge about the quality of this work with regard to the generalization potential to for example other levels of health services.

## **4.2 Case study research design**

There are different perceptions of knowledge production in social science. In this study, I chose an approach in the tradition of organizational science, in which the question of “what is being studied?” drives the choice of methodological approach (Morgan 1987, p. 19). Several other broadly used methodological approaches were less suitable for the purpose of this study. Since the characteristics of the clinical situation are anticipated to be important factors for understanding the process of regulation

through the RTIP, an experimental approach could not be applied, as it separates the study object from its social context in order to focus on a few variables. The context is critical to consider in history designs; however, these focus on the analysis of the past rather than the present situation. Survey approaches may handle the relationship between the phenomenon and the context, but the ability to explore the context is limited (Yin 2009). Due to these factors, the choice of this case study as a research design is considered optimal.

The goal with this section is to justify the choice of case study research design. This is a study of clinical specialists and how they render health services in times when their autonomy is contested by the legislative regulations in the context of public domain. Case study research design is especially suitable for the studies of public administration.

In many ways, the choice of the case for this study may be seen as rather strategic because of the specificity of its context. The studied clinical field has traditionally been characterized by the dominance of paternalistic practices (Kjønstad & Syse 1992 p. 197; Kjønstad 2007, p. 36). It was to a large extent a matter of discretionary evaluations to decide upon the practices of information and participation in treatment. Legislation of individual patient rights aims at narrowing down the possibilities of exercising a professional discretion. The goal of this legislation is to increase the patients' chances to hold the thousand-year old paternalistic medical practice into account (Kjønstad & Syse 1992, p. 197).

Furthermore, the Norwegian public health service has traditionally been

representing a model of treatment in which doctors and other health workers had the authority to decide both about the form and distribution of health services, while citizens had few individual rights within the public health service (Kjønstad 2004b). Legally enforceable user rights in general have not been a part of culture of the legal system in Norway (Fallberg 2000). In this area, an extensive intensification of legal regulations has occurred. These changes indicate a shift in the relationship between patients and health care specialists to a more liberal one, also with regard to access to information and possibilities to influence the treatment (Skålevåg 2005).

There is a number of other reasons for constructing the case within the area of legal regulations, information and participation as well as professional clinical practice. First of all, the area of information given to patients in health services has traditionally been neglected (Syse 2009). A report published by the Norwegian Board of Health Supervision in 2016 concludes, among other things, that the area of information still has a tendency to be neglected in health care services (Statens Helsetilsyn 2016).

Furthermore, it is important to mention that the possibility of enforcement of the individual right to information and participation seems to be rather weak. Since 2001, according to the patient and user ombudsman in Hordaland, there have not been any complaint cases that are based on this right (Helsenorge.no 2016). It begs the question about the effectiveness of the procedural legal rights (see chapter 2). It is, therefore, especially important to explore how the right is actually practiced. There is little knowledge about how legal changes towards more individualistic and right-oriented direction influences clinical decision-making. Very few empirical studies explore this topic (Feiring & Nese 2005, p. 5). The area of psychiatry is chosen in this work. This

is not accidental. The issue of participation and information for psychiatric patients has been on the political agenda and has been debated for more than one decade now (Magnussen et al. 2009, p. 11). The relationship between specialists and patients in psychiatry has traditionally been characterized by a particularly great degree of paternalism (e.g., Jensen 1979). The Directorate of Social Health has emphasized a number of times that there is a necessity to change paternalistic culture in mental health services (Sosial- og Helsedirektoratet 2003). Furthermore, an evaluation report published by the Research Council of Norway concludes that patients' participation in influencing their treatment is weak and information provided to them and their families is deficient (Brofoss & Larsen 2009). This is also one of the conclusions drawn from SINTEF's evaluation report of DCPs (Gråwe et al. 2008). A case study embedded in this context may reveal more information than a typical case could provide (Flyvbjerg 2006).

Furthermore, the enforcement of individual rights in the area of health was justified by the objectives of health services based on respect for human dignity, the fair distribution of rights and duties, and equal access to health care. The area of psychiatry can be seen as a special case in health care services since psychiatric patients have not been on the equal footing with all the other, somatic arenas of service, with regard to the unconditional access to the individual rights until 2006 (see section 2.3). Thus, the practice of the regulation, in this area, has been shorter than in the somatic medicine. Furthermore, in psychiatry, a number of cases of violence of patients' autonomy brought to public attention has been larger than in the somatic services (i.e. <http://www.mentalhelse.no>).

Considering types of treatment in psychiatry, this study can be placed in between what may be seen as extreme cases. If one sets coercive procedures on the one end of the scale and non-medical voluntary treatment on the other end, voluntary treatment within the scope of established treatment procedures may be placed in between these two. It is first of all coercive treatment and the issue of human rights and autonomy that has been extensively studied by the scholars (for example, Raboch et al. 2010). To the best of my knowledge, there are few studies exploring the practices of patients' rights within the area of voluntary psychiatry and specialized health services at the District Psychiatric Centres (further called DPC). Most attention has been devoted to the question of coercive treatment and patients' rights (Frahm Jensen 2011). This study gives insight into the practice that covers the largest number of patients, i.e. those who suffer from chronic and mild health conditions. It will provide knowledge about the practices and understandings of the regulations from the specialists who treat the largest group of patients in Norway. However, it is not the aim of this study to contribute to statistically representative scope of knowledge. Case study was chosen since it has a potential to develop analytical generalizations. Thus, the aim is to establish generalizations based on the specific characteristics of the case, described in this section. At the end of this section it is specified which of them are important for the generalization potential of this work.

Since the regulatory framework unconditionally concerns psychiatry patients, it has been claimed by many clinical practitioners that the paternalistic treatment regime has been changed to a more liberal modern approach. Rights are claimed to allow patients to get access to their medical records at request and choose the health provider.

There seems to be little insight into the day-to-day clinical practice in Norway in general and in psychiatry in particular, and this area needs to be further explored. Case study research design is well suited for studies in which the knowledge base is scarce (Creswell 2007, p. 101).

Case study design has a number of characteristics that make it suitable for the purpose of this study. It may be applied to the hypothetico-deductive model of exploration. In this work, a set of various hypotheses are introduced, and explored in chapter 6.

Furthermore, case study generates new ways of understanding. The purpose of this work is contributing to the knowledge of the mechanisms that drive the outcomes of regulations through the law for the professional action. This is done by suggesting an approach that combines organizational and professional perspective, contributing to new understandings of the relationship between traditional professional practices and neoliberal legislative control.

Otherwise, case study design is useful to analyse real-life clinical practices studied in this work. The aim is to apply an open approach that captures all the possible outcomes that the reality may bring (Byrkjeflot, 2005). Case study also allows combining different data sources. In this work, various data sources are combined. I ask questions about the content and the characteristics of the data material, as well as compare it within and between the data sources to understand the various forms of outcomes of legislative regulations.

Case study design is, among other things, aimed at exploring the processes

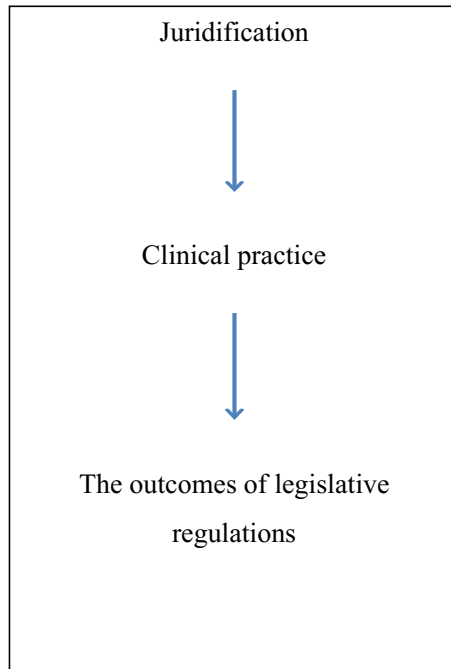


within certain time boundaries (Creswell 2003). Two points bound this study in time: the date of the enforcement of the law (2001) and the period of data gathering (2011).

A case study design may be either multiple or single and may further be holistic or include several embedded units of analysis (Yin 2009, p. 40). Exploring the outcomes of juridification as a case study, aimed at gaining a holistic overall understanding of the phenomenon being studied, suggests a holistic and single case study design. It is an intensive study of a spatially bounded phenomenon aimed at its particularization (Willis 2014).

#### **4.3 A case of juridification – individual user rights and clinical action**

This is a study of juridification embedded in the field of clinical practice, as illustrated by Model 1 below. It comprises the analysis of the outcomes of regulation through the RTIP in the field of psychiatry.



Model 1. The outcomes of the legislative regulations for clinical practice.

It appears that clinical action may depend on a combination of situational knowledge, personal identity, suggested actions and individual strategizing. Clinicians may be faced with various treatment situations, and their choice of action alternatives could likely be influenced by different factors such as rules, situational factors, pragmatic reasoning, consequence-oriented action, which might lead to different outcomes. Thus, the actors' understandings of the context must be included in the analysis in order to make sense of the action. All of the factors mentioned above may present the actors with appropriateness, i.e. institutionalized, scripted ways of behaving specific to certain roles and situations (Olsen 2009).

However, it has been observed that not all actors behave the same way in similar situations. Some scripts may be open to interpretations (Olsen & Maassen 2007), and there can be leeway to operate within certain parameters. Furthermore, not all contexts are understood identically (Schmidt 2008), the scripts and outcomes are not universally known. Finally, actors possess their own personal contours, whereby their knowledge, preferences are shaped through their own experiences. What they know about the situation is incomplete and within what they believe to be available options and outcomes they may be able to apply logic of consequence (Olsen 2009), hoping to achieve the preferred result. In the context of this study, these theoretical assumptions are applied to explore experiences, knowledge and preferences to understand the broad scope of clinicians' interpretations. The institutional context may form the action to some extent, but the creative judgment of the actors who reason may lead to great differences of the outcomes in the reasoning process. This creative judgment can be based on the expected future consequences, appropriate expectations, pragmatic thinking, as well as a combination of these. Therefore, the goal in this work is to capture different possible outcomes of regulation by the RTIP. Having said that, the legislative regulations, the organizational and the professional background are given special attention in this work. They are focused upon as they may provide actors with guidance for understanding the appropriateness in the explored context.

The three specific dimensions chosen for further exploration are discussed in the following sections.

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#### **4.4 The legislative, the organizational and the professional dimensions**

The explanatory dimensions that are anticipated to influence the understanding of clinical action are the legal, the organizational and the professional dimension. One general hypothesis is attached to each of them. The first hypothesis is that the legislative regulations may influence the clinical action. I chose to define legislative regulations as the law and the guidelines that expand the content of the RTIP. This hypothesis provides one type of guidance for how to perceive and explain clinical action. The second type of understanding clinical action is embedded in the hypothesis that organizational structures may influence clinical action. The third one concerns professional background and its influence on the clinical action.

Furthermore, one may expect that variations within each dimension can result in variations within the clinical action.

The three hypotheses represent three normative platforms to understand clinical action. However, it is not taken for granted that the specific factors within each dimension could lead to similar outcomes for clinical action. It has to be possible to capture the differences within the scope of each dimension. Thus, for example, it is anticipated that the organizational structures may influence in a different way how the priorities are set for day-to-day decision-making.

Similarly, professional theory could suggest various expectations with regard to professional background. It could be expected that socialization into profession might for example lead to variations in clinical action.

Within the scope of the general hypotheses mentioned above, it is not sufficient to assume that the actors respond to the institutional contexts and that the characteristics of each dimension are important to understand the specific clinical action. A more specific approach is necessary, since the actors are professionals in the clinical field, they are employed at the specific organizations and their work is framed by the RTIP. Therefore, a detailed analysis is required. The particular characteristics of each dimension are described below together with the specific data sources explored to understand their influence on clinical reasoning.

#### **4.5 The law and the guidelines**

In this section, the sources of data related to the legislative dimension, that is, the guidelines for clinical practice, are described. The Directorate's interpretations of the RTIP found in these sources are the only existing advisory extensions of the legal formulations aimed at clinical practices.

There are no restrictions with regard to the number and form of the guidelines that may exist at the same time within the same area of practice. From 2000 to 2011, the Directorate created more than 140 guidelines, about 50 of which are related to health care services. Of these latter ones, 17 are concerned with the area of mental health, and six concern the area of practice regulated by the RTIP. These documents may be divided into two groups. The first one is the recommendations developed mainly by the clinical specialists. These documents prevail among the guidelines. The representatives of users' organizations define the second group.

All of the guidelines are consensus-based recommendations; even though professional groups developed them, the representatives of user organizations that cooperate with the Directorate have accepted them. All the parts agreed upon the content and the wording in the documents. The Directorate publishes all of these documents. There is no permanent layout that the Directorate follows systematically in the process of the development of the legislative regulations.

There are no regulations with regard to the level of precision and the number of guidelines that should concern the RTIP. The Directorate does not specify a hierarchy order of the guidelines in relation to each other. None of the characteristics of the guidelines mentioned above are problematic for selecting the data in this study. The guidelines are treated as comprehensive and sufficient sources of knowledge about the implications of the RTIP for the recommendatory framework in clinical practice.

The following section answers the question about the specific data sources that provide knowledge on the aspects described above. I further present the specific guidelines chosen in this work.

#### ***4.5.1 The choice of the particular guidelines***

Table 4.1 below presents an overview of the Directorate's documents containing interpretations of the RTIP and therefore chosen for analysis in this study.

Table 4.1. The Directorate's guidelines chosen for the analysis in this study.

Number of the Guideline	Title
IS-12/2004	The Act on Patients' Rights
IS-1388	District Psychiatric Centers: municipalities and specialized health care services
IS-1315	User Participation in Psychiatry – goals, recommendations and measures in the National Action Plan for Psychiatry
IS-1253	The Individual Plan

The structure of the guidelines varies. Some of them follow the structure of APR, such as the directive IS-12/2004, and concentrate on the interpretation of the Act in general (Sosial- og Helsedirektoratet 2004). Some documents concern one specific issue, such as the right to an IP.

Written guidelines tend to be structured according to the areas of application, such as administrative or clinical practice. One of the documents, IS-1315, was issued in the form of a report and focuses only on the interpretation of the concept of user participation (Sosial- og Helsedirektoratet 2006b). None of the documents issued by the Directorate relate exclusively to the RTIP. The Directorate has published eight

documents that include interpretations of the RTIP. Four of these have been chosen for analysis in this study. Each of the documents contain between 40 and 80 pages.

The documents chosen for the analysis are related to clinical practice. In four of the eight documents comprising the RTIP, the Directorate describes the organizational level. The documents define the obligations of health service providers concerning procedures, routines, and quality measures. These guidelines are IS-2-2005, IS-2-2006, IS-2-2007, and IS-1579. These documents were therefore excluded from the analysis.

The most important characteristic of the Directorate's interpretations is that all of them are currently valid and recommending the best practice for the clinicians.

Two of the guidelines chosen for analysis (Table 4.1), IS-1253 and IS-12/2004, are directed at clinical practice in general. These guidelines are directly relevant to the analysis as they provide interpretations of the RTIP in the relationship between patients and clinical practitioners.

The two other guidelines, IS-1388 and IS-1315, are directed particularly at practitioners in the field of psychiatry. One of these, IS-1315, focuses specifically on the concept of user participation in psychiatry. The main actors involved in the development of these documents were patient organizations.

The guideline IS-1253 concentrates on the understandings of the right to an individual plan. However, the document also includes interpretations of the RTIP with regard to clinical practice in relation to an individual plan. A number of guidelines are related to the right to an individual plan. Of these, I chose to include this guideline,



which interprets the individual plan with regard to the RTIP in the most extensive way. The remaining guidelines discussing the right to an individual plan overlap in their interpretation of the RTIP with the one chosen for the analysis and may therefore be omitted from the discussion.

A similar reasoning was applied to the choice of the guidelines for interpreting APR in general. The contents of Directive I-60/2000 and IS-12/2004 are exactly the same with regard to the interpretation of the RTIP. Therefore, these two documents are perceived as one interpretation, and only one of the two, IS-12/2004, was included in the analysis.

The guidelines which have mainly been developed by the professionals are called Group A in chapter 5. This group includes IS-12/2004, IS-1388, and IS-1253. IS-1315 has been developed mainly by the patients' organizations and constitutes Group B in chapter 5.

#### ***4.5.2 The online sources of the Directorate***

Another type of data within the scope of the legislative dimension comprises the online sources. However, it is seldom that in its online sources the Directorate refers to the interpretations presented in the other guidelines. One exception to this is the documents the Directorate publishes on its two websites, the official webpage of the Directorate (Helsedirektoratet.no) and its information portal (Helsenorge.no). These are included in this study as major sources comprising interpretations of the RTIP.

The Directorate employs professionals from various medical specializations, as well as a few lawyers and political scientists. Therefore, these professional groups are the main actors who have authored the text presented on the websites, with the exception of the direct quotations taken from the written guidelines. The websites contain a more general description of the guidelines and are therefore discussed in chapter 5 with regard to either Group A or B.

The Directorate does not specify the status of the information provided through the online sources except suggesting that they have an informative function for the general public. While the official webpage mostly contains interpretations already found in the guidelines, the information portal also introduces interpretations that were not included in those documents. At the official webpage, the Directorate refers to and publishes both the existing guidelines and APR. The information portal focuses on the development of understandings without referring to existing sources. The online sources are included in the analysis in this work since they represent the interpretations the Directorate has developed. They are legitimate sources of interpretations of the RTIP that inform clinical practice.

All of the guidelines and the online sources mentioning the RTIP were incorporated into this study. This serves to provide the most comprehensive insight into the legislative framework.

### **4.5.3 Precision and strength of legislative regulations**

Regulations may be worded in a general or less general way. The vaguer the wording, the greater the space for discretionary interpretations and variations among them. Precise regulations may bind clinical discretion stronger than vague ones.

The balance between specific and vague wording can affect the outcomes of regulation through the RTIP in various ways. For example, vague wording might make it difficult to answer the question about compliance with the law and lead to greater variations in the interpretations of the RTIP in clinical setting than precise wording. At the same time, too specific wording might bind law interpreters to the extent that it might not be possible to adjust clinical action to the new developments in social understandings of patient's role in treatment.

Another aspect of the analysis related to precision is the strength of the interpretations. The Directorates' recommendations vary from strong (i.e., containing "shall," "will," or "must") to weaker recommendations that allow a deviation from the main principle (i.e., containing "may," "preferably," "can," or "should"). It is important to note that not even strong recommendations are obligatory for the practitioners to follow, since the guidelines do not have a legally binding power.

At this point it may be mentioned that the RTIP is legally binding framework for action in clinical practice. It belongs to the category of procedural health rights, which are vaguely formulated in the law and are elaborated upon in the guidelines for clinical practice. The vagueness of the regulation might make it difficult for their interpreters to determine the content of the right. It may be difficult to draw conclusions

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about whether the right has been fulfilled. When a right's content is loosely defined, exactly what the right holder is entitled to and how he or she will get it is to a large extent to be determined by the administrators of the right.

#### ***4.5.4 The content of the guidelines***

As mentioned above, legislative regulations may be worded in a general or less general way. Furthermore, they may have strong and weak wording. The content of the regulations is also the subject of the analysis in this study. In this regard, the guidelines are particularly important for this study since they offer an insight into the best practices of information and participation recommended by the Directorate. Thus, the guidelines are analyzed here with regard to the content of information and participation. The question is which types of information (about the methods of treatment and the content of suggested treatment) and forms of participation are incorporated in the guidelines.

The specific concepts developed in the guidelines to describe information and participation are also explored.

#### ***4.5.5 The procedure of the analysis - the RTIP and the guidelines***

The analysis of the outcomes of regulation through the RTIP, presented in chapter 5, is based on the definition of the RTIP given in APR and on the guidelines expanding the content of the RTIP. The characteristics of the RTIP as the procedural right and the wording of the legal definition have been analyzed. The next stage of data

analysis was to read all the guidelines, including the information published on the portals, in order to get a general impression of the data material. This step provided an overview of the existing interpretations found in the guidelines and on the websites. All of these (four documents and two portals, see above) were included in the analysis.

The next step in the analysis required a description of the interpretations in each source (both the documents and the portals), which would be independent of the chronological order. This description was based on the extensive use of quotations translated into English (my own translation). At the end of each description, the content of the interpretations was analyzed and systematized with regard to the analytical design described above.

At the end of chapter 5, a comparative approach was applied, which provided an insight into differences and similarities in the content in various sources. Their complementary and/or contradictory characteristics are explored. In order to get the insight into the characteristics of the Directorate's interpretations and understand the goals behind this specific form of regulation, the focus is on the actors involved in the process, the target groups representing different interests are identified, as well as other procedural characteristics of the process of the development of the guidelines. The actors involved in the development of the guidelines are assumed to have influenced the characteristics and content of the guidelines. The quotations from the guidelines are presented as illustrations of the main tendencies.

The question is if the regulations support the Directorate's goal to guide the clinical actions in an effective way. The insight into how the Directorate chose to

develop recommendations for clinical practitioners allows establishing hypotheses about the possible outcomes of the guidelines for de facto clinical practice. In the analysis of the guidelines the relationship between the legal goals and clinical norms is explored.

To explore how the content of information and participation is understood by the Directorate (the traditional and promoted by the legal goals) I apply the same concept of co-determination, as described in chapter 3 (section 3.3.1.3). I chose the concept of co-determination as it draws a demarcation line between new ways of treatment endorsed by the RTIP and the more traditional ways to provide information and involve patients in decisions about the treatment. The concept of co-determination is further applied in the analysis of clinical practice.

#### **4.6 Hierarchy and organization of work**

The organizational dimension includes the organization of work and hierarchy relations. All of these are anticipated to influence clinical action. The locally accepted ways to perform practice, called local rationality in this study, may also have some explanatory power. A number of scholars has suggested that there may be differences in local practices among organizations, especially in the field of psychiatry (Froestad & Jensen 1985). Clinical reasoning can be influenced through the process of establishing local standards for treatment (local rationality). Thus, hierarchy, local rationality and organization of work may lead to variations in the clinicians' understandings.

It has been suggested that hierarchical authority calls for behavior that conforms to pre-established regulations and seeks to align actions with jointly established laws (Nystrom & Starbuck 2003, p. 515). Exercising hierarchical authority may then be seen to be designed to enforce behavior that adheres to the regulations. However, in the context of organizations dependent on the professional-based knowledge (expertise), the behavior might also be influenced by professional codes of conduct.

Part of this study has focused on combining leadership and clinical responsibilities. Thus, having the role of a leader by the professionals may have an impact on their clinical work as well. Health care has been associated with leadership aimed at coping with the consequences of legal changes and finding effective ways to deliver health care (health management) (Noordegraaf & Van der Meulen 2008). This logic of thinking may influence clinical reasoning in different ways. New organizational positions and roles have arisen, such as clinical managers, who are clinical specialists as well as managers (Noordegraaf 2007). Combining the two roles may have an impact on the decisions of individual leaders. The leaders may to a larger degree than other professionals align clinical actions with organizational strategies. Alternatively, clinical managers may buffer the external influence on the clinical practice (decoupled organization structure).

In clinical practice, professionals not only become part of hierarchy structures, with planning and control and strategic frameworks. Organization members are taught to adopt locally prescribed practices. It directs attention to internal contexts embedded in traditions and local practices. These suggest what the appropriate course of action is. If the professionals comply, they shall in return be treated fairly and appropriately

by the organization. Individuals in a public organization will have a certain amount of freedom to choose between different identities and rules. Thus, the organizational dimension can give guidance for what to expect, although not necessarily an understanding of de facto human action. In this study, the question is under which circumstances unit-specific routines and standards as well as practices among the units and within the internal groups and departments will be preferred over other rules defining appropriate conduct.

According to organizational theorists, formal organization of tasks may limit what is deemed acceptable, reasonable, appropriate or valid perceptions of a situation. It may impose limitations on an individual's choice of action and create a capacity to realize particular goals and values (Christensen et al. 2007). Furthermore, it has been suggested that how professional acts and practices are connected depends on whether the professionals cooperate (Noordegraaf 2016). Whether and how professionals will (re)organize their work will affect whether and how they combine treatment and cost control (Noordegraaf 2016). For example, division of tasks into working groups may influence how the tasks are solved. Teams may develop their own rules, values and norms, which in turn exert an independent influence on decision-making behavior. In this study, the question is how individual decision of team members will be affected by the other members of a team (by collective decision-making).

It has also been suggested that in team-based work individuals develop beliefs about their own and others' preferences and may act based on it (March & Heath 1994, p. 112). Furthermore, the teams are characterized by group loyalties. Expectation of loyalty may shape the outcome of individual decision-making.



The following section answers the question about the specific data sources that provide knowledge about the organizational aspects described above. I present the specific organizational units chosen in this work.

#### **4.6.1 *The DPCs***

The DPCs (District Psychiatry Sources) are the main actors chosen for the analysis since they provide services in the target area chosen in this work, i.e. the voluntary psychiatric patients. A further reason for choosing DPCs is that according to the Ministry of Health and Care Services, DPCs have to integrate user involvement perspective throughout the whole treatment process (Neuman 1997). Strong political emphasis on the area regulated by the RTIP, in the service delivery by DPCs, makes studying professional practices of patients' involvement and information and their relation to the RTIP in this organizational context especially interesting.

The individual informants interviewed for the purposes of this study, were all clinical specialists, employed at the DPCs. They could provide an extensive description of their interpretations of legislative regulations and describe information and involvement in treatment practices. The clinicians work mainly with the mild and chronic group of voluntary patients in the organizational context of DPCs. All of them have to relate to the legislative regulations in the clinical practice.

I chose to focus on the clinical units in the administrative region of Helse Vest (Western Norway, including Bergen and the provinces of Hordaland, Sogn og

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Fjordane, and Rogaland). There has been an extensive engagement of specialists in the debate about the development of actual methods of involvement of patients in the development of psychiatric treatments in this region. A number of research projects were devoted to this subject in the Helse Vest area (Hummelvoll 2008; Ekeland & Heggen 2007).

The invitation to participate in this study was sent out to the leaders of 9 DPCs, and 5 of them agreed to participate under the condition of anonymity. All of the units which agreed to contribute to this work were included in this work. An access to specific units within DPCs which offer voluntary treatment was requested. The aim was to choose the units which were accessible and which are at the same level of service delivery to the group of voluntary patients. It gave access to the informants who had experience with the target area of study, i.e. voluntary services. The goal was to choose the most representative target group within the 5 DPCs with regard to knowledge about legislative regulations and clinical practice.

#### ***4.6.2 Websites and internal documents***

The subject of analysis comprised the organizational charts, internal documents, home websites of each DPC unit and the interviews. The first step in the analysis was to read through the all the data to get an understanding of the organizational structures, i.e. what kind of internal departments and groups the DPCs are divided into, as well as the official hierarchy relations. The goal was to gain a general impression of the internal structures and differences and similarities among the DPCs. Furthermore, the aim was

to understand the type of treatment services and units that have responsibility for providing them (division into teams and departments).

The next step was to explore the dynamics of the teams and how they function with regard to decision-making. The purpose was to gain an overall understanding of the actual process of decision-making in the teams as compared to official routines and procedures. Furthermore, the descriptions of the hierarchy relations and organization of work were explored to gain an understanding of particular local practices.

The aim was to explore how all the studied DPCs in Helse Vest are organized, in particular, whether there are polyclinics or day/outpatient treatment. The focus was also on the type of the treatment offered at the DPCs (whether the units offer medical and psychological measures, rehabilitation or psychotherapy).

#### **4.7 The professional field, profession and experience**

Within the scope of the professional dimension the question is how the professional field, profession and experience may structure clinical reasoning. Based on the professional theory it could be expected that the field of clinical practice could to some extent unify the clinical perceptions of reality.

The major assumption within the professional dimension is that clinical practice may have common characteristics institutionalized in the clinical norms of practice. Socialization into the profession contributes to the homogenous professional knowledge and identity (Halvorsen & Michelsen 2002, p. 19). It establishes a clear

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distinction between those within and outside the field of practice (i.e., professionals and nonprofessionals). Therefore, clinical practice may to some extent be considered as a united, homogenous professional field. Based on this assumption, the unification of interpretations among clinicians could be expected. Furthermore, professional values in clinical practice are based on universality<sup>23</sup>, functional particularity, neutrality, and collective orientation (Parsons 1991).

Another perspective suggests variations with regard to different professions. According to it, professionals with various backgrounds may be preoccupied with marking the variations among them. Thus, an alternative approach can comprise a perception of professional practice as consisting of various occupations organized in social groups and characterized by numerous types of knowledge (Freidson 1994, p. 79). Different occupations may be perceived as being in conflict with each other over others, such as training or work placement (Freidson 1994, p. 84). Specializations within the same professional field may also be in continuous conflict regarding enforcement of their knowledge and perception of the professional reality. In such a case, there is no space for discussion among professional environments, and differences between professional groups could be seen as potential battlefields. This idea challenges the classical perception of homogenous practice within professional theory.

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<sup>23</sup> - called reliability and objectivity by Malt et al. (2003).

In this study, the division concerns two professions, the psychologists and the psychiatrists<sup>24</sup>. They are both called clinicians in this study.

Assuming that younger professionals have less experience with the job than older clinical specialists, it has been argued in the literature that they tend to have different occupational ideas, identities, and dedications than older professionals (e.g., Noordegraaf 2011a). It is reasonable to anticipate that it may influence their ideas about connections between practice, the RTIP and the guidelines. Experienced professionals know how to relate to specific cases. They, ideally, act according to a shared code of ethics (cf. Wilensky 1964), and they know how to behave and also appear professionally. They know how to act, speak, and dress; they know how to act as professional, even when they do not treat cases. A medical doctor, for instance, does not merely treat patients. He acts as a doctor (Noordegraaf 2007). It has been argued in the literature that inexperienced professionals may relate better to written rules, procedures and education-based knowledge (Dreyfus & Dreyfus 2005).

For the sake of simplicity, I choose two analytical categories which concern the level of experience of the professionals, i.e. the experienced and inexperienced specialists.

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<sup>24</sup> Psychiatry as a discipline is at the crossroads of social and natural science. While psychoanalytic and social psychiatric theory and practice may be in general stronger associated with psychology, psychiatrists are medical doctors who can prescribe medical treatment (Kringlen 2012).

The following section answers the question about the specific data sources that provide knowledge about the clinical action. I present the specific groups of the professionals chosen for interviews in this work.

#### **4.7.1 *Psychologists and psychiatrists***

Two types of professionals (psychologists and psychiatrists) who work clinically with the patients in the field of psychiatry were interviewed for this study. To provide the most extensive data basis possible, the study includes all of the 30 clinicians who agreed to contribute to this study. Qualitative, open-ended interviews were carried out with these practitioners. I carried out three trial interviews to begin with, to gain background information, obtain access to interview subjects, and develop a semi-structured interview guide (see section 4.7.2.2 below). The results of the trial interviews have also been included in the analysis. The 30 interviews covered a group of 15 psychologists and 15 psychiatrists, including 2 psychologists and 1 psychiatrist during the trial interviews. The aim was to get access to the specialists who work clinically with patients at the DPCs. Furthermore, the purpose was to gain data from experienced and inexperienced specialists, as well as those who make decisions about the treatment on their own and those who work in teams. Another criterion was to include clinicians who share clinical responsibilities with a role of the leader.

#### **4.7.2 The interviews**

Interview data is the major source of data in this study. It provides the information about clinical practice and the clinicians' understandings of the regulations, as well as about the organizational and professional dimensions. It gives an insight into clinical practice and understandings of the RTIP and the guidelines by the specialists. It has also provided extensive knowledge about the informal organization of work, the actual hierarchy relations, the local practices within each of the DPC. Furthermore, interview data gives access to information about profession and experience.

The first step in the analysis was to read through all the interviews to gain a general understanding of how the specialists understand legislative regulations, de facto practice of information and participation, but also the organizational relations, professional associations and experience and their influence on the clinical action. The data analysis is based on the clinicians' interpretations, as they are, rather than their implied meaning.

The interviews are analyzed and systematized with regard to the hypotheses mentioned above. The interpretations are presented based on an extensive use of quotations (translated into English - my translation). I present long quotations from the interviews in chapter 6 in order to provide the reader with the possibility to understand the context. The quotations are presented thematically according to various aspects also found in the guidelines, in order to make it possible to compare the interview material with the guidelines.

The practitioners' assessments of de facto actions are presented as direct quotations representing the general understanding, as it grew more apparent from the interviews. All of the quotations were presented with the goal of maintaining the precision in the information that the interviewees want to convey. Quotations are compared with each other and differences as well as similar tendencies are discussed.

The RTIP suggests an alternative to the traditional understanding of involving and informing patients in treatment (see chapter 2). The aim of the interviews is to explore if the content of the regulations, the precision and the strength of their wording, as well as the variations found in the regulations, influence the specialists' assessments and how. Furthermore, the aim was also to check whether the specific concepts developed by the Directorate to describe information and participation have been incorporated into the practice. For this reason, the analysis of the interviews has focused on the understandings that may be closely related to the legal goals or to the traditional perceptions. The characteristics of the clinicians (experience, profession) are explored as well. The interpretations are compared with each other.

Furthermore, the interview data is analyzed with regard to the content of information and participation. The question is which types of information (about the methods of treatment and the content of suggested treatment) and forms of participation (self-responsibility and involvement in decisions) are incorporated from the guidelines. Besides, the question of circumstances when the information is not given as well as content of it is of interest.



The dependence of clinical, discretionary reasoning on a combination of situational knowledge, appropriate scripts for action, and individual strategizing is discussed.

The practical procedures related to the interview process are described below together with the description of the interview guide used in the interviews.

#### *4.7.2.1. The procedure of the interviews*

Data on de facto clinical action was obtained by means of the purposeful sampling procedure, i.e. the individuals being selected according to the relevance of the knowledge they can provide on the studied issue (Penrod et al. 2003; Creswell 2007, p. 125). The choice to contact the clinicians through their leaders and organizations they are employed at is justified by the otherwise difficult access to the psychiatrists and psychologists.

To gain access to clinical practitioners, the leaders of DPCs in Helse Vest were contacted by email with a request to arrange interviews with the specialists who work clinically with patients. The leaders forwarded the request to the clinical specialists, and those who wanted to participate in the study took contact with me.

The practitioners were informed in advance about the subject of the study and that the interviews were going to be recorded. The interviews had both an informative and an explanatory character, providing insight into the reasons for the clinicians' understandings of legislative regulations and clinical action. They included questions

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regarding the practitioners' opinions about the RTIP and guidelines, specific examples about informing and involving patients in treatment. Most of the interviews had a duration of two hours. The justification of choices regarding which information to provide and which form of involvement should be chosen provided the knowledge about the organizational and professional dimensions. The differences between the clinicians, for example, working in teams or on their own, have been captured.

The interviews were based on the interview guide, which focused on the depth and the details of the practitioners' assessments of their actions. The interview guide is shown in Appendix 1. This guide was divided thematically according to the various research questions (i.e., how the clinicians inform and involve the patients, which aspects are covered by the information, or how the information and involvement are individually adjusted to the patients). Furthermore, opinions about the legal concepts of information and participation, as well as the attitudes towards the existing recommendatory framework, have been gathered.

#### *4.7.2.2. The interview guide*

An interview guide restates the qualitative and open-ended research question in more precise terms (Creswell 2003, p. 108). In this study, the research question is operationalized by the detailed questions regarding how clinicians actually inform and involve patients in treatment and how they understand the legislative regulations. The approach to the interview guide was flexible, and I revised the guide as I learned more, especially during the three trial interviews. Two of them were divided into two

meetings, and each of them lasted 2 hours. The third one lasted 2 hours during one meeting. This approach was chosen since there is little knowledge regarding the implications of regulations through rights and the RTIP for specialist health care services. A flexible approach allowed the questions to be formulated more precisely and gradually, which provided a better insight into the practitioners' relation to the legislative regulations and the informing and involvement in clinical treatment (Henwood & Pidgeon 1992). The flexible approach also meant that I could ask spontaneous follow-up questions in order to ensure that I had obtained optimal responses from the participants.

A qualitative interview is one of the most important sources of data in case study approach. There is no single clear rule for achieving a proper balance between the structure and openness of questions in conducting the interview technique (Rubin & Rubin 1995; Sandelowski 1995). In this case study, interviews were rather a guided conversation than a structured line of inquiry. I asked open questions with the goal to provide the fullest data on how the practitioners inform and involve patients within the existing regulatory framework of legislative regulations and what mechanisms guide their assessments of the clinical actions (Creswell 2007, p. 134).

Bias is always present in any data collection (Van Meter 1990). The main strategy to consider the researcher's bias is called reflexivity. According to Bruke, the idea is to actively engage in critical self-reflection about the bias while the data material is gathered and analyzed (Burke 1997). In this work, I read the interview data looking for patterns and questioning the observed variations until it was possible to explain the

differences in the data material and the overall conclusions about the patterns could be reached within the theoretical framework presented in chapter 3.

The following Table 4.2. is an illustration of the operationalization of all the dimensions, indicators and values related to them. A summary of all the data sources is presented below.

Table 4.2. The outcomes of legislative regulations through the RTIP for the clinical practice.

Dimensions	Legal (Legislative regulations)	Organizational	Professional
Indicators	Precision, strength	Hierarchy, local rationality, organization of work	Professional background Norms
Indicator values found in the study	<ul style="list-style-type: none"> <li>• Precise or vague wording of the guidelines</li> <li>• Strong or weak wording of the guidelines</li> </ul>	<ul style="list-style-type: none"> <li>• Leadership</li> <li>• Local practices</li> <li>• Team work</li> </ul>	<ul style="list-style-type: none"> <li>• Experience: long and short</li> <li>• Professions: psychiatrists and psychologists</li> </ul>
Sources of data	All of the guidelines including interpretations of the RTIP (4 written documents and two online sources of the Directorate)	5 DPCs The websites of the DPCs Internal documents Interview data	Selection of interviewees from DPCs 30+3 interviews 17 psychologists and 16 psychiatrists

Table 4.2 shows how the analysis has been structured with regard to the relationship between the data sources and the three dimensions introduced above. In the following sections I present the procedures and the subject of analysis.

Insight into a number of explored aspects concerning outcomes of regulation through the RTIP has been achieved in this study. Data sources described in the table provide extensive information about the regulations, their characteristics and content. However, an insight into how the Directorate perceives the outcomes of the regulations for clinical action has not been gained. This has not been necessary for answering the research questions posed in this study. Rather than that, a good understanding of organizational structures and hierarchy has been gained. A comprehensive knowledge of the relationship between the norms, professional background and the length of experience has been provided as well. There has been rather limited knowledge about how associations with specific organizations influence clinical action. It has to be, however, emphasized that the data gathered in this study has given extensive knowledge about the core questions of how juridification through individual user rights within health sector and the field of psychiatry influences the clinical discretionary action. The various data sources (documents, websites and interviews) provide different perspectives on the studied phenomenon.

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#### 4.8 The relationship between data analysis and the final analytical design

Case study research design allows making major changes even after one proceeds from design to research, as the research area becomes progressively clarified and redefined. Thus, case study methodology allows introducing adjustments to the research design during the process of data analysis. The research design in this study was originally based on general assumptions of the institutional theory. The aim was to explore how the space for discretion is structured and how clinicians evaluate and choose the best treatment to the individual patients. The focus was on the relationship between clinical practice and two types of the rules, namely, clinical norms and the legislative regulations. Two major guiding assumptions were made, i.e. informal norms and legal goals might be seen as potential drivers for human action. Both of them could to some extent be seen as the appropriate rules for clinical discretionary action. The analytical design was based on the two dimensions, the legal and the professional. They were broadly defined. The legislative dimension comprised *de facto* given legislation and the core values of the legal system (such as the principle of legal security) but also general legal goals. The professional dimension comprised the general rules, reasoning, and persons qualified in particular professional fields. It also comprised the professionals' autonomy and the theoretical knowledge that makes the background for clinical practice. The general assumptions embedded in the institutional theory were developed into two analytical categories, *professional juridification* (PJ) and *juridification of the professional* (JP). JP reflected a stronger influence of the legal goals than PJ in the evaluation of questions concerning information and participation. PJ suggested a domination of professional norms. Generally, JP was related to the

strengthening of the legislative dimension by, for example, incorporation of the legislators' goals into interpretations of law. PJ was associated with strengthening the professional dimension compared to the legal. It could suggest that legislative regulations become incorporated into clinical ways of thinking, such as traditional clinical norms.

The two categories were, however, too similar to capture the extensive variety characterizing the data material. They did not sufficiently capture situations where rules were not followed, for example when the situational factors influenced clinical decision rather than legal goals or clinical norms. The analytical design was adjusted in the process of analyzing the findings. Thus, in this study the research design is the outcome of the theoretical anticipations but also the outcome of the on-going interaction with the analysis of the empirical data. The analysis of the interview data has shown that the organizational factors as well as professional norms and background and the characteristics of the regulations are critical in explaining the clinical action. It was therefore, necessary to adjust the research design and incorporate some of the organizational and professional characteristics in the research design as well as the relationship between them. Neither the organizational nor the professional dimensions were included before the data analysis was carried out. Discretionary reasoning may take various forms, however, some of the above-mentioned factors seem to be more important when clinical decisions are taken than others. Thus, the general anticipations embedded in the institutional approach have been expanded into a set of hypotheses concerning the specific characteristics of each of the three dimensions.

This approach can be seen as being better adjusted to the purpose of this study

than the research design that would be based only on the theoretical assumptions.

In order to explore the relationship between the three dimensions (legal, organizational and professional) and clinical action, the knowledge about the characteristics of the legislative regulations, organizational context and the clinical reasoning were obtained.

In the following section I discuss the quality of the gathered data and the potential to generalize the findings.

#### **4.9 Generalization potential of this study**

This study is a case of juridification with a focus on user individual rights in health care services. Specifically, the area of patients' rights is explored. The legislation is distinctive from other regulations, since the Supreme Court and patients' organizations have been important actors in the development of its content together with the specialists at the National Health System (Kjønstad & Syse 1992, p. 189). The primary goal with the regulations was to change the paternalistic treatment culture in health care services. Addressing the authority of the professionals through individual rights makes this form of regulation context rather narrow, quite specific, and difficult to compare with other areas regulated by individual rights (such as rights to social services). The RTIP, explored in this work, is a procedural right. This right was developed in order to strengthen the patient's formal position with regard to health personnel's former authority to make decisions. The aim was to give a patient an



increased opportunity to decide on questions concerning medical examination and treatment (Syse 2009, pp. 36, 194). The values of dignity and self-determination in treatment can be related to the goals of the international human rights, however, the tradition for lack of this form of regulation in Norway makes this case difficult to compare internationally. The Norwegian Public Health Service had traditionally been based on the assumption that patients are sufficiently protected by the duty and role prescriptions that were imposed on health care personnel and units (Syse 2009, p. 36).

However, it may be reasonable to suggest that this study contributes to a general understanding of regulation through weak procedural rights. The weak procedural health rights are vaguely formulated in the law. Vague regulations are characterized by general concepts and non-specific wording. The vagueness of the regulations makes it difficult for their interpreters to determine if the rights have been fulfilled. When a right's content is loosely defined, exactly what the right holder is entitled to and how he or she will get it is to a large extent to be determined by the administrators of rights. Weak rights tend to lead to differences in practices (Magnussen & Brandt 2014). Weak rights have limited possibilities to make legal claims on their violation (Bernt 2003, pp. 169–70; Bernt 1997; Syse 2009). It could be compared to similar regulations through the procedural rights in other areas such as employment.

The idea of worker participation in Norway has a long tradition. Participation rights are not only regulated by legislation. They are also covered in nationwide collective agreements between trade unions and employers. This is, however, mainly granting workers participation in decision-making bodies (at the collective level). In the area of health care, the RTIP takes the form of individual participation between the

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specialist and the patient. However, participation for workers has been practiced longer than participation for patients in health services. Differences between worker rights and patients rights concerning collective versus individual form of participation and length of experience with the regulations make it difficult to transfer the knowledge about practices of procedural weak rights between the field of health services and the area of employment. Besides, the specific history of practice characterized by the paternalism in health care could make the existing practices rather context-dependent as well.

Furthermore, this study addresses the specific field of psychiatry. The somatic practices have been unconditionally regulated by the procedural right of the RTIP for a longer time than the area of psychiatry. It makes the experience and existing practices with regard to the RTIP more extensive than in the field of psychiatry. In somatic health services the vague wording of the RTIP has been interpreted for a longer time than in psychiatry, and the practice is thus better established, which provides health professionals more specific content of the right. In this way the experiences from somatic clinical practice cannot be directly transferred to the field of psychiatry where the unconditional regulation through the RTIP has been introduced in 2006. Based on the institutional theory, it could be expected that the existing practices of the RTIP (in case of psychiatry) might be more difficult to change than establishing new practices based on the new regulations (in case of somatic treatment).

Among different fields of medicine, psychiatry has traditionally been particularly strongly characterized by authoritarian decision-making embedded in professional expertise and reasonably little openness with regard to the information offered to the patients (Kjønstad & Syse 1992, p. 189). Therefore, it seems reasonable

to suggest that the generalization potential to the other areas of health care is rather limited.

Furthermore, the organizational context seems to be important to consider with regard to the potential to generalize the outcomes of this study. DPCs have different assignments from the other levels of psychiatry services, such as hospitals and municipalities. They provide less specialized services than the hospitals and are placed on the organizational chart between the municipalities and the hospitals. They have also different organizational characteristics. They are, for example, much smaller and less hierarchic in structure than the hospitals and provide services to other patient groups than the municipalities. For example, the municipalities are much more involved in the provision of mental health services based on self-help groups.

Furthermore, both the municipalities and hospitals differ with regard to composition of specialists and organization of work that makes the explanatory power of the professional background in this study difficult to apply beyond the context of DPCs.

The municipalities provide a wide spectrum of more general services within mental health such as psychotherapy, social services as well as social housing services (Ose & Slettebak 2014).

Compared to DPC, municipal psychologists, GPs and nurses work rather individually when treating their patients. Thus, organization of work differs from the other levels. It is therefore reasonable to suggest that there could be expected larger

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individual differences in the way clinicians inform and exercise patients' participation within the municipal health care services than at the DPCs and hospitals.

Hospitals are the central actors in specialized psychiatry treatment of the most serious diagnoses (Myrvold & Helgesen 2009; IS-2156). It has been claimed that it is especially at the hospitals that the decisions about treatment have been characterized by a large degree of individual autonomy (e.g. Grant 2003; Rothstein & Downer 2012; Blau & Scott 1963; Bentsen et al. 1999). This may suggest that professional expertise may guide action within the hospitals in a different way than at the DPCs.

Furthermore, treatment of acute cases at the hospitals and municipalities might require a very different approach to, for example, information delivery than in treatment of chronic, mild conditions, which mainly takes place at the DPCs, as acute situations require rapid evaluation and short-term intervention. In such cases, information process might be strongly reduced.

The organizational characteristics of various DPCs concerning hierarchy relations and organization of work as well their small size and simple organizational structure make the findings in this study difficult to generalize beyond this specific organizational context. It is suggested in this work that these factors have played an important role in explaining the outcomes or regulation through the RTIP.

Since most of the DPCs have a similar organizational structure and tasks, it is reasonable to suggest that the findings in this study can be generalized to other DPCs. This is important, since DPCs treat most of the mentally sick in Norway. Thus, the generalization potential of this study could be reasonably large.

Certain characteristics of DPCs make the context of this study interesting with regard to another aspect, namely, the fact that their organization of work requires interdisciplinary cooperation among different professionals. This might give interesting insight into the mechanisms of interpretations of legislative regulations in the context of professional, collective fora of decision-making.

Furthermore, the interdisciplinary organizational context, with flat hierarchy relations, differs from traditional hierarchic hospitals. The case of DPCs may be placed at the intersection of traditional practices, simple organizational context and liberal legal regulations in the form of individual right. This constellation may provide interesting insight into the process of regulating the traditional professionalized contexts of clinical practices. At the same time, the cooperation context of interdisciplinary working environments contributes to the complexity of the studied context. To the best of my knowledge, there are few studies of professional practices and outcomes of legislative regulations at this level of service delivery in psychiatry. Thus, further studies are needed to understand the complexity of the outcomes of juridification in the voluntary psychiatry as well as in voluntary coercive treatment.

Within the approaches of professional theory it is not usual to incorporate theoretical anticipations about the organization (Halvorsen & Michelsen 2002, p. 40). Despite the extensive attention for professional services, this study also provides a good understanding of the state of relations between organizational contexts and professional work. By means of analysis of the specific organizational characteristics and professional practice, the goal is to contribute to scholarly debate about the existing

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ambiguities in the relationship between these two dimensions and the legislative regulations.

I suggest that the knowledge about the relationship between the regulations, organization of work, hierarchy and professional norms and background, achieved in this study, may be applied to other organizations with similar structures in the field of psychiatry. The specific types of this relationship are further explored and discussed in chapter 7.

#### **4.10 Summary**

In this chapter, a research design to study regulatory tendency that moves *beyond professionalism*, seen as restricting autonomies of the professional work, is developed. It pays attention to practices embedded in traditional norms, organization of work and hierarchy relations<sup>25</sup>. Organization theory and the theory of professions provide different analytical strategies to study the professional practice and outcomes of legislative regulations. Each of them may suggest rather one-sided understandings. I suggest that the understanding of clinical practice in relation to the established professional traditions and organizational structures may be central to the exploration

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<sup>25</sup> The existing research shows different responses to regulations. As discussed in chapter 3, a number of studies have shown that legislative reforms of the hospitals, with well-established traditions, often set no limitations on professional autonomy (Blomgren 1999, p. 194). Thus, in a hospital, reform logic often becomes subjected to clinical logic. Other work has illustrated that professions are often considered to be weakened by organizations, and managers are seen as adversaries of professionals (Noordegraaf 2011a).

of the outcomes of regulation through the RTIP.

Using institutional theory, the goal of this work is to capture the broad scope of various responses of the clinicians to the legislative regulations. These may be influenced in various ways by the characteristics of the legislative regulations. The anticipations of how the regulations may affect clinical action are established in chapter 3 and are further explored in chapter 6.

The characteristics of organization, profession and legislative regulations are assumed to influence clinical action. Their influence on clinical action is analyzed. The analysis results in the development of various analytical categories (see chapter 7) that may be applied to similar contexts in the future studies. The aim is to grasp different mechanisms that can drive clinical practice and elucidate the understandings of the legislative regulations within the context of professional, clinical work.

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## 5. The legislative regulations of clinical practice

### 5.1 Introduction

#### 5.1.1 *The guidelines for clinical practice based on the RTIP*

In this chapter, I pose an open question about the characteristics of the legislative regulations, i.e. the RTIP and the guidelines published by the Directorate of Health. I explore variations and similarities in the content of the guidelines, which regulate patients' co-determination in clinical practice. In the text of the APR, the RTIP is characterized by vague wording, which may be due to the political debate regarding the acceptable amount of patient influence on discretionary powers. The Directorate of Health has the authority to elaborate on the vague wording of the law and has done so in the aforementioned guidelines. The question that guides the presentation of data in this chapter is how the content regarding the right to information and participation is interpreted by the Directorate. Are the interpretations characterized by variations in the studied guidelines and, if so, what kind of variations are there? This analysis focuses on the content as well as the mechanisms, which may contribute to explaining the interpretations.

I present the guidelines according to the similarities and differences based on the two types of actors involved in their development: those developed mainly by the specialists (Group A) and those created by the patients (Group B). Since Group A is based on more extensive data, it dominates the discussion. The online portals are referred to as W1 and W2. I make comparisons within each group and also between them. This manner of presenting the data is justified by the differences between and



the similarities within those two groups of regulations. I divide the interpretations of the RTIP between those that are related to participation, which are presented first, and those that are associated with information, which is the result of the thematic distinction made by the Directorate. Before I proceed to the analysis, I suggest how the variations found in the guidelines may influence clinical discretion. This allows one to establish a link between the results presented in this chapter and the data from the interviews with the practitioners, interpreting *de facto* action, which is presented in chapter 6. The aim is thus to discuss how the variations in the guidelines structure practitioners' possibilities to make discretionary judgments.

As described in chapter 2, the RTIP represents a declaration of legal rules, which is an attempt to systemize the legal goals of self-determination<sup>26</sup> and informed consent that have been the subject of public debate in health care services for a long time (Aasen 2000). The guidelines as such are not legally binding documents<sup>27</sup>. In the legal hierarchy, the text of the law is the most important source for its interpretation (Kjønstad & Syse 2012). In the case of the RTIP, the definition of how to make patients participate and how to inform them, which was given by the legislators in the APR, would be the starting point of legal interpretations developed in so-called legal sources<sup>28</sup> (Kjønstad 2010). This is also the case in the Directorate's practice, which is

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<sup>26</sup> Self-determination is understood as a freedom to make choices about ones' own health care and treatment

<sup>27</sup> From a legal point of view, these are administrative and not legal documents that are aimed at law administrators.

<sup>28</sup> "Legal source" means the origin from which a rule of conduct derives legal force. For example, preparatory works for a law, being the outcome of the process leading to legislation, are used as the guidelines on how to interpret and define legislative intent (Kjønstad & Syse 2012).

why the wording of the law with regard to the RTIP will influence the content of the guidelines.

The interpretations of the RTIP studied in this chapter are an example of regulation through guidelines that are aimed at structuring and standardizing clinical practice. The purpose of these guidelines is to reduce ambiguities of the legal concepts and at the same time enable individual adjustments in clinical practice (Pierre & Peters 2000). The recommendations given in the guidelines address the process of the distribution of rights by clinical practitioners. These guidelines may be regarded as the Directorate's descriptions of best practices. In this chapter, I present and analyze these descriptions based on the guidelines, which regulate information and participation.

### ***5.1.2 An analysis of the guidelines***

The RTIP may be seen as structuring the framework for discretionary practice. Legislative regulations in clinical practice may become a norm for appropriate clinical action. In this study, clinical action consists of the choice of treatment methodology (matching diagnosis to treatment), the patients' participation in it, the delivery of the information about it, and an adjustment of clinical reasoning to the situation (consideration given to the individual patients).

The goal of regulation is to bind to some extent the decisions regarding how and which types of information should be given and what kind of participation is encouraged. The way this is clarified is described in the guidelines analyzed below.

The strength and the precision of the wording of the statements in the guidelines are explored in the analysis. Furthermore, the content of the statements with regard to the influence of the legislators' goals and clinical practices is explored. The implications of structuring clinical discretion by means of the regulations provided in the guidelines are also discussed.

The analysis of the guidelines is based on the assumption that it is possible to analyze and compare the statements given in the guidelines directly against each other. This assumption is made possible by the fact that even though the recommendations aim at a variety of target groups, the analyzed documents address the same area of practice. Of the two groups of interpretations mentioned in section 5.1.1, Group A and Group B, one group at a time is analyzed, and the statements are further compared between the groups. The quotations from the guidelines are presented as illustrations of the main tendencies within the three dimensions of vagueness, strength, and embeddedness in clinical norms and legal goals. The goal in this chapter is to capture the broad scope of different characteristics of the guidelines.

Precise statements comprise specific, clear, and concise concepts and leave little space for discretion. Vague statements are characterized by imprecise words and general concepts, which allow discretion. The vagueness and precision are not to be measured with mathematical precision, but are instead to be used for characterizing the particular recommendations with regard to their ability to bind the space for professional discretion. The more details there are in the particular interpretation, the more precise it is considered to be.

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Another dimension in the analysis related to the precision is the strength of the interpretations. To establish this classification, it is natural to follow the Directorates' recommendations, which vary from strong (i.e., containing "shall," "will," or "must") to weaker recommendations that allow a deviation from the main principle (i.e., containing "may," "preferably," "can," or "should"). It is important to note that not even strong recommendations are obligatory for the practitioners to follow, since the guidelines do not have a legally binding power.

The difference between statements embedded in legal goals and professional norms is established by the following criteria. Legal goals comprise wording that focuses on two dimensions of self-determination (see sections 2.5.3, 2.6.2.) and informed consent (see section 2.6.2.). In cases where either self-determination or informed consent are encouraged, the statement is classified as an interpretation embedded in legal goals. In cases when the wording encourages discretion and reliability, it is suggested that such statements allow clinical evaluations based on clinical norms and that the interpretations are embedded in the professional norms.

The key analytical concept used in the analysis is "the space for discretion." The extent of the regulation of discretion is discussed in regard to the strength and the vagueness of the wording, and its structure is analyzed with regard to the legal goals and clinical norms. The area of practice regulated by the RTIP is analyzed using the concept of co-determination (the concept and its dimensions are developed in section 3.3.) It is then discussed how the Directorate balances between legal goals and clinical norms when co-determination is regulated.

Two forms of written guidelines are analyzed in this chapter: written documents and websites (also called “sources”). The latter is an internet-based form of communication with the general public. The guidelines represent consensus documents, which are regarded as parts of a dialogue-based process of developing regulations.

## **5.2 Guidelines for clinical practice**

### ***5.2.1 The purpose of developing the guidelines***

The guidelines are not legal but administrative documents (Molven 2012, p. 32). They are developed to guide public administration. There is an expectation from central administrative organizations that practicing administrators of the law will follow the guidelines that concern their field of practice. In cases where the guidelines regulate questions of treatment, their interpretations should be based on individual discretion (Molven 2012, p. 31). It has been suggested that guidelines in health care aim at structuring instead of extinguishing discretionary evaluations. The main purpose, as defined by the Directorate, is unifying the law with *de facto* clinical practices. Furthermore, the aim is to reduce variations in clinical practice and provide clinicians with a concrete reference platform for good practice in the area of involving and informing the patients. The guidelines describe the principles and good practices to consider when informing and involving patients.

The Directorate recommends that any deviation from and advice on the part of the practitioners should be well justified, preferably in a written form (Molven 2012, p.15).

### **5.2.2 *The procedure of developing the guidelines***

The Directorate has established a guideline devoted specifically to the procedure of developing the guidelines for clinical practice (IS-1870). This guideline has been created by a working group that consisted mainly of clinical personnel and lawyers.

According to this guideline, the group of professionals that works with the guidelines should in general always have an interdisciplinary background and experience from a variety of administrative levels to decrease the discrepancy between the guidelines and clinical practice. Clinical experience should be common to all who are involved in the process (IS-1870, p. 13). To make sure that the legislative regulations are as close to clinical practice as possible, the involvement of patient organizations as a second actor is required.

When regulations are developed, an ad hoc group of clinicians, users, and lawyers is put together. External experts may be asked to take part in the process. It is the professional environments that decide who gets to participate in the working group (IS-1870, p. 11).

Furthermore, important criteria in the development of the regulations are that all the guidelines must be in accordance with health care laws and with the professional principle of reliability. The guidelines are the background for evaluations of accountability in clinical practice, and they are carried out by the national supervisory authorities (IS-1870, p. 39).

The Directorate emphasizes that the guidelines must reflect a balance between political goals, professional knowledge, and the patients' preferences (IS-1870, p. 12). They are aimed at a variety of target groups, such as the practitioners, patients, patient associations, or administrative units. Some of them address the field of psychiatry, somatic medicine, or concern both of these disciplines simultaneously. They are aimed at different target groups. The guidelines have an informative character. They were established to regulate practice but also inform users about what type of information and involvement they can require from the specialists.

The process of the development of regulations for clinical practice described above suggests that there may be variations in the perspectives on information and involvement in treatment.

### ***5.2.3 A brief description of the guidelines discussed in this study***

All the four guidelines concerning the RTIP were chosen for analysis in this study. The content of the guidelines is presented in this section. The first three guidelines, A1, A2, and A3, fall into the category A mentioned above since they have

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been developed mainly by specialists, while the fourth guideline falls into category B as it was developed by a user group.

The directive IS-12/2004 (A1), called “The Act on Patients’ Rights,” was published by the Norwegian Directorate of Health and Social Affairs<sup>29</sup>. Actors including the county governor, medical doctors, the Norwegian Board of Supervision, and the patients’ ombudsman were involved in the development of the Directive. This is the only guideline written in the form of a document that includes text annotations complementary to all of the statements of the APR. The interpretations of the RTIP that it provides are the shortest and vaguest as compared to the ones found in the other investigated sources. The interpretations tend to be general. Even though this document is entitled a “directive,” it is neither higher with regard to its legal status than the other guidelines nor does it have any authorization in law. It has the same advisory role as all the other regulations considered in this chapter. I will now focus on the interpretations developed with regard to the RTIP.

The guideline IS-1253 (A2) includes interpretations of the right to an individual plan (IP). The document is called the “individual plan.” This guideline includes interpretations of the RTIP in a clinical context. The Directorate refers to individual plans as the best tool to implement the RTIP. It comprises an extension of regulations pursuant to the APR (in Norwegian, *Forskrift om individuell plan*). The plan is in the form of a written agreement that defines the methods and types of

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<sup>29</sup> The Directorate changed its name from the Norwegian Directorate of Health and Social Affairs to the Norwegian Directorate of Health) in April 2008.



treatment. I focus on this particular understanding of the IP in clinical practice, rather than on its status as a patients' right.

Two of the guidelines created specifically for the field of psychiatry are IS-1388 (A3) and IS-1315 (B1). IS-1388, called "District Psychiatric Centers: Municipalities and specialized health care services," was issued by the Norwegian Directorate of Health and Social Affairs in 2006 (Helsedirektoratet 2006, p. 13). It was developed by the specialists in the field of mental health and is aimed at clinical psychiatrists. The guideline was accepted by the Directorate's reference group for user organizations and was selected for the analysis since apart from addressing the organizational routine, the focus in the document is on describing the best professional practice in the area of the RTIP with regard to the goals of the National Action Plan for Mental Health.

The guideline IS-1315, "User participation in psychiatryGgoals, recommendations and measures in the National Action Plan for Psychiatry," was published in the form of a report. It suggests a number of improvements to areas that are reported as deficient in the practices of information and participation. It is based on the experiences of the users and their families. It is aimed at implementing the goals in the National Action Plan for Mental Health. Contrary to the other documents, this guideline is the only regulation that was developed exclusively by user organizations. The guideline has one major goal: to establish a common platform for best practices in the area of user participation in psychiatry services.

The guidelines aimed generally at health care services focus on the interpretations of both parts of the RTIP: the right to information and the right to participation. IS-1315 and the Directorate's official webpage concentrate mainly on patient participation.

The official website of the Directorate, *Helsedirektoratet.no*, as well as the governmental health information portal, provide an overview of the interpretations developed in the written guidelines. There, the Directorate addresses the general public. The goal with this form of guidance is establishing a channel of communicating information to users, rather than having a dialogue-based tool for the active exchange of information. The website is referred to as W1. In 2011, the governmental health information portal, *Helsenorge.no*, was launched. Its target group comprises all the users and providers of health services. It will be referred to as W2. Even though the guidelines have been developed by a variety of actors, they are all published and maintained by the Directorate.

### **5.3 Patients' participation**

#### **5.3.1 Patients' participation and medically sound treatment**

In the guidelines for Group A, participation is understood as a necessity for achieving recovery. The focus of this general but consistently encountered understanding is a combination of two aspects: participation and the outcome of treatment. It may be illustrated by the following example from A1:

The patients who receive medical help have the right to participate... The right to participate presupposes an interaction between the patient and the staff... in order to carry out the treatment (A1:Q1).

The patients' own efforts and contribution is the underlying anticipation required to make participation real. Except for the participation necessary to carry out the examination, it is up to the patient to decide upon how much he or she wants to additionally participate. (A1:Q2)

The link between participation and the application of treatment is established here. Patients' participation is conceptualized as a precondition to achieve a positive outcome of the treatment procedure. As long as the interaction between two parts takes place, practitioners are provided with some degree of freedom to define the content of participation in a specific clinical situation. Treatment cannot take place without participation, while the content and the forms of participation are not specified.

Further, the Directorate emphasizes one particular dimension, the choice of the method in treatment:

For a patient it can be difficult to choose when there are no obvious advantages and disadvantages... health care personnel should recommend the patient the best method from the professional point of view... The patient has the right to participate in the choice of available and professionally reliable methods of treatment and examination. It does not mean that the patient has the right to choose which method is to be applied... The choice among different methods may be between a short but painful method versus a time consuming method

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with no pain, and a middle solution of moderate pain and duration, but less certain outcome... For the patient it can be difficult to choose when there are no obvious advantages and disadvantages. There are therefore increased requirements as to information from the health care personnel... In this example health care personnel should recommend to a patient which method from the professional point of view is best to apply... patients' right to participate in the choice of method will under no circumstances exempt health care personnel from taking responsibility for decisions. Professional decisions must secure reliable treatment of the patient. Health care personnel cannot let the patient choose the treatment that will not be reliable from a professional point of view.

(A1:Q3)

The Directorate emphasizes the importance of clinical knowledge in the choice of the method in treatment:

The degree of participation will vary depending on what is practically possible and how complicated is the medical help provided. The higher the level of competence required, the lesser the patients' real possibilities to participate will be (A1:Q4)

A professional evaluation of the reliable methods is the primary recommendation of the quotations above. Here, participation is related to the three aspects of treatment: the choice of method as well as the criteria of availability and the reliability of treatment. Furthermore, the professional expertise required to make the

choice of treatment is highlighted. The more complicated the treatment, the smaller the possibilities to participate.

Another interpretation specifies a different type of participation. It emphasizes that the feedback from the patients on the received treatment can take place after the treatment has finished:

Partly, the right to participation means providing patients with a possibility to express their opinion and evaluate the health help after it has taken place. If the offered services are at all evaluated by the service provider, the patients will have to be involved in giving feedback based on their experiences as much as it is possible. (A1:Q5)

This statement concerns the situation when participation takes place outside the context of treatment, which represents an adoption of the legal goal to allow participation in treatment.

The quotations above illustrate a consistent attempt to combine two aspects in treatment: reliability and patient participation. Therefore, these statements do not appear to provide one clear direction for practicing participation. The wording and the variety of understandings of participation encourage discretion, which allows space for the confluence of legal goals and clinical norms in practice. The quotations in Q1-Q4 highlight an adoption of the requirement of reliable treatment and also include some form of participation. A general impression is that norm-based practice has to be adjusted to the new participation-oriented legal goals but not relinquished altogether.

It may be argued that traditional ways to perceive questions regarding information and participation become influenced by new legal goals. There is, however, not much that suggests that understandings based on legal goals or on clinical norms overpower each other. The stronger and precise recommendations have a tendency to be followed by the statements that suggest vague and weak wording. Because of that, whole statements may be perceived as considerably vague.

When patients have insufficient knowledge, it creates a barrier to their participation in decision-making regarding their health. The statements may point to the principle of reliable treatment, which is defined in the legal goals as well as in the norms. For example, in the following statement, participation is associated with involvement, while also suggesting an expectation of compliance with the treatment procedures:

The patients' own efforts and contribution is the underlying anticipation required to make participation real. Except for the participation necessary to carry out the treatment, it is up to the patient to decide upon how much he or she wants to additionally participate. (A1:Q6)

In this quotation, participation is described in a reasonably precise way. Some variation in the strength of statements may, however, be noticed. Participation when carrying out the treatment is required, while the content of this participation is to be decided upon by the patient. This distinction may illustrate an attempt to balance the clinicians' focus on the procedure of the treatment and the patients' freedom to influence its content.

The content of the statements in A1 reflects a tendency to combine the legal goal of expanding the information background and the involvement of the patients with the reliability of treatment methods based on the best professional knowledge. The combination of vague and precise statements allows a reasonable degree of individual interpretations of how to allow participation and inform the patients within the scope of reliable treatments.

### **5.3.2 *Self-mastering and empowerment in psychiatric practice***

In the context of psychiatric practice, patients' participation is strongly based on the patients' own resources that may be used to manage their sickness (Sosial- og Helsedirektoratet 2006b, p. 6).

Participation is therefore understood in the guidelines as follows: "to give the patients with mental disorders a possibility to live a normal life characterized by participation, independence and ability to master their own life... patients must become experts in their own lives," (A3:Q1). There is a strong focus here upon establishing a relationship between the patient's autonomy and their responsibility to manage the sickness. This suggests that the idea of participation is to redefine the expert's role and to transfer it to the patients.

Other recommendations focus more precisely on participation in treatment: "The goal is to involve users and provide them with a possibility to exert influence in treatment" (A3:Q2). This statement does not specify the form and the contents of

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participation but focuses instead on the legislators' general goal related to strengthening the patients' involvement in treatment. It refers to an active rather than a passive approach to the patients, but its context is unclear. It might, for example, be applied to the mobilization of patients' own resources but also to treatment decisions. This statement is vaguer than the previous one. The combination of vague and precise understandings suggests that there is space for individual understandings as well.

The following recommendation is the most precise and the strongest understanding of participation: "(The patients') experiences and preferences shall be central in all the phases of this process, i.e. evaluation, examination, planning, and termination of treatment," (A3:Q3).

In the statement above, the focus is on the patients' preferences, as well as their experiences in the precisely defined treatment phases. This part of the statement may be seen as precise. It clearly sets the focus on the legal goal of patients' involvement in treatment. The specification "central" leaves clinicians with plenty of space for interpretations regarding how to consider patients' preferences. Thus, even the most precise regulations allow a reasonably large freedom of interpretation.

The following statement illustrates the same point: a combination of precise regulations with those that are reasonably vague and allow individual adjustments. In this case, such regulations concern the respect shown for the patients' experiences of their sickness as follows:

Health care personnel shall treat the patients with respect and take patients' description of their sickness seriously. The specialists are professionals in their



field and the patients are specialists on their life... Treatment measures shall as much as possible build on and develop the patients' experience of self-mastering. It means that psychiatric services must be provided in a way that ensures the patients' use of their own resources in order to master their sickness.

(A3:Q4)

This interpretation of participation addresses professional attitudes. The above conceptualization combines respect with the patients' understandings and their self-mastering. The concept of self-mastering is defined more clearly here than respect with regard to the patients' experiences. It is about the patients' resources, which have to be involved in mastering the illness. This is an example of the general tendency of the Directorate to provide precise, extensive statements with regard to patients' self-mastering.

Furthermore, the same paragraph illustrates the common trend of the Directorate that emphasizes that the patients have to involve their own resources. They have to be specialists in the management of their own sickness. The clinicians' responsibility is to work towards and support the patients' self-mastering. Two rather different concepts are thus put together in the same recommendation: respect for the patients and management of the sickness based on the patients' own resources.

The above quotation (A3:Q4) is an example of the tendency to include different understandings of the legal goal of expanding patients' influence in treatment in the same statement. The recommendations in this statement are strong, obliging professionals to comply with a different logic of action than the one based on

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professional norms. This illustrates the recommendations for action, which allow free choice among different yet strong interpretations.

The following statement illustrates another form of variations in the precision of the recommendations:

Medical help provided is to be adjusted to the needs expressed by the users... it is therefore important to develop a dialogue... The users' experiences shall be reflected in the treatment plan... The recipient of health care shall preferably be actively involved in the development of a health service offer concerning both its form and its content. (A3:Q5)

The Directorate includes a reasonably obligatory suggestion about the adjustment of services to the needs expressed by the patients. Furthermore, it emphasizes the possibility of not complying with it by stating that involvement in the development of a health service "shall preferably" reflect the patients' preferences, which again must be included in the treatment plan. The above quotation also illustrates a variety of precise and less precise recommendations. The Directorate suggests that preferences should be documented in a written form in the treatment plan. Furthermore, it allows adjustments to the individual preferences.

The overall impression from the guidelines with regard to self-mastering and empowerment is that there are significant variations in the interpretations of participation introduced by the guidelines developed mainly by specialists. It may be understood as the right to reliable treatment, the involvement of one's own resources, and the responsibility for self-mastering the sickness, including the patients'

preferences regarding the treatment plan in a written form, developing a dialogue and a relationship based on respect to the patients, involvement in the development of the treatment offer, and enabling the influence of the patients in treatment. The recommendations may also take the form of obligatory recommendations or advisory suggestions. They may furthermore be reasonably precise, suggesting which information to document, as well as vague, leaving the clinicians with space to develop its content in practice. This variety leaves practitioners with a great complexity, and might quite often suggest a necessity to choose which interpretation they are to relate to.

### **5.3.3 *The influence on the contents of the services***

In the recommendations developed by patient organizations (document B1), the Directorate makes a distinction between user participation at the individual, organizational, and political levels. It emphasizes that “patients’ participation concerns patients and their family members” (Haukelien et al. 2011). The notion of participation in clinical treatment is termed ‘user participation at the individual level’ (In the recommendations developed by patient organizations (document B1), the Directorate makes a distinction between user participation at the individual, organizational, and political levels. It emphasizes that “patients’ participation concerns patients and their family members” (Haukelien et al. 2011). This notion of participation starts from a general conceptualization, as follows:

User participation means that the person receiving services gets to exert influence on the contents of the services he receives... that is, he gets to participate in the choice, formation and application of health care services that are available... The user has to experience that his contribution has a real influence on the development of the services. (B1:Q1)

The quotation above represents a tendency apparent in most of the interpretations, which begins with the general overall guidance of clinical action in the rather particular direction of providing the patients with the possibilities to influence the treatment. The Directorate does not specify the form of influence. More precise information follows within the scope of the same paragraphs and focuses on the choice of available treatment, its formation, and the patients' experience of real participation.

Further on in the same paragraph, a different understanding of participation is found:

(Participation) highlights a great deal of autonomy, authority and control in the patients' own life... It means that the user will have the responsibility for his part of working towards a better life... users get the offer of self-help and self-mastering courses. (B1:Q2)

The quotation above represents a major understanding included by the patients' organizations. The focus is on the requirement that the patients face in regard to their responsibility for improving their health.

In the following quotation, participation takes the form of an equal power to influence cooperation. A more precise statement is followed by a vague reference to human rights: “The primary aim is an equal cooperation between specialists and patients based on mutual trust and where partners share equally the power and exertion of influence...it is a human right to exercise influence on decisions concerning one’s own health,” (B1:Q3).

Thus, with regard to the patients’ influence on the content of the services, the Directorate has introduced a variety of conceptualizations into the guidelines developed by the patients’ organizations. The main conceptualization, however, is the same as in the guidelines developed by the specialists (section 5.3.2), giving precise recommendations which support self-responsibility, self-mastering/self-help, and the patients’ opportunity to exert equal influence in treatment. The same statements combine different understandings of participation and different degrees of precision and strength, which results in the complexity of the regulations.

#### ***5.3.4 Participation and the written plan of treatment***

In the IP, the primary focus is on how an individual’s influence may be reflected in the plan. The main idea is that it is a tool to achieve an individually adjusted treatment. Furthermore, the patients have to experience that the treatment has been individually adjusted. The following represents the main understandings of participation defined with regard to the IP:

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An IP shall be a tool for participation between a patient and service provider... The individual plan is a tool that encourages increased participation and user-involvement within health care services... Patients have to participate throughout the planning process... the outcome of IP must be that users experience individually adjusted services. (A2:Q1)

The above quotation illustrates different interpretations of participation. It also suggests variations in the degree of precision, as it encourages participation in general while at the same time being associated with the planning of treatment. The obligatory form of interpretations is used throughout the quotation. The extension or the form of participation in the process of planning the treatment is not specified. It is, however, rather well specified that clinicians are obliged to give the patients a feeling of individually adjusted services.

The other major tendency found in the documents shows participation to be perceived as responsibility for 'self-mastering' in treatment:

It is important to achieve the treatment goals since it gives the patients an experience of self-mastering and strengthens motivation for even greater improvement... It is much easier for the patient to struggle towards goals that he has defined himself... Specialists must actively... motivate patients and make them play an active role in their own progress... The plan shall reflect the patients' preferences, but it is not legally binding for the service provider... (A2:Q2)

This interpretation is consistent with the idea of self-mastering as an active struggle towards progress in treatment. The Directorate emphasizes the relationship between the patients' self-responsibility and the outcome of the treatment. The quoted statement holds the same level of precision and has an obligatory form, except for the final remark of the plan not being legally binding. The clinicians may therefore make this choice if they apply it in clinical practice.

Thus, the interpretations of IP vary with regard to the content and the precision, as well as their strength. For example, the same paragraph may contain an obligation to develop IP and a possibility to deviate from it in practice, thus rendering it as not legally binding.

### **5.3.5 Promoting self-mastering**

The official website of the Directorate (W1), HelseDirektoratet.no, mainly devotes its the RTIP-related section to the patients' control over treatment. The following quotation illustrates the main tendency of the text:

Patients' participation has its own value since all the individuals who seek help want to have control over important areas of their life, receive medical help on their own premises... they want to have their needs to be seen, respected, and fulfilled. (W1:Q1)

This quotation takes the form of a rather general statement. Most of the users would agree with it. The main focus is on the patients' own control of their life, but

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other understandings may be found as well. Thus, the importance of setting premises on the reception of health services is an example of a rather prevailing pattern of vague and recommendatory interpretations that provide a general direction for the practice rather than giving precise advice.

The previous statement is followed by other statements that may also be seen as having only general value, such as the following example:

When users can exert influence on their surroundings by their own choices and resources, it will influence their self-image in a positive way and strengthen their motivation. It will contribute to health improvement of the users and have therapeutic effect in treatment. (W1:Q2)

This statement focuses mainly on the positive relationship between the patients' own motivation and resources and the outcome of treatment. It also considers the improvement of patients' self-image.

Another aspect of self-responsibility concerns providing information to the patients. This has been the primary aim of introducing the portal (W2). The Directorate's goal was to extend the patients' self-awareness and stimulate to *self-information*. This goal is expressed as "help to self-help," which means encouraging the patients to take the responsibility for their life, health, and treatment. This seems to be one dimension of the general concept of self-mastering: "(Self-help means the) ...patients' own efforts in treatment. It is a fundamental principle that concerns all the patient groups... Help to self-help means to motivate patients to take active responsibility for their own life situation and health," (W2:Q1).



Self-engagement in the improvement of the outcome of treatment is the main understanding here. The Directorate goes as far as to illustrate it with particular examples. It is related to the field of psychiatry in the following way: “(The patients must) apply cognitive and behavioral self-techniques... in order to cope with exigencies of the workplace,” (W2:Q2).

A variety of concepts is applied by the Directorate in relation to the patients’ self-responsibility for the treatment: self-motivation, self-information, help to self-help, and self-help. Another example of how patients’ self-responsibility is expressed is the concept of informed patient, which was published in W2. The concept is understood as the following:

[The Directorate’s responsibility with regard to informed patient] ...is to provide the best possibility to gain information. (This is) in order for the users to follow up on their treatment and progress... (by) encouraging more active cooperation with the health service... patients must be enabled to become active participants in answering questions related to treatment... The goal is to enable people to prevent health problems, but also help themselves in case they have developed such problems. (W2:Q3)

The conceptualization above is reasonably precise and consistent. It starts with a general focus on the patients’ responsibility to gain information. These statements are followed by specifications concerning self-responsibility for treatment as well as the prevention of sickness. The consistent content in quotation W2:Q3 bears some differences in the level of precision.

Thus, the online sources offer interpretations of the RTIP, which are considerably clear and consistent in their focus on self-responsibility. Some variations may, however, be noticed. The content of participation includes the possibility for the patients to receive treatment on their premises and also a number of concepts related to self-motivation. The vagueness of the recommendations is combined with a more precise understanding. A variety of concepts is applied in relation to the patients' responsibility for treatment, suggesting that they provide only a general direction for practice and allow variations in it.

Some of the particular variations are worth noting, especially when viewed in the context of clinical practice. The Directorate's idea of patients' self-information in the meeting with the health care services illustrates a different approach than the one based on the clinicians' obligation to inform.

A focus on self-responsibility for applying self-techniques requires information and may be seen in relation to the legal goals of informed consent and self-determination. The patients themselves have to make a choice to apply the treatment and make the necessary changes in their lifestyle.

The introduction of these concepts suggests that the Directorate's approach has been that there is no such thing as too much information or too much responsibility for the application of treatment. Thus, the more information one receives, the better one is prepared to gain more. Following this logic, the more responsible the patient feels to follow treatment, the better its outcome.

#### **5.4 The process of providing the information**

Clinicians are specifically made responsible for providing the patients with information. The main tendency illustrated below is that the Directorate does not specify which information to provide:

An obligation to provide the patients with information lies with health care personnel who have the responsibility for providing patients with medical help... In general, health care personnel who have been in contact with a patient will always have to inform and answer all the questions... A responsible specialist always has to make sure that necessary information is given and that provided information is in line with legal requirements. A responsible specialist has to give the patient comprehensive and complete information. (A1:Q7)

There are variations in the precision of the interpretations in this quotation. A number of adjectives used here, such as “necessary,” “comprehensive,” and “complete,” contribute to the vagueness of the way information is understood, which allows the opportunity for individual understandings in the practice. The part of the quotation concerning answering the patients’ questions is, on the other hand, more precise.

Another tendency is for precise guidance regarding which information should be given. A statement recommending a particular content of information would sound as follows:

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The patients shall receive information about the health condition, the contents of the medical help provided, that is the care, diagnostics and examination methods that are offered or applied... Information has to be sufficient so that the patient could use his/her right to participation and contribute to the choice of methods when there is more than one alternative possible... Important oral information should be supported by written material. The obligation to inform has to as well be adjusted to the situation. (A1:Q8)

Significant variations characterize the quotation above with regard to its content and precision. The first part of the paragraph is interesting in that it incorporates types of information that could be seen as related to traditional clinical practice (i.e., information about medical help, recommended treatment methods, and health conditions). Furthermore, this interpretation is precise and strong. However, the suggestion of individual adjustment allows a variety of individual practices and suggests variations in precision.

In accordance with the legal goals, the same paragraph makes a vaguer specification with regard to information concerning the alternative methods of examination and diagnostics as well as participation possibilities. This interpretation is based on the legal goal of providing good information about available diagnostics methods, examinations, and treatment, and may allow the possibility of self-determination and informed consent in treatment to be expanded. The written form of information delivery is, however, quite precise. In addition, with regard to the content, it is specified that the clinicians have to allow questions from the patients and provide clarifications in response to any questions. The clinicians may decide upon the form of

the process of asking questions, but the matter of incorporating it in the treatment is not left up to individual clinical evaluation. Combining these two points in one statement illuminates the attempt of balancing between legal goals and traditional clinical action.

The variations described above may allow a flexible approach to choosing which information to provide. Thus, one may opt to offer information about the available methods of treatment, or about the methods that are actually applied. However, the Directorate's recommendations for the provision of information in itself as a precondition of participation are precise. The decision power of the patients may thereby be encouraged:

For the patients' right to participation to be real, it is critical that the users get sufficient and adjusted information so that they get as much insight into the health condition as possible, as well as into the contents of health services provided and the rights they have as patients... The patient shall be informed about the side effects and possible risks related to the received treatment.

(B1:Q4)

The quotation above also represents a combination of precise and vague statements. The information has to be sufficient and adjusted, as well as give insight into the specific dimensions of treatment, such as health conditions and side effects but also rights. This list suggests a variety of aspects it should include.

The interpretation above comes closest to fulfilling the legal goal of expanding the patients' insight into their rights in treatment. The Directorate further specifies the

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criteria of individual adjustment: “an adjustment to individual pre-conditions such as age, maturity, experience and cultural and language background,” (B1:Q5). The criteria are rather numerous and are of different character, which again may result in various understandings in clinical practice.

It is interesting that the information that is recommended to be provided also includes legal information about patients’ rights. This may be regarded as being outside the scope of clinical information and may be seen as a direct implication of the RTIP. The recommendations about some of the rights are quite precisely defined:

The information about the rules concerning complaints are complicated and it is obvious that it may be challenging for users to apply them... service providers should therefore have a strengthened obligation to provide patients with assistance and guidance with regard to possible complaint cases. (B1:Q6)

This statement recommends that clinicians should not only inform patients about the possibility of getting professional assistance with fulfilling the patients’ rights in general, but they should also assist the patients with submitting a complaint.

## **5.5 The legislative regulations – discussion and analysis**

The aim of this subchapter is to discuss the variations and the similarities in conceptualizations of the RTIP found in the studied sources. The extent of embeddedness in either clinical norms or legal goals will also be discussed. Furthermore, the variations are discussed with regard to precision or vagueness,

strength or weakness, and the content of the recommendations. Some of the recommendations may be placed more easily than the others within the boundaries of the proposed dimensions.

### **5.5.1 *General tendencies found in the studied sources***

Two types of data sources, namely the law (the APR) and the guidelines (four documents and two online information websites), make the legislative framework for clinical practice. In this chapter, I focus on the documents and the online sources. Two questions are explored: first, if there are variations in the regulations, and second, if more extensive legislative regulations can suggest stronger boundaries for clinical discretion. The expectation, which was based on an institutional approach, was that the characteristics of the guidelines, such as the variations in and the vagueness of the recommendations, as well as the possibility of free choice among them, could influence clinical discretion (see chapter 3). The overall suggestion to consider each patient's case individually is consequently recommended in the studied documents, allowing clinicians to apply their own discretion. This approach suggests that the relevant question is not about binding the discretion but rather about structuring it through the regulations.

Being complementary to law, most of the interpretations of the RTIP in the studied sources expand the legal goal of increasing patients' possibilities to some degree to gain information and practice self-determination. These two aspects are an integral part of the RTIP and combine to make up the analytical concept of co-

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determination. The overall impression from the studied documents is that there is a great variety and complexity in the regulations. There are different types of varieties discussed below. They concern vagueness and precision, strength, and weakness as well as the content of co-determination in the regulations. The common tendency in the guidelines, however, seems to be that both legal goals and clinical norms often appear to be at work when the RTIP is interpreted. The hierarchy relationship between them cannot then be established.

The main tendency in the structure of the interpretations of the RTIP found in the documents is that a general main statement is followed by more specific secondary statements, which expand its content. Secondary statements may specify which aspects of treatment the co-determination concerns. The main and secondary statements can, however, have a different strength and content. Their difference may lead to different recommendations with regard to the scope of co-determination in treatment, for example, by regulating the aspect of co-determination in the choice of treatment methods. The regulations include two different types of methods, namely “the available and the existing treatment methods.” The latter suggests a wider range of methods to consider than the former. The expanded information background concerning treatment is one of the major goals set by the legislators. The concept of an *active patient* becomes an ultimate and normative principle that overpowers the scope of all the guidelines. A variety of concepts referring to the logic of an active patient is introduced in the regulations. The focus on the types of variations in the interpretations guides the analytical discussion.



### **5.5.2 The variations in the studied sources**

#### *5.5.2.1. Vagueness and precision of the recommendations*

One of the major characteristics of the variations in the guidelines is the vagueness and precision of their wording. Every quotation presented in this chapter comprises either more or less precise wording. Furthermore, the interpretations could also contradict or complement each other. It may be suggested that the greater the variations in precision and vagueness, the more contradictory the overall statement. An alternative interpretation may be suggested as well; the Directorate could in this way provide clinicians with the opportunity to choose among precise and vague understandings.

Recommendations that may be seen as reasonably precise relate to the clinicians' obligation to provide reliable treatment and information. The main tendency is for the demand of reliable treatment, overpowering any recommendations concerning co-determination. The same logic of precise interpretations concerns self-mastering, which tends to be associated with the patients' own responsibility and resources and the clinical obligation to motivate patients to seek self-involvement.

Another major tendency that was identified was the concept of participation and vague information. The content is mainly left to be defined in practice. This is done by stating that participation in general has to take place in treatment, or by setting the requirement of providing comprehensive information. The Directorate may still in some cases be very specific and provide precise and concrete understandings of participation. This is done, for example, in the case of feedback regarding received

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services after they have been provided.

Reasonably precise recommendations are frequently combined with quite vaguely worded ones, which allows for a great scope of interpretations. The following example is taken from A3:Q3: “(The patients’) experiences and preferences shall be central in all the phases of treatment.” Here, participation is narrowed down to the patients’ experiences and preferences, but the demand that these shall be central in all the phases of treatment may be understood in various ways. Similar examples may be found in statements that emphasize ensuring the patients’ experience of participation. These statements are vaguely worded when suggesting that the patients have to be satisfied with regard to their feeling of being involved. The most consistent example of this type of wording may be found in the interpretations of individual plans. The Directorate makes precise recommendations with regard to dialogue-based development of a treatment plan and its written form, while emphasizing that the plan is not binding from a legal point of view. A precise description of the process of the development of the plan is followed by the vagueness concerning the practical value of this tool. Finally, the recommendations regarding the provision of information also follow the same pattern. These interpretations are also characterized by great precision, focusing on a number of specific aspects, but are usually followed by statements suggesting individual adjustment in practice.

The forms of vagueness and precision may differ. They may occur as combinations of precise and vague wording together, as precise wording followed by vague statements and vice versa, or as recommendations suggesting a voluntary choice between several precisely worded demands. Precise wording, therefore, does not

necessarily suggest a stronger binding of discretionary judgment. The most common example of it is the recommended relationship between the patients' preferences and reliable treatment. The choice of treatment method is subject primarily to the criterion of reliability. Reliable treatment may, but does not have to, be in line with the patients' preferences.

It may thus be concluded that discretion is structured differently in different cases by means of various relationships between precise and vague wording. The various combinations of vague and precise statements may contribute to the impression of inconsistency when a choice must be made among them.

The vagueness or precision of the recommendations is further related to their length. The more precise the information, the longer the recommendations tend to be. The length of the recommendations is, however, not related to binding the space for clinical discretion. As discussed above, a combination of precise and vague interpretations still may leave a lot of space for discretionary understandings.

#### *5.5.2.2. Strength and weakness of the recommendations*

As discussed above, all of the recommendations have an advisory status for practice. One of their main characteristics, however, is a variation in the strength of their wording. The Directorate tends to employ the word "must" in order to state an obligation, found in strong statements, and the word "should" to state recommendation,

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which are found in weak statements. These are the two main ways of expressing the categories of strength and weakness located in the regulations.

There are, however, also other kinds of wording. The first one, stating reasonably strong expressions, concerns statements that apply to rights: “patients have the right to...” followed by the Directorate’s definition of the specific right. Another kind is that concerning the rather strong requirements related to the patients or clinicians, such as, “The patient’s own efforts and contribution is... required to make participation real.” Other examples of strong wording include expressions such as “the underlying anticipation is...”

There are three types of weak statements. The first one concerns the wording related directly to the choice of action, suggesting that it can be followed in practice. It may be illustrated by the following example: “It is up to the patient to decide...”. The second type can be related to the definition of concepts that have neither the form of advice nor the form of a requirement. This type may be illustrated by such statements as, “Participation means providing the patients with a possibility to express their opinion and evaluate the health care...” This statement is the opposite of other statements in which the definition is in confluence with strong wording. In such cases, the overall meaning could be strong as, for example, in “The patient has the right to participate in the choice... It does not mean that the patient has the right to...” The third and the most common type of weak wording is expressed by the form “should,” as mentioned above.

The overall tendency found in the guidelines is to combine both weak and strong statements in the same sources. This approach may represent contradictions, especially when strong expressions are followed by weak ones. An example of this is shown in the following statement: “The patients’ own efforts are the underlying anticipation required to make participation real... it is up to the patient to decide upon how much he or she wants to... participate.”

#### *5.5.2.3. Variations in the content of co-determination*

A major difference between the guidelines lies in the content of co-determination. This difference creates a freedom of choice for practitioners who may choose to follow different recommendations. The most commonly encountered content concerns self-responsibility and has different aspects related to it, from the ability to master one’s life in general to the ability to prevent sickness in particular. Furthermore, it is related to the responsibility for the application of treatment. The idea of self-responsibility is also associated with the responsibility for the patients to take an active approach to obtain information.

Apart from self-responsibility, the content of co-determination may also include equal power, a dialogue-based relationship in treatment, and patient involvement in decisions throughout the whole process of planning the treatment. Furthermore, co-determination has also been associated with the clinicians’ obligations. The obligation to document co-determination in the medical record, the requirements for providing reliable treatment and any information about it, the assistance with making complaints,

and the obligation to motivate the patients to agree to treatment are all present as aspects of co-determination in the guidelines.

The significant variations in the content of co-determination could be explained by the different actors who have been involved in their development. An alternative explanation could be that the guidelines have different target groups. One may also explain the variations in the content as the Directorate's way to enable clinical discretion as an outcome of regulation through the RTIP.

The differences in the content of the co-determination concept are thus found to be large, with one particular understanding apparently predominating. It concerns the aspect of the patients' responsibility to master their sickness and gain information. The guiding principle for conducting the interviews presented in chapter 6 was therefore whether this main understanding of the RTIP found in the regulations dominated among the clinicians.

In order to further analyze the variations in the content of the regulations, the content may be discussed in relation to the extent to which it reflects the legislators' goals and the clinical norms.

### ***5.5.3 Co-determination based on legal goals and clinical norms***

#### *5.5.3.1. Clinical norms in the legislative regulations*

One of the theoretical assumptions in this chapter was that clinical norms would to some extent influence the recommendations for clinical practice. In this regard, the

recommendations that are primarily characterized by the norms suggest the critical role of professional expertise. Thus, there has been a strong focus on the choice of treatment based on the reliability of knowledge throughout all the guidelines.

Furthermore, the dominant emphasis in the guidelines is on *patients' self-responsibility* with regard to mastering of their own illness. One possible explanation could be the traditional way of thinking in clinical practice, which is based on compliance. This explanation is supported by recommendations concerning motivating the patients to accept treatment, which is defined as a clinical obligation. Traditionally, clinical treatment has been based on the principle of alliance building. It meant a trust-based relationship and was seen as a necessary background for convincing patients to undergo treatment. The strategy of convincing was to be embedded in a discretionary evaluation of the patients' best interest that only the clinician could perform. If the obligation to motivate is seen in relation to the Directorate's interpretation of helping patients to self-help, it may be perceived as a new way to describe the existing tradition of compliance.

Another side of the alliance relationship was protecting the patient by providing the best outcome of treatment. This protection was achieved by means of selecting the information provided to the patient, especially with regard to any side effects and risks associated with the suggested treatment. Thus, a strong focus in the guidelines on the patients' responsibility to keep themselves well-informed instead reflects the legal goal of informed consent than the traditional norms. In line with this logic, the Directorate has developed an information portal (W2) that is aimed at informing the patients. The logic of self-responsibility, which includes self-mastering and self-information, seems,

therefore, to be inconsistent with compliance-based practice.

As discussed in section 5.5.2.3, there is a number of different aspects covering the area of co-determination. They may be based on the legal goal of informed consent or the clinical norm of reliability. In clinical practice, it might turn out to be problematic to follow the legal strategy of informing the patients when the Directorate provides inconsistent recommendations about the information. If self-information is based on inconsistencies and vague wording, it may lead to large variations and arbitrariness in practice. The obligation to provide information will then only in a limited way provide the patients with the possibilities for informed consent.

Another aspect that could contribute to inconsistencies within clinical practices concerns the precise interpretations that focus on the traditional norms of informing in treatment. Such information is provided due to the treatment recommendations of specialists. The Directorate, however, also mentions other types of information as obligatory to be provided, such as side effects or rights. These recommendations may not be in line with the clinicians' traditional perceptions of good practice and instead suggest the integration of an active and well-informed patient able to question the recommendations given by the professionals who suggest particular treatments.

#### *5.5.3.2. Encouraging self-responsibility*

The strongest focus throughout the recommendations seem to regard the aspect of patients' self-responsibility for treatment and self-information. In general, these



recommendations tend to reflect the patients' obligation to self-activation in treatment. They may be seen both as an influence of the norm of compliance as well as of the legal goals of self-determination and informed consent.

The focus on self-responsibility in general may be explained by the legal goal of expanding the patients' influence on their treatment. This is due to the fact that one of the aspects of self-responsibility is usually associated with achieving the aims in treatment set by the patients themselves and not the clinicians as well as ability to gain and understand information. It may therefore be seen as a way to strengthen the main legislator's idea behind the RTIP (i.e., increased self-determination in treatment). Such recommendations tend to be precise. The same guidelines, however, comprise statements that could suggest compliance aimed at the best effect of treatment. These statements tend to be precise and suggest a development towards professional norms. In cases where patients are held responsible for the application of treatment defined by the clinicians, the norm of compliance exerts a stronger influence than in those when the patients define the goals. Such understandings have the potential to decrease the space between legislative regulations and norm-based clinical action.

The discretionary evaluations structured by the idea of self-responsibility might stimulate self-determination by allowing patients to influence the choice of the method according to their preferences. This line of legislative regulations suggest that not only is the treatment to be reliable, but the patients should be allowed to influence the decisions made about the treatment.

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### *5.5.3.3. Regulations dominated by the legal goals and their prevailing inconsistencies*

One of the assumptions of this chapter was that the legal goals as well as the professional norms might structure the recommendations to some extent. There are only a few recommendations that may be seen to be dominated by the legal goals rather than by the clinical norms. The clearest examples of these are found in the precise recommendations concerning the legal goal of expanding the patients' information background.

This goal is included in the recommendations in a number of versions, which may contribute to inconsistencies. One source suggested that the available treatment should be the background for the information, while another source recommended the existing treatment. The recommendations provide precise contents of the information to be delivered to the patients, which may also strengthen the inconsistencies due to the contradictory character of different and precise recommendations. For example, A2 recommends that the patients define their goals for treatment, as well as recognizes that is not necessary to actually implement them in treatment.

The legal goal of informed consent implemented through the concept of self-information suggests obligations for both the clinicians and the patients. The major point of this goal is met when specialists encourage their patients to learn more about health conditions and treatments that could concern them. In accordance with this goal, the recommendation to make the patients aware of existing information and its sources is being introduced in the regulations in order to influence the discretionary evaluations of the specialists. The space for clinical action can be affected by these regulations,

which are relatively precise. Well-informed patients may pose more questions and have suggestions regarding any received services. An alternative understanding of this legal goal may be that the patients only have the responsibility of keeping themselves informed.

The concept of self-information has not traditionally been a part of clinical practice. This fact in itself may lead to inconsistent understandings in clinical practices. Furthermore, the concept of a well-informed patient could in practice transfer the responsibility for informing the patients from the specialists to the patients only. Patients are specifically obliged to take responsibility for obtaining their own information with regard to treatment. At the same time, despite this encouragement, the regulations specify rather extensively which information should be precisely given by the clinicians. It may be seen as an inconsistency in the regulations with regard to the recommended way of providing the patients with the information. All of the recommendations, however, may be viewed as being in line with the classical democracy argument that the more information one has, the better one is prepared to receive additional information.

The space for clinical discretion thus is structured by several inconsistencies in the regulations, which are embedded in the legal goals.

#### *5.5.3.4. Regulations dominated by the clinical norms*

In cases where co-determination is perceived as being embedded into the norm of reliability, the focus in the recommendations tends to be on the choice of the optimal treatment. This choice creates the background for the provided information. Reliability may in this case be seen in relation to the norm of compliance, based on the idea that the patients may not have sufficient knowledge to exert an influence on the choice of treatment. Instead, they are expected to comply with the treatment suggested by the clinicians.

This tendency suggests that the clinical norms may dominate the structure of legislative regulations. Such a way to structure the regulations is in line with the traditional, norm-based structure of clinical discretion. It does not necessarily mean that it will contradict the legal goals of self-determination and informed consent; however, it provides a different framework for clinical action than the regulations, which reflect the legal goals in a stronger way.

When the dominating norm is the norm of reliability, the treatment recommended to the patient is the one to be chosen, rather than selecting from any available or existing treatment methods, as the legal goals would demand. When the norm of compliance is the dominant one, it tends to be discussed mainly with regard to the patients' motivation to accept the suggested treatment. This is different from the demand of the legal goals, which let the patients define their own treatment goals. Furthermore, the type of understanding that suggests a stronger influence of the norms

includes that which suggests that motivation to undergo treatment is a pre-condition for participation to take place.

In general, although it is dominated by clinical norms, this line of regulations also encourages certain legal goals due to the fact that these recommendations are combined with the clinicians' obligation to inform. This suggests a strengthening of the legal goal of informed consent, which encourages an increase in information in its most understandable forms. This trend may increase the possibilities of self-determination in treatment and the likelihood to make conscious, well-informed decisions about it.

The space for discretion seems therefore to be structured by the various degrees of the dominance of either the legal goals or the clinical norms and may therefore express both in the same documents. These two ways of interpreting the law are encountered in confluence, although in different proportions, throughout all the recommendations for clinical action. Nevertheless, interpretations dominated by the clinical norms seem to contribute the most to the regulations.

## **5.6 Characteristics of the legislative regulations**

It was assumed in chapter 3 that the content of the guidelines may vary. An overall conclusion from the analysis of the studied guidelines for clinical practice is that they differ with regard to content, precision and strength, and contain a number of inconsistencies. Stronger tendencies towards legal goals or clinical norms do not

necessarily suggest clearer recommendations. For this reason, the recommendations may leave their followers a reasonably large space for discretionary interpretations.

The legal goals of informed consent and self-determination are expressed in different ways in the regulations, which may encourage a more or less extensive process of information and involvement in treatment. Furthermore, a number of recommendations contain vague interpretations that are based on the clinical norms or legal goals. These recommendations do not, however, provide clear guidelines for practice.

Some inconsistencies observed in the guidelines may be explained by the sequential approach (Cyert & March 1963), such as when the goals are being addressed separately, with each statement comprising a different content. The sequential way to structure the recommendations may suggest a desire to achieve a consensus.

The majority of the statements introduced in the guidelines tend to embrace two different types of interpretations: both norm-based ones and legal goal-based ones. There is nevertheless a systematic way to express these differences, since they may be seen to be based on different balances between legal goals and professional norms. Such statements may appear to be inconsistent due to combining considerations embedded in the legal goals or in the clinical norms, while being at a similar level of precision. They may to a larger or lesser extent reflect different perceptions of treatment. For example, reliable treatment and equal sharing of the decision power could be seen as an inconsistent combination of recommendations. Some recommendations may indeed be regarded as a breakthrough in the way of conducting

the treatment, as compared to the traditional mode based on compliance. They encourage the practice in which patients may exert an influence on the diagnosis and its matching to particular types of treatment, such as with matters that have traditionally been left exclusively to professional expertise.

Cases in which the patients are made responsible for the implementation of treatment may be classified as compliance according to some recommendations (e.g., A1) and as self-determination according to others (e.g., A2). This is an example of the same concept (self-responsibility) being expressed in the two different ways. For example the interpretations may provide vague understandings of participation, while offering rather precise recommendations with regard to information. This may result in an inconsistency in the guidelines, suggesting that the RTIP is only concerned with an obligation to inform on the clinicians' part. The opposite may be the case with the recommendations that tend to focus on the clinicians' obligation with regard to participation in a rather precise manner, while the patients are the main responsible component with regard to information. This distinction could suggest that the RTIP is only concerned with the aspect of involvement in making the decisions about the treatment, while the responsibility for gaining the relevant information about it is put on the patients.

The large variety of understandings may be regarded as one way to achieve a balance between the newly established legislative framework and the one-thousand-year-old clinical practice without having a well-established method for handling these two logics of law and profession from before. It may be that the Directorate will be

able to handle the two different logics of acting and thinking by accepting the existence of diversity of understandings.

Another factor that may be seen as allowing the autonomy of interpretations of the guidelines is a lack of prioritization of the sources or of the interpretations within them. These findings could support the studies that emphasize the space for clinical autonomy as an important factor for structuring legislative regulations (e.g., Sahlin-Andersson 1999).

Studying the various sources of regulations has provided the necessary insight into the inconsistencies that characterize the existing regulatory framework that could affect clinical space for discretion. These implications are further discussed in the next chapter, chapter 6. Even though the purpose of this study was not to explain the actions of the Directorate, some insight into the organizational characteristics of the Directorate and the process of the development of the guidelines has been gained.

The instrumental value of the new ways to perceive practice is high since they allow a new approach for informing patients and making it possible for them to participate. It may not only open the practice for inexperienced clinicians but also allow experienced professionals to practice without interruptions. Traditional norms and legal goals may function as active guidelines together in the recommendations that structure practice. The new way to understand participation allows practices that may appear contradictory to break with the traditional ways to practice compliance.

This analysis presented above shows that regulation through the RTIP facilitates different types of actions rather than making them compete with each other. They are



incorporated together into many of the regulations, which thus contain significant variations and therefore provide clinicians with largely inconsistent and vague recommendations. The variations were discussed here with regard to their content, precision, and strength. General patterns of the variations suggested certain inconsistencies in most of the recommendations.

The incorporation of the legal goals into the recommendations is the desired outcome of the RTIP. The variations in the Directorate's interpretations of the legal goals could result in differences in individual actions in clinical practice. The question of the next chapter is therefore how clinicians assess their actions in view of the regulations. Clinicians have been one of the major groups involved in creating the regulations, with an abundant inclusion of clinical norms in the regulations as a result.

The goal of the regulations is to have a direct influence on the practices. However, the regulations may not have the planned by the legislator effect if they are seen as an external to practice regulatory tool by the practitioners. Furthermore, even if they are recognized, they may lead to uniformity of action or contribute to variations among clinicians. Will the regulations be sufficiently conducive of the law for the practitioners to influence the practice of co-determination? How will the inconsistencies and the variations be seen by clinicians when they interpret the recommendations? Will the legislative regulations intended to standardize practice in fact lead to a more uniform practice?

An attempt to find an answer to these questions is made in the next chapter, chapter 6, based on the empirical data collected in this study. The following

anticipations about the relationship between the regulations and clinical action were made in chapter 3:

*Weak wording may allow deviation from the main principle in practice to a larger extent than the strong ones.*

*Precise regulations are characterized by specific, clear, and concise concepts. They leave practitioners little chance to re-define them in practice.*

These hypotheses are explored in the following chapter.



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## 6. Legislative regulations – a guide for clinical practice?

### 6.1 Introduction

In this chapter, the assessments of *de facto* practice<sup>30</sup> and of the legislative regulations made by clinical practitioners are presented and analyzed. These assessments are based on qualitative, open-ended interviews with 30 clinical practitioners, including 15 psychologists and 15 psychiatrists. The goal was to explore and explain the clinicians' assessment of clinical actions in the area of participation and information in treatment.

As studied in this chapter, clinical reasoning is a process that begins with a description of the patient's situation and proceeds to a decision on the medical course of action based on the accepted norm for it. Norms, in this case, may mean for example the legislative regulations or traditional clinical norms. Without norms for action, it might be difficult for the clinician to determine what ought to be done based solely on a description of the situation.

As discussed in the previous chapter, legislative regulations may be dominated by for example legal goals or could, to some extent, reflect clinical norms, they could also be influenced by both without either one clearly dominating. I ask an open question

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<sup>30</sup> The expression "de facto practice" is applied in accordance with earlier studies of administrative practices in organizations (Maggetti 2012; Despotovic et al. 2007, Roness et al. 2008).

about how and why clinicians make the particular assessments of their practices and the legislative regulations through the RTIP.

All the practices explored in this chapter are reliable (for the criterion of reliability, see chapter 3.2.2.1) and are based on discretion to some extent. Furthermore, some degree of patient participation and some form for information delivery will always be found in *de facto* clinical practice. The question of the implications of the legislative regulations in this study concerns the explanation and specific content of the clinicians' understandings.

The analysis of data is driven by the set of hypotheses developed in section 3.7.

### **6.1.1 Studying the clinical practice based on the institutional approach**

The RTIP regulates the areas of participation and information in treatment. Clinical practice in these areas is analyzed by employing the concept of co-determination. The traditional approach, in which the patients' participation and the process of information delivery could be used as a tool to manipulate the patients to comply, is outside the scope of the concept of co-determination.

Based on the institutional approach, this chapter aims at contributing to the understanding of how the clinicians assess the actual process of informing and involving<sup>31</sup> their patients. The discussion provides an insight into how this area of

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<sup>31</sup> In this case there is no difference between patients' involvement and participation.

clinical practice is influenced by the legislative regulation through the RTIP. More specifically, the focus is on how the legislators' idea of expanding the patients' decision power in treatment becomes institutionalized in traditional, norm-based clinical evaluations.

As discussed in the previous chapter, the regulations in general have been characterized by vague, imprecise wording. This fact may stimulate a variety of discretion-based practices. The concept of vague interpretations is used in this chapter to capture the assessments that combine the traditional clinical norms with the new logic of the RTIP.

Based on the institutional theory, it may be expected that assessments of *de facto* practices will be characterized by a co-existence of the logic of legal goals and well-established norms. It is an open question in this chapter whether the legislative regulations lead to variations in clinical practices.

Studying the various sources of legislative regulations in the previous chapter has provided necessary insight into the characteristics of existing regulatory framework and implications they may have upon clinical space for discretion. The relationship between organizational structures, norms, *de facto* action (i.e., the situation at hand), and their link to the legislative regulations is discussed below.

One further goal of this chapter is to explore whether institutionalized practices could be seen as a barrier for the implementation of the legal goals and how. Legislative regulations come into play in clinical action when specialists are confronted with practical questions about what ought to be done and the task of finding practical

solutions to real-treatment problems. These regulations will always leave clinicians some freedom of interpretation. Interpreting legislative regulations using *de facto* clinical action means finding justifiable answers to questions concerning participation in the choice of treatment and the receipt of information about it. Specialists evaluate the situation (they consider individual patients), choose the treatment methodology (matching the diagnosis with the treatment), and relate to the legislative regulations.

A variety of concepts introduced by the Directorate covers different aspects related to participation (see chapter 5). Concepts of self-mastering, self-responsibility, self-determination, and assistance in self-help dominate the recommendations of the Directorate. It is explored to what extent these concepts have been adopted in practice.

Furthermore, I ask an open question of how the clinical practitioners understand the guidelines when they assess their practices and why.

### **6.1.2 The structure of the quotations from the interviews**

The specialists interviewed in this study may be divided into two groups: those with little clinical experience and those with long experience in their clinical work. The more experienced specialists may not have learned the current interpretations embedded in the guidelines through their education. Legal goals cannot therefore be seen as an integral part of their socialization into the clinical work. This generalization may be contrary to those specialists who have received education after the RTIP was legislated (see chapter 2). While evaluations of experienced practitioners are expected

to be to some extent based on the norms, in case of inexperienced ones evaluations are expected to be to some extent based on the legal goals.

It is assumed that it is possible to compare the interpretations made by the clinicians among as well as within the two groups (experienced and inexperienced professionals). Furthermore, it is assumed that it is possible to compare the clinicians' perceptions with the guidelines.

It was noted in chapter 5 that the Directorate has involved clinicians in the development of regulations. Clinical norms of discretion, reliability and compliance have been to some degree institutionalized in the guidelines. In this chapter, it is not distinguished between the norms embedded in the regulations and those embedded in experience of the actual interviewed practitioners.

The aim with giving the quotations from the interviews in this chapter is to present the assessments made by the practitioners in a most extensive manner, in order to illustrate the context. Some of the quotations are therefore considerably longer than others. The subject of the RTIP was extensively commented upon by the specialists. The quotations are representative for each of the groups of clinicians. Various understandings of clinical practices and the legislative regulations will be explored based on these quotations.

The previous chapter suggests that a higher degree of regulation does not necessarily mean binding the clinical space for discretion. However, regulations embedded in legal goals tend to be more precise than the interpretations rooted in clinical norms and bind discretion to a larger extent in this manner. Thus, clinicians



with more experience could have a tendency to follow vague legislative regulations when reasoning about the treatment, since such regulations could allow them to adhere to the traditional norms that they might be used to. As suggested in chapter 5, the guidelines embedded in clinical norms can have a tendency to reinforce clinical discretion.

In order to answer the question about the relationship between legislative regulations and clinical practice, it is necessary to present the data in a way that makes the implications of legislative regulations for practice possible to explore. I therefore take as a starting point the interpretations of the RTIP presented in chapter 5. They specifically addressed the patients' possibilities to influence the choice of treatment, their self-mastering and self-responsibility for applying the treatment, and the possibilities to obtain information.

While the interpretations that concern self-mastering and self-responsibility for the application of treatment and for getting information about available methods are rather similar throughout all of the quotations, variations may be noticed with regard to the interpretations concerning co-determination in the choice of treatment and information. The degree of co-determination and information tends to differ to a large degree.

I divide the presentation of the interview data into two subchapters. In the first one, 6.2, I discuss the interpretations given by inexperienced practitioners, including those who work in a team with experienced ones and those who work on their own. The focus of the next subchapter, 6.3, is upon the interpretations that are given by

experienced specialists, including those who have leadership positions. This method of presenting the results is justified by the two different tendencies in assessments of clinical action and of the regulations, which are set by both experienced and inexperienced practitioners. It also has to be possible to capture situations when various types of regulations may guide clinical action or when it is a challenge to classify the statement.

## **6.2 Inexperienced practitioners**

Of the 30 specialists interviewed, 13 contributed data material relevant for the analysis in this subchapter, as they have less than 5 years of experience in clinical practice. Eight out of 13 work in close cooperation with experienced specialists in psychiatry, while 5 are not associated with any experienced team and work independently.

### **6.2.1 *Self-determination and informed consent***

The assessments of the practice of deciding upon treatment methods encountered in the interviews may be divided into three following types of tendencies:

The first type of statements made by the practitioners on this subject may suggest a dialogue-based process. This type allows patients the chance to self-determinate and provide informed consent to treatment. Clinical decisions may to some degree involve patients in the process of choosing a treatment methodology.

The second type of interpretations provides patients with a larger degree of influence on the choice of the method than the first. In this case, clinicians offer few recommendations for treatment and accept suggestions from the patients. The methodology of treatment has been adjusted to the patients' individual preferences.

Finally, a third type of interpretations suggests a large degree of self-responsibility for patients in applying the treatment chosen by the clinicians. Information provided to patients about the reliable and best method facilitates their informed consent to the optimal treatment.

While all the types incorporate legal goals and clinical norms, it is the legal goal of self-determination that dominates the first two types. In contrast, the third type appears to follow the norm of compliance.

#### *6.2.1.1. Dialogue-based self-determination*

Practitioners make different assessments of the legal goal of patients' self-determination in the choice of a treatment methodology.

The major tendency in the assessments is to accept self-determination based on a dialogue adjusted to the patients' preferences and the outcome of the treatment. It may sound as follows:

The first thing is to just ask them (the patients): what do you want me to help you with? What is it that they would like to get out of it (treatment)? I can recommend something if they want me to. Then they tell me if there is

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something they want me to change. It is always an open discussion. My patients must feel that they profit from the treatment. They and their opinions are the most important here—this is what really counts. (Interview 1) (6.1)

A consistent precondition for the treatment is obtaining information about the patients' preferences. Their preferences influence the decisions about the treatment throughout the process. If necessary, changes are made within the scope of reliable methods to accommodate the preferences of the patient. The treatment strategy is based on the assumption that the best outcomes are reached when forms of treatment preferred by the patients are followed. This method of matching the treatment with the diagnosis can be thus related to both the reliability and the legal goals. The patients' preferences, however, bear strongly upon the decision.

#### *6.2.1.2. Reliability in decisions about treatment*

In a different interpretation of self-determination, the important criterion used by the clinicians when the decisions on treatment are taken is reliability. The considerations of the patients' preferences are not usually excluded in this case. It may sound as the following:

The patients must be able to ask for certain forms of therapy that they know of... and then one has to evaluate if it is something that is professionally reliable? A doctor will not operate on the healthy foot, right? One has to evaluate the reliability of such treatment at the same time as the patients make their choices...

I cannot impose my treatment methods on the patients without first discussing the methods with them. We have the professional knowledge they do not have... but there are just some things that we do not think are right to do. (Interview 2)  
(6.2)

This interpretation balances between the legal goal of encouraging the patients to choose and the norm of reliability. It appears to be similar to 6.1 with regard to the form of participation, as it is emphasized that if the patients have preferences regarding the methods of treatment, the clinicians must consider them. The main difference from 6.1, however, is that in 6.1, specialists cannot define treatment without subjecting it to the patients' evaluation. In 6.2, the decision has to be based on the criterion of reliability, which is emphasized strongly in this interpretation, as compared to 6.1. Reliability seem to carry more weight than self-determination. This trend is similar to the criterion of reliability defined in A1:25.

Participation may otherwise still be perceived as being closely related to self-determination in treatment. Clinicians allow patients to influence treatment decisions. This interpretation is also emphasized in B1, in which the Directorate suggests the combination of the patients' participation in the choice of treatment in cases where there is a possibility of choice (B1:14).

It was observed that specialists who derive their interpretations from advice given by experienced colleagues were more likely to consider the reliability of a chosen treatment first of all:

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I have all these experienced people around me whom I can always ask if I am not sure what to do... I can always get support from them... and this I have had since the beginning... we discuss it as a team... a reliable plan for treatment of every patient. (Interview 3) (6.3)

Work organized in teams seem to contribute consistently to prioritizing the reliability of the treatment methodology. This approach suggests a difference with the interpretations of inexperienced clinicians working on their own.

#### *6.2.1.3. The patients' understanding of their sickness*

The patients' experience of sickness is another point related to the clinicians' assessments of self-determination. The tendency to select a methodology based on the patients' description of the symptoms may be illustrated by the following:

My goal is to get the patients' definition of the problem, not the doctor's. You never know if the patient's interpretation is in line with what you read in the referral. The most important thing is to get the patients' interpretation of what the problem is. (Interview 3) (6.4)

The assessment above seems to be rather consistent. It is defined in a similar way in the guidelines with regard to accepting the patients' understanding of the sickness as the background for the choice of the treatment methodology. This conceptualization follows the legal goals directly (see A3). This may suggest the tendency to comply with legal goals, which influence clinical practice. This quotation

illustrates a shift in the way decisions regarding the choice of treatment are made, from the traditional practice of the experts' interpretation of sickness being decisive to the patients' definition of the symptoms being the basis for the decision. The quotation above belongs to inexperienced specialists who work on a team. This may suggest the flexibility of practice because it allows interpretations based on legal goals. It could further suggest that newly educated clinicians who work on a team may choose to follow the interpretations embedded in the legal goals as well as the norms.

These clinicians also were more likely to emphasize another point. They are willing to try methods suggested by the patients. On this point, the criterion of reliability is hardly given consideration. Clinicians explain it in the following way:

Participation is about their (the patients') right to decide upon the treatment... patients can prefer a particular form of therapy—then we do it and see if it works... We must talk to the patients; it is an ongoing dialogue (about the method... my goal is not to tell them how they must live their life. It is their therapy, not mine... my experience has been that they know best what is good for them. I have to be really careful not to use a therapy form they wouldn't like. (Interview 4) (6.5)

As another clinician explained,

We must know what is important for the patient. At the end of the day, it is the patients who shall profit from the treatment. The most important issue is the one that they think they need help with. Their preferences are our priority. (Interview 1) (6.6)

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Quotations 6.5 and 6.6 represent consistent interpretations that are in line with the legal goals. It is central to these interpretations that the decisions about treatment have to allow patient influence; this concern affects how specialists decide upon the treatment.

An alternative explanation might be that clinicians follow legal goals because they may lead to greater compliance with treatment. This explanation could suggest that the legislators' purpose to expand the patients' power in treatment would be assessed as a tool to achieve compliance. It would also mean that the RTIP becomes an instrument for achieving the most effective recovery.

Another example revealed that the practitioners interpret participation as the expansion of the information background about the treatment methods recommended by clinicians, as well as about the variety of treatments. In line with legal goals, it may sound as follows:

We must give them (the patients) enough information so that they could participate and knew what it is they are participating in... (participation is about that.) We explain and give them (the patients) alternative solutions (methods of treatment) that they may accept... we try to show that we understand their point of view. (Interview 6) (6.7)

This quotation seems to be rather consistent with regard to the expansion of the possibility to express informed consent. It suggests that clinicians have a tendency to combine traditional information given about the treatment: the recommended method as well as any information based on the legal goals of available treatments.



In this case, inexperienced clinicians who work independently choose to provide information about alternative treatment possibilities that patients can evaluate. Following patients' preferences is the ultimate aim when diagnoses are matched to treatment. An alternative explanation could be the anticipated better compliance with treatments that are even partially defined by patients, or transferring the responsibility for the choice of treatment completely to the patients.

#### *6.2.1.4. Withholding information*

A most common feature in the interviews was that the specialists tend to make sure the patients have the opportunity to give informed consent. However, some of the interpretations did not follow this pattern: "There are many different methods of treatment, but I try not to emphasize that. The method you get depends on which therapist you get... patients cannot choose... we are not there yet," (Interview 7) (6.8). This quotation can suggest a clearly practical approach that is not based on legal goals. Instead, the norm of compliance is at work in this situation.

Specialists tend to be well aware of the requirement for informed consent, but practical considerations nevertheless dominated clinical action and led to withholding information about the methodology of treatment, as in the following interviews:

There are not so many alternative methods here. It is just me basically, so the patients cannot say, "I would prefer to have another psychologist or a

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psychiatrist” It is clear they have no possibility to choose here. This is how the treatment reality is. (Interview 3) (6.9)

And,

I think that if patients do not want to follow the treatment that I think is best for them, then I will just reject their application if they apply for the treatment at our DPS one more time. I cannot offer them anything else (than the treatment they had rejected). (Interview 8) (6.10)

Consistent and clear interpretations can be seen to be embedded in the norm of compliance and reliability. Compliance seems to be achieved by withholding information about relevant treatment methodologies and suggesting practically available ones. Quotation 6.10 illustrates the strong version of compliance that preconditions a patient’s access to treatment. The main focus is on the treatment methodology. It is not the subject for dialogue. Consideration of patients’ self-determination in treatment and also their information background, both of which could enable informed consent, seems not to be given in these interpretations. Instead, specialists focus more on the practical question of which treatment is available at the treatment facility.

The assessments above may appear to be closer to the clinical norms. Traditionally, information about evaluations concerning the choice of treatment and alternative methods were not made available to patients. Patients were only given information about the treatment they were expected to undergo.

Furthermore, the aforementioned interpretations do not appear to give consideration to individual patients. The instrumental practice is likely to be that all patients will receive the most practically available treatment. Even relevant aspects from a clinical point of view, such as the diagnoses, do not appear to be considered.

All the previously mentioned interpretations were given by less-experienced specialists. One explanation for this pattern may be that the differences in these interpretations in practice may originate from variations in legislative regulations. Clinicians choose regulations that are closest to their perception of self-determination and informed consent when recommending treatment. They walk a fine line between practical considerations, clinical norms of reliability, and compliance as well as the legal goals of strengthening the power of patients' influence and the possibility to evaluate information. Accepting a variety of interpretations in clinical practice can be seen as a strategy that the clinicians introduce to handle the differences in legislative regulations.

Thus, in the interpretations described above (6.1–6.7), clinicians seem to accept legislative regulations based on legal goals and clinical norms literally through the following:

- Enhancing the patients' self-determination and informed consent when making decisions about treatment
  
- Withholding information about existing treatment possibilities

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- Prioritizing the reliability criterion over the patients' preferences when the choice of method is made
  
  - Accepting the patients' definition of their sickness.

In all of these interpretations, specialists seem to manage a variety of legislative regulations by developing heterogeneity of these interpretations in practice. This strategy may suggest a flexibility of the interpretations accepted in the clinical practice of inexperienced clinicians and may be seen as an important implication of regulation through the RTIP.

## **6.2.2 Self-responsibility in treatment**

### *6.2.2.1. Self-responsibility as assessed by inexperienced practitioners*

Inexperienced practitioners are especially favorable to the idea of patient self-responsibility for applying the treatment:

“We really do not like to be made responsible for everything... We take over only if the patients refuse to take a stand in their own case,” (Interview 9) (6.11).

This focus on self-responsibility can be viewed in relation to the legal goal of expanding the patients' responsibility for the treatment. An alternative explanation may be the compliance with the treatment and the self-responsibility associated with it:

“The patients have a right and an obligation to be active in their own treatment... the patients’ motivation is about making them take responsibility with regard to the application of the most effective treatment,” (Interview 10) (6.12).

Quotation 6.12 could be seen to relate to the norm of compliance with the best treatment. This may suggest that the assessments of how to involve the patient in treatment are embedded in the existing norms for practice. Self-responsibility was extensively described in A2 and A3, and it is followed in practice in the same form. In quotation 6.11, the clinician may be seen more as a consultant than the traditional decision-maker who takes over all control and responsibility for the treatment. In this case, the clinician is merely an advisor who provides knowledge if the patients ask for it. Therefore, the self-responsibility seen in 6.11 is more heavily associated with self-determination than it is in 6.12.

The most specific example of employing the legal goal of self-responsibility into the practice is the individual plan (IP). An IP is assessed by most clinicians who work on a team as the best tool to make the patients responsible for complying with the treatment. It may sound as follows:

When you develop the plan, you cannot press them too much. They oblige themselves not do certain things when they sign the plan for treatment (individual plan)... I tell them that they must promise to keep up with the plan. I tell them that we expect them to make a good effort at achieving the goals defined there... The most important thing is to make them feel the responsibility... many patients are, however, really passive, and then it is

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extremely difficult to keep them involved... (in treatment, it is the) patient who does the entire work. We are just advisors for them... our job is to make them responsible actors. (Interview 4) (6.13)

The interpretation in quotation 6.13 reflects a traditional approach towards an active patient who is motivated to comply. The strongest focus is on the patients' responsibility for the application of the treatment.

A similar way to understand self-responsibility that is clearly embedded into the expressions introduced by the Directorate is as follows:

We need to follow the Directorate's recommendations and help them (the patients) to self-help... The patients who take on this responsibility feel proud of it, and it is usually much easier to prevent a recurrence of sickness with these patients... no one can demand improvement without contributing to it... we need to motivate them to change their behavior patterns. (Interview 11) (6.14)

Quotation 6.14 can illustrate a direct application of the concepts developed by the Directorate. In many cases, it is the concept of "help to self-help" that clinicians identify with self-responsibility for treatment (see B1 and W1, as described in sections 5.5 and 5.7.), as well as the norm of compliance. According to A2, participation is defined as motivating patients to accept responsibility for compliance with the treatment defined in the IP. In all its recommendations, the Directorate suggests that patients should be responsible and active with regard to choosing their treatment methodology. In practice, the Directorate's goal of self-responsibility can be seen as a means to achieve compliance with treatment procedures. The patients' motivation and

their own efforts to improve their health appear to be most important. The most efficient recovery seems to be embedded in clinical expertise. Self-responsibility that has been defined as a major aspect of participation in treatment tends to be interpreted in the guidelines as a fundamental legal goal (see section 5.7).

One exception to this may be mentioned here. The recently educated, younger clinicians who work on their own often refer to legal goals in their assessments, especially the goal of self-determination:

When we make a plan for treatment, we must consider the routines at our department. I also ask the patients if they need anything more than what is included in the plan. It is about trying to make them reflect over what it is they think they need to get help with. (Interview 12) (6.15)

This is similar to the interpretations presented in section 6.2.1, in which the clinicians refer to education in their interpretations.

#### *6.2.2.2. Written rules as the basis for practice*

Quotations 6.14–6.15 illustrate the main tendencies in how inexperienced clinicians assess their actions. They usually adopt guidelines by following legal goals. There seem to be rather few variations in the interpretations regarding the self-determination of patients in treatment among the inexperienced specialists who work on their own. Homogenous interpretations of IP, for example, are thought in this case to be one outcome of a similar education process. The specialists seem not adopt the

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Directorate's definition of IP but instead unanimously associate this concept with one precise interpretation of the RTIP.

Indeed, in case of the adoption of the regulations embedded in legal goals, the clinicians themselves emphasized that they learn about legal regulations through the education process. They suggest that it stimulates them to follow the regulations embedded in legal goals in practice:

Legal concepts weigh very heavily here... I do realize that there is a whole legal system behind all the things that we do... and every day, when I do these things, I think. You get all this education and training, so we know very well what our obligations are. (Interview 8) (6.16)

Furthermore, in practice, inexperienced clinicians tend to apply written procedures developed by experienced specialists in the same manner as they do with legislative regulations. Most of the clinicians express it in the following way:

We have internal routines for it (plan for treatment)—our own quality handbook in the internal electronic system (developed by experienced colleagues). This is actually something that is used to evaluate our work. We must follow the procedures—we have to make sure that, irrespective of who comes to the clinic, they can expect more or less the same from us. We must provide a similar model of treatment for all the patients—this also gives them the feeling of security... it is very strict here, not like in private practice. (Interview 13) (6.17)



Thus, the internal routines developed by the experienced specialists tend to lead to the standardization of internal practice of inexperienced specialists. This trend might be explained by the fact that complying with routines is embedded into the training process but, in this case, is also assessed by the measurement of the outcome of services.

At the same time, inexperienced clinicians who work on their own emphasize that their assessments differ from the ones made by experienced clinicians:

We really try to move away from the old authoritarian style and become much more of a consultant-style service... you can tell me what you would like to achieve, which goals, and I will tell you if there is something that I could do for you. (Interview 9) (6.18)

This example shows that inexperienced clinicians can be both positive and negative towards the legislative regulations embedded in well-established clinical practices. While specialists working on a team tend to prefer the regulations embedded in norms (see, for example, 6.7.), some of them, especially those who work independently, might be sceptical of experience-based practices. This attitude illustrates tendencies towards internal variations in clinical practice.

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### **6.2.3 Information about rights and treatment – the basis for patients' informed consent**

While the two previous sections have focused mainly on self-determination in treatment, the following assessments of the RTIP are related primarily to expanding patients' information background. Clinicians tend to provide a particular type of information that concerns patients' rights and treatment methods. There are variations with regard to which of these aspects clinicians choose to emphasize.

An example of the main tendency, such as interpretations based on legal goals, can be seen in 6.18. It comprises the main goal of informed consent in treatment and is an interesting assessment that illustrates patients' self-responsibility for using information to make well-informed decisions regarding their treatment. The application of the legal goal of self-information in treatment is discussed in section 6.2.2. Clinicians may appear to comply with the legal goal of informed consent by transferring the responsibility to inform to the patients. The general perception among clinicians is that the better the possibilities for self-information in treatment, the better the patients' compliance with the treatment.

The interpretations encountered in this section may be divided into two groups: the ones concerning information that is *not* provided to the patients by the practitioners, and the ones concerning information that *is* provided. In both cases, the clinicians comply with the legislative regulations that are precise and embedded in the legal goal of reliability.

Seven out of the 13 specialists gave interpretations that focused on withholding information. These were the specialists who work on a team with experienced clinicians. Specialists almost always withheld information regarding patient medical records and side effects of treatments. This information was very likely not to be provided or to be given only in a limited form.

Other interpretations of information that tend to be made concern suggested treatments that are based on the best available clinical knowledge. These interpretations were encountered in 6 out of the 13 interviews.

#### *6.2.3.1. Legal language external to clinical practice*

Legal language, such as that related to the information concerning rights, tends to be assessed as being external to day-to-day clinical practice. In general, clinicians prefer to leave the responsibility for implementing the legal framework into practice to the leaders. Clinical action has a tendency to be seen as the opposite end to the law. Most clinicians report that the reality of treatment does not leave space for legal rhetoric:

I do not usually say, “Welcome, your rights are the following”... I think anyway that the patients generally know what their rights are... We do not have to tell them that... It is taken care of automatically... At least, this is my impression... I really do not have to sit down and read all these laws, paragraphs, and things like that because it is well taken care of... my boss said that we (the DPC unit)

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received good remarks from the Norwegian Board of Health Supervision (audit authorities), and I am very happy about it, of course... This legal language, it is not part of our everyday language in our ward. It is not how we talk. It is more like we know that it is a part of our basic training, so we always keep it in mind. There is this small bulb in your head that goes off. It reminds you—remember the law... but law as such—well, it is a very small part of my clinical reality. (Interview 3) (6.19)

This interpretation is closer to the legislative regulations that are based on the principle of reliability. Specialists followed the recommendations of the Directorate in A1, where the information to be delivered tends to be related to *de facto* treatment. It is interesting that the responsibility for compliance with the legal framework for clinical practice in general tends to be perceived as the responsibility of the leaders. In most of the guidelines, the Directorate demands that the practitioners provide the patient with comprehensive information (e.g., A1, section 5.3). Legal goals seem to be perceived as general values that the practice is based on. Clinicians tend to be aware of their existence, but they tend not to apply them in practice. The legal goals are not interpreted as precise guidelines for clinical action. Quotation 6.19 can illustrate the perception of legislative language as being external to clinical practice. However, it also may suggest that the regulations embedded in the clinical norms may be more likely to be followed in clinical practice. Legal goals tend to become recognized in the form of a normative general idea that patients' self-determination and informed consent are important in treatment.

### *6.2.3.2. Compliance and withholding the information*

Information that tends to be excluded from the clinicians' assessments is not limited to information about the legal aspects of treatment, as discussed above. Information registered in the medical record is also interpreted as necessary to withhold from the patients, in order to protect them and achieve compliance:

Some people ask if they can get access to their medical records, but none of them have gotten access to them in the end... but they (the patients) said to me that they were thinking about it... I usually tell them, "You can do it if you want to. This is your right as a patient. However, if I were you, I would rather reconsider it... I would really think over it, actually." For some patients, it can be very tough to read about themselves in the record. I rather encourage them to reconsider. So far, I have succeeded. They agreed with me and did not come back to this topic afterwards. For some of them, it could be an overwhelming experience, I think. It could endanger the outcome of the whole therapy. (Interview 4) (6.20)

This assessment does not contradict vague legislative regulations that leave clinicians the autonomy to decide which information to provide to specific patients. At the same time, even the most precise interpretations found in the guidelines do not mention information registered in the medical record (see B1 or A1, chapter 5). This is also the case with the legislative regulations embedded in clinical norms (see A1, section 5.3). They are especially focused on the criterion of reliability in treatment. In this case, the clinical goal to achieve compliance with reliable treatment might be seen

as more important than the legal goal of giving the patients access to information, especially in response to a particular patient's request.

The legal goal of informed consent sets a demand on the responsible specialist to make sure that the patients receive comprehensive and complete information when they ask for it. Access to the information registered in the medical record tends not to be given. It suggests that the clinical strategy to make patients accept the treatment is achieved through manipulating the information. Thus, there is a tendency to institutionalize the legal goals into the clinical norm of compliance. It may, therefore, be argued that the practitioners follow legislative regulations that allow them to practice based on clinical norms. The Directorate's demand of answering all of the patients' questions is disregarded in this case. This may suggest different approaches to follow the demands of the regulations.

#### *6.2.3.3. Informed consent – the basis for reliable treatment*

Another line of assessments developed by the inexperienced practitioners concerns the content of information. According to them, the information about the patient's rights and the patient's access to the medical record are most important to provide in the clinical context:

To give (the patients) a feeling of support and stability is a very important topic in our education program. The patients must feel that they have received all the information they need. Thus, we must be very cautious about informing them

about their rights. It is an important topic for students of psychology. Here, it is a crucial focus of treatment as well. It is in the system everywhere—in the form of routines and even the clinical approach to the treatment... I have never seen anything else than that since I started working... This is the first thing one does or, at least, I do... I give them (the patients) information about their rights. The right to access the medical record... they must know that I register information in the medical record every time we meet... and that they can get access to it whenever they want... It is also about showing them that you are open for questions all the time if they need information... they must have the chance to influence their own treatment situation, and they need to get all the information about it... I want them to be involved and express their opinions... I ask them all the time if they enjoy this form for therapy, as I cannot apply something they would not like. (Interview 1) (6.21)

This assessment is consistent and is based directly on the Directorate's recommendations that incorporate the legal goal of increasing the patients' insight into their health situation as the primary principle of reliability. The legal goal of informed consent to treatment seem to become the primary clinical goal in the treatment procedure. This is an example of the legal goals being adopted directly into practice. Clinicians tend to emphasize the patients' feeling of security as an important aspect of treatment, which can be seen in relation to the clinical norm of building a trust relationship with the patients.

The trust-based relationship with the patients has traditionally been an important strategy to achieve compliance in treatment (see 6.15). In the regulations, it is called

alliance-based treatment. It may be seen as an example of including precise recommendations from the guidelines into clinical practice. It, however, does not mean that clinicians do not consider individual situation of patients when determining which information to provide. The ongoing evaluation of what information to provide is influenced by the strategy of informed consent.

Quotation 6.21 may also be seen to suggest an internalization of information delivery to the clinical norm of alliance building; traditionally, treatment has been based upon the trust patients had in clinicians. In this case, a good alliance was used as a manipulation strategy to make patients comply with treatment that they might be reluctant to accept otherwise.

#### *6.2.3.4. Education, experience and legislative regulations*

The clinicians' assessments of the information based on the legal goals are the outcome of clinical education that comprises, among others, the legal framework for practice. This pattern appears to be rather different from the interpretations given by those practitioners whose interpretations are based upon the legislative regulations that incorporate clinical norms. Those clinicians have a tendency to work on team with experienced colleagues.

As for the interpretations of participation discussed earlier, clinical knowledge based on both education and experience may cause practitioners to follow different regulations embedded in legal goals, clinical norms, or both, when providing



information. The main impression is that approximately half of the interview data is based on vaguely worded legislative regulations mainly embedded in clinical norms. The other half focuses specifically on the precise definitions that tend to reflect legal goals. These examples illustrate a seamless integration of legal goals into practice.

There is a number of examples that suggest that even though legal goals influence practices directly, they might not be voluntarily accepted (see Quotation 6.36). This is true even in cases where it is impossible to follow the goals.

Considering that there is a number of regulations, which to a large degree allow discretion-based interpretations, legal regulations cannot be seen to be contradicted by the practitioners' assessments in any case. Practitioners are free to choose which regulations they follow.

Those practitioners who act based on experience tend to avoid introducing information about the rights to treatment. The interesting aspect of this situation is that no matter which regulations experienced clinicians tend to follow, their actions are aimed at the clinical goal of compliance. Their manipulation strategies can be either oriented towards providing or withholding the information in the clinical context.

### **6.3 Experience – a barrier for legislative regulations?**

In this section, I discuss the interpretations of the legislative regulations made by the experienced practitioners. The data material presented here consists of interviews with 14 practitioners from five DPCs who had over 10 years of experience.

Five of these occupy a leadership position (further called “the leaders”) at each of the five DPCs. Each leader also works clinically with patients. Data from the pilot interviews were also incorporated in this section.

A difference in the interpretations of the RTIP was found between the interpretations made by the practitioners occupying no leadership position and by the leaders. It is therefore natural to present the results based on this distinction.

### ***6.3.1 The practice of legislative regulations by the leaders***

As follows from the interview material presented below, the leaders seem to be rather unanimous in how they assessed the legislative regulations. They had a tendency to combine legal goals and norms in the same statements, without giving priority to any of them. The discussed assessments concern the transparency of services and specify more or less vaguely which information should be given to the patients. The precise and the vague wording of the regulations seem to guide the practice.

#### *6.3.1.1. Access to information*

Informing the patient is normally associated with the development of an individual plan (IP). The IP tends to be understood as a tool to document the treatment methodology for the patients. The leaders tend to focus on the legal goals in the legislative regulations when defining the content of information and deciding upon involving the patients. At the same time, they recognize that the other practitioners

make interpretations of the RTIP based on clinical norms, as illustrated in the following example:

One thing is to give people precise information about what is actually available with regard to the treatment methods. We must be quite clear about our limitations and tell them what they can expect here. Limitations in what we actually can offer are pretty large... we do not really have the technology that is good enough... The results we have obtained with what we have (psychotherapy and medications) are not as impressive as we might wish... We should inform them about the various types of treatment. Treatment includes everything from the different types of techniques, as well as the support they can get at home... It must be based on a dialogue. The Norwegian Board of Health Supervision (NBHS) has become really strict about it... In the plan for treatment, we must write that it has been developed based on patients' participation. That we have agreed upon this and that. We have worked out the internal routines for how the treatment should look... We must include, for example, the fact that we agreed upon the treatment... However, I realize that the practice is individual and that some specialists just do it the traditional way and tell the patient what to do. (Interview 1) (6.22)

This interpretation suggests that the leaders comply with the legal goal of expanding the patients' insight into existing treatment. A clear example of this is the information about various forms of treatment, which is considered to be important. By providing this information, the leaders give the patient a chance to influence the

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decision about the choice of treatment method or to consent to treatment. The core of these interpretations is also illustrated by the following:

You inform about it (treatment), preferably in a written form about advantages and disadvantages of various things (methods of treatment)... We really try to move away from the old authoritarian style and become much more of the consultant style service... you can tell me what you would like to achieve, which goals, and I tell you if there is something that I could do for you. (Interview 2)

(6.23)

In 6.22–6.23, the possibility for the patients to develop their preferences regarding the treatment is a critical point of the information. The reference to the necessity to comply with the NBHS and the aim to develop internal routines suggests that the leaders present themselves as followers of the legislative regulations based on the legal goals. The assessment involving practical availability suggests a norm of compliance with a treatment that can actually be offered.

The balance between norms and legal goals in the same statements may also be illustrated by the fact that the leaders tend to distance themselves from well-established practices. “Authoritarian style” in treatment refers to the traditional type of decision-making that excludes consulting the patients, while emphasizing the choice of treatment based on compliance with clinical knowledge and discretion.

### *6.3.1.2. The diversity of the leaders' interpretations*

The leaders combine the Directorate's aim of standardization and the legal goal of transparency with their acceptance of individual practices among experienced clinicians in the same statements.

The transparency of information is also concerned with the information about patients' rights:

We generally think it is important to say something about the medical record, since it is the patients' right... Once they come to us they have gotten... information about the right to complain and who they can complain to, etc. They receive it all in a letter." (Interview 3) (6.24)

The leaders chose to follow the Directorate in including information about patients' rights in their assessment of the RTIP (A2:20). Furthermore, the one type of information that has been consistently included in the interpretation of rights by most of the specialists is information about the medical record. This interpretation incorporates the legal goal of expanding the patients' insight into the process of documenting, including informed consent. Such information provides the transparency of clinical judgment and also serves as a justification for it. It may be seen in relation to the regulations, which place the responsibility for providing information about rights on the clinicians.

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The interpretations made by the leaders are thus characterized by some inconsistencies. The leaders do not rank the interpretations. The various interpretations, therefore, seem to have the same degree of importance.

#### *6.3.1.3. The legal goal of self-responsibility*

Another kind of assessment made by the leaders concerns the patients' responsibility for applying the treatment. The involvement of the patients in the process of defining the treatment varies. There is a tendency among the clinicians to avoid the topic of the patients' involvement and focus on their self-responsibility and self-motivation. Most of the specialists associate self-responsibility and motivation with the development of an IP. This is in accordance with the legal goals:

In the plan... we (the professionals) must write that we agreed with the patients upon treatment measures... I am sure it is the implication of this law (the RTIP). Patients must be responsible parts in this dialogue (development of IP). Then this plan becomes an important tool for implementing participation... The patients are obliged to participate... we demand their participation—they have to make the changes in their lifestyle that the treatment requires. They have to make difficult choices, and it actually costs them something. (Interview 4) (6.25)

This assessment complies with the Directorate's recommendation to motivate the patients to self-responsibility in treatment by applying an IP agreement (A2:22, section 5.6).

It is noteworthy that the dialogue between the specialist and the patient when developing the IP is central to interpretations of the RTIP made by the leaders. This interpretation complies with the legal goal of self-determination. The patients' responsibility to become actively involved in the application of the treatment is another aspect illustrated by the above statement that may be related to the norm of compliance. The idea of involving the patients in the development of the IP as well as the application of the treatment reflects legislative regulations based on the aim of the patients' self-responsibility (e.g., A2; A2; W1). Assessments of IPs tend to comprise both the involvement and self-responsibility in the same statements.

This point may be further illustrated by the following quotation:

This is cooperation, even though they (the patients – *A.S.*) actually do not even sign it (the plan – *A.S.*). They may not get a copy of it, either... Before, the plan was just one of the points in the anamnesis. Now, an entire concept has been developed. We write the whole plan for the treatment. It must have a summary part with a specification of the diagnosis and what is going to take place after the evaluation... in the plan for treatment, we must write that the plan has been developed in cooperation with the patients... that they participated. This is a very good way to make the patient take responsibility for the treatment. (Interview 5) (6.26)

This interpretation of the RTIP suggests that actual practice may not be influenced by the legal goal of expanding the patients' influence on the choice of treatment. IP seems to become in some cases a pro-forma action for patients'

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involvement in decisions about treatment. The patients are not always involved in the development of the treatment, even though the plan is actually created in conjunction with them and their participation in the process is registered as consent to treatment. This discrepancy suggests variations in practices, when the clinical norm of compliance and the legal goal of involvement may both be at work as the IP is developed. This issue may also illustrate instrumental action in which the legal goals related to the transparency of registration are not followed voluntarily but instead just for the sake of conforming to the rule. This action tends to be accepted as a way to comply with the legal requirements that cannot be avoided. Clinicians often interpret the patient's signature as written evidence of participation having taken place in the development of the IP.

Some of the interpretations illustrate a strong association with the norm of compliance. These tendencies may be represented by the following statement:

There are some dilemmas with the RTIP. The treatment depends on the patients' contribution to it. But if we think of participation as a right rather than an obligation to participate, then it is problematic. We know that patients have their rights, but in order to talk about treatment at all, they must participate actively. If they then sit there with the attitude that they are just the recipients of treatment since they have the right... it is just wrong from the very beginning. I cannot cure people if they are not willing to actively participate in it... participation can just make the treatment less vivid in a way. It actually can undermine (the patients') personal responsibility to apply the treatment. The most important aspect of it is that the patients must understand that this is their responsibility!



We oblige them to participate. They are not here to receive the treatment... They cannot demand anything here without giving something. (Interview 4) (6.27)

An acceptance of the obligation to comply with the treatment, as defined by the specialists, is the major point of this interpretation. This aspect of the RTIP can also be found in the legislative interpretations called *help to self-help* (see *W2*, chapter 5.7.2.) The Directorate tends to define it as a basic principle of treatment, based on clinical norms.

#### 6.3.1.4. *The transparency of information*

The RTIP tends to be interpreted as having a transparency of information about the plan for treatment. These interpretations are in accordance with the legal goal of informed consent. The following statement illustrates it:

They get a checklist in which they can see exactly what the time schedule for them is. It (IP) states that we will examine them. The patients must know which condition we are going to treat them for. They must be able to check if we have done everything that we said we would. It says in an IP that we are going to have an appointment with them at the beginning. Then the examination part will take place as well as appointments with an occupational therapist, a physiotherapist, and a doctor. We create an IP for the treatment of each patient. After that, we give them feedback. When the patients have it on paper, they are able to control

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us. They are able to check if they have received everything they were entitled to...’ (Interview 1) (6.28)

Information about the treatment is seen as a control mechanism for the patients. The involvement of patients in the process of deciding upon these methods is not normally considered in these interpretations. The interpretation made in 6.28 suggests that clinicians define treatment for the patients as part of a team. As such, it may be regarded as being related to the norm of treatment based on clinical expertise. An alternative understanding may be associated with the norm of standardized treatment rather than on individually adjusted expertise.

#### *6.3.1.5. Information registered in the medical record*

Both of the next two interpretations focus on the information registered in the medical record but are opposite to each other with regard to how they regulate access to information and what they consider to be necessary to register. The interpretations of information that is necessary to register are based on discretion, as illustrated by the following:

So you are obliged to register relevant information and then I can say, “Well, this information I do not register because this is not really relevant.” Another specialist might say, “I will register it since I think that this is relevant,” about the exact same information. Then I can say, “Well, this is really stupid because patients may ask for a copy of the record and distribute this information, and

this can be... well, the information is sensitive but not really necessary to register in order to give patients the treatment they need.” So one should really think through what information is documented in the record... according to the law, only the information that is necessary for providing the treatment should be registered. Assuming that they could distribute the record on the Torgalmenningen because they cannot take care of it – right? Do you see what I mean? (Interview 1) (6.29),

The norms of discretion and the protection of patients overpower the legal goal of transparency and informed consent in this case. This interpretation represents two different points in the practice of leaders. The first one concerns protecting the patients from the registered information by documenting limited information. The second one is that leaders tend to adopt discretion-based interpretations in their practice, which is in line with the legislators’ interpretations as defined in §3-5 of APR.

A different interpretation was made in one of the interviews. It concerned making all the registered information available to the patients:

I always send a copy of a summary of the medical discharge to the patients’ home addresses. I do this... because it is a pedagogical document. I write there what I think about them. It does influence them. One of them got really angry once and came here afterwards and said that he never ever wanted to receive this information again. He was not interested in my opinion about him. I said, “That might be the case, but I will send it to you anyway. You don’t have to read it if you don’t want to; it is your right. But then at least you know that it has been

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written and that we have it here in the system... You cannot come back here and say that you did not get it.” (Interview 3) (6.30)

It may be concluded that leaders use registered information as a pedagogical tool to achieve changes in the patients’ behavior patterns, which can be interpreted as a way to follow the norm of compliance. This situation is in direct contrast to the legislator’s goal of not providing information against the patients’ expressed will (§3-2 of the APR). The interpretations in statements 6.29 and 6.30 are embedded in the clinical norms.

### **6.3.2 *The RTIP as a new way to practice compliance***

In this section, I focus on the interpretations made by nine specialists with much experience who currently occupied no leadership position. The content of the interpretations throughout the data material tends to be rather homogenous. Within this group of specialists, the perception of the RTIP is similar.

#### *6.3.2.1. A good clinical relationship based on the RTIP?*

Experienced clinicians have a tendency to assess the RTIP with regard to establishing a relationship with the patients. A trust-based relationship is perceived as a critical aspect of implementing the RTIP by most of the specialists in this group, as opposed to the other groups of practitioners discussed above. Establishing a good relationship is considered to be the first task for those who have contact with patients

and is the most important basis for establishing the trust-based application of treatment methods. If this basis is well-developed, the patients tend to be more eager to accept the treatment procedures that might not otherwise be preferred by them. It concerns treatment methods suggested by specialists that might not be considered optimal by some patients. Most of the specialists claim that treatment cannot be carried out if solid trust has not been established. This requirement suggests that a positive attitude on the part of the patients towards treatment procedures is seen as a precondition of treatment. It may be illustrated by the following: “The most important (in the first meeting with a patient) is to develop a relationship based on trust. You say, ‘Welcome!’ and make them feel secure,” (Interview 1) (6.31).

Any type of information that may have the potential to endanger a good relationship tends not to be given. Most clinicians include information about medications in this category:

If I know that the information about medications will cause a conflict with my patient, I would play the role of an ally... I would try to avoid introducing it and risking a conflict... I would do everything not to contaminate the relationship with my patient.” (Interview 2) (6.32)

The information that may be considered as a possible source of conflict tends not to be given in an established treatment relationship. The side effects of the medical treatment may serve as examples of such information.

Trust-based relations are used first of all in order to convince patients to apply the treatment defined as optimal and most effective by clinicians. The practitioners

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adopt those legislative regulations that emphasize compliance with the recommended treatment and accept responsibility for applying it (see A1, chapter 5.3).

We must have a good relationship... they must first of all know that I understand their objections. I have to show them that I understand their argument, that I understand their dilemmas. If I do it, then they are willing to accept that I actually say things to them that they would rather not hear. It is typical that I do recommend things that they do not want to get recommended. This is, for example, regarding the use of medications. They are here voluntarily and they must trust and rely on me to accept it... they must be able to see it from my point of view...' (Interview 3) (6.33)

In line with quotation 6.30, the experienced specialists tend to suggest treatment based on reliable judgment. A trust-based alliance may be seen as a tool to convince the patients to comply. It suggests that the strategies to get patients to agree to treatment are well established in practice. The clinical aim to achieve an improvement of health conditions as defined by the clinicians is prioritized in this case.

#### *6.3.2.2. Informed consent and clinical discretion*

The largest variations when assessing the RTIP concern the content of the information that the clinicians adjust individually to each patient. For example:

You always evaluate the situation and meet the patient where he is right now... Information has to be given when it is possible for a patient to take it... I usually

inform... What exactly I tell them varies... there is a little bit of information... I say that it costs 295 NOK, and that if they do not come, they will have to pay anyway.” (Interview 4) (6.34)

Some common tendencies among clinicians may, however, be noticed. Most of the experienced clinicians consider information about rights as being necessary to provide in case of coercive procedures:

In case of coercive treatment, I am obliged to tell them that they can complain on how this procedure is carried out... some of them might actually understand a little bit of what I say... but this is mainly just to show them respect... I also often tone it down for my own sake. You just do not want to increase the temperature... they could kill the ambulance driver or something afterwards... you want to keep them calm. (Interview 1) (6.35)

The statement above illustrates that when clinicians are not able to internalize the legal goals into the norm of compliance, they implement them in practice by following them, making minor adjustments to the situation of individual patients. Information on patients’ rights, even though provided, is seen as an obligation that is not accepted as appropriate for the context of treatment. The strongest example of providing information about the legal rights which is assessed as inappropriate in practice sounds as following:

I don’t know if you have seen the official letters the patients get from Helse Bergen (local health enterprise)? It goes like this, to translate it to my language: “You as... le, you have the right to medical help. That is why you will get an

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appointment scheduled at our DPC within the next three months. ‘Bye ‘bye, kind of.” I think that this official letter is terrible. They refer to many legal paragraphs, and this is just not friendly. No one understands these letters. There are many pages with all these rights: a right here and a right there. In reality, most of the people do not get any appointment at all. It is ridiculous, and it is just bad human treatment. I see no point in these letters, and I don’t send them out. I actually wonder if these letters are composed by some special kind of “plant species” that has some sort of bureaucratic sickness: “Human cr.p has gotten some rights and we unfortunately have the assignment of fulfilling them (the rights). We do not actually know if we have the time; therefore, if you don’t hear from us within three months, then you can complain to someone here or someone there.” I push it to the extreme but I just don’t want to work in this way. (Interview 4) (6.36)

Quotations 6.34-6.36 illustrate that even though discretion is a major mechanism applied when the practitioners decide which information to provide, there are some common tendencies. The clinical norms guide the discretionary evaluation of information in most of the cases except for the information about rights.

The interviews have furthermore shown that experienced clinicians have difficulty employing the language of the law directly in clinical practice, since it does not appear to be accepted within the scope of clinical norms:

When I was young, I wanted to discuss such things, I mean, with the judicial perspective at our work with my colleagues... Well, it was very much



interpreted as a personal critique, and I just learned to keep my mouth shut... I was told that we are not qualified to use the judicial jargon here... we are clinicians. We must avoid the use of this kind of language. It is just not legitimate for us to do it. I just learned that it is up to every clinician to evaluate... we are all ethically responsible, so one has to watch his mouth and keep such judicial language away from clinical practice... we are not lawyers, and it is just not legitimate to introduce this language into clinical practice. (Interview 5) (6.37)

The interpretation above shows that when the clinicians are socialized into clinical practice, the law is overpowered by the clinical norms. Thus, it may be suggested that the longer the experience, the more weight the norms bear in clinical action.

Information delivery is triggered by patient interest in acquiring information. Thus, the less often the patients ask for information, the less information they will get. Clinicians with much experience describe this as follows:

The patients are actually not interested in it (information) at all. They need to get (medical) help; that is important... They are not interested in that they have access to the medical record... I do not quote the rights, but I inform them if they want me to... if they ask for it. (Interview 4) (6.38)

This interpretation reflects the legal goal of self-information. According to the information above, it is the patients themselves who define the need for information and act accordingly. If they express that they need the information, the clinicians tend

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to respond to their questions. Information about rights contrasts with the understanding of the information delivered in a clinical context.

### 6.3.2.3. *The power of clinical integrity*

Many experienced clinicians incorporate the RTIP into defining the treatment along with their own clinical knowledge and discretion. This instance is usually followed by the expectation of the patients' compliance and may be illustrated by the following interpretation:

Today, people have this critical approach to everything... but no one can press me to do something, if it is not reliable. If it happened, well, then I could quit as a doctor... It might be that I am so authoritarian in my working style that people do not try to force anything upon me; I can be quite confident if I am certain that this is the right thing to do... The patients, of course, have the right to participation and information—but they have to trust me to do my job. They come here because they want my help... I tell them if you do this, you will get better. It is all based on trust here... It does not mean that they get what they want in treatment, but at least they have the right to say what they think, which is a critical and rather fundamental element. For us who work on the planet Earth—well, we think that this (the RTIP) is not really relevant for us. (Interview 5)

(6.39)

The above assessment may serve as an illustration of practitioners subjecting the legal goal of increasing the patients' influence on the clinical norms of discretion, reliability, and compliance. Treatment is based on clinical expertise. It seems that the RTIP influences the practice and leads to involuntary compliance with legal goals in the practice. At the same time, in their assessments of *de facto* practice, the clinicians may be willing to make space for the patients to express their point of view.

The practitioners adopt both precise and vague regulations directly in practice if they are not in conflict with the established clinical norms. This tendency may be illustrated by the following example, which emphasizes the importance of reliability in treatment, which is common for all experienced clinicians:

This is an example of a law formulation that is completely idiotic; they cannot choose (treatment method). The way we practice it is that if we are cool and nice, we can tell them, "Okay, you can be allowed to say no to ECT and say yes to other things." But it is my right not to agree to what they want... The patients might say "I will not use medicines," and then I make a decision if I can take responsibility for a treatment method that will not include medicines. I must judge it based on my theoretical background and national recommendations... and then, if there are other methods that could be as good as ECT... (Interview 6) (6.40)

Clinicians are influenced by the RTIP and evaluate the patients' preferences if they are within the scope of reliability.

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Many of the experienced practitioners tend to follow vague legislative regulations, which do not contradict practice, and define the treatment in the way they had always done, based on their own discretion and clinical knowledge:

I do not know how it is formulated in the law. It is not something that I have an active relation to in my clinical work... I have not really been interested in it since I think that it is important that a professional has a strong opinion about what it is that the patient should do and clearly expresses it... I don't think that others know more than that the patient must be involved and that there must be user participation... when one is depressed, then it is not so easy to sit here and make conscious choices among treatments. You need someone who will tell you to go to bed at 9 p.m. and get up at 7:00 a.m., eat your breakfast, and come here tomorrow at 10:00 a.m. This is what they need rather than, "Do you want to have this or maybe that, because you can choose?" (Interview 4) (6.41)

The Directorate also tends to be very specific with regard to reliability throughout A1. On this point, it demands that clinicians always make decisions regarding treatment (chapter 5.3). This is an example of a precise recommendation known and recognized by the clinicians in practice.

#### *6.3.2.4. Informed consent and information about side effects*

Similar mechanisms as those that follow vague legislative regulations, which do not contradict clinical norms, are employed in cases when experienced clinicians

provide information about the side effects of a treatment. It seems to be used as a strategy to gain the patients' agreement to treatment. It tends to be practiced by many clinicians and may be represented by the following quotation:

I would never list side effects. I must take the responsibility for what I think is the right thing to do. I have to control the patient for side effects, but I cannot list them up... I know that some facilities would have tendencies like that. I think that this is something that you can just simply forget about... it is not realistic at all. You have to convince the patient that it is reasonable to follow your advice... this is what you have to do... This is what they get from me. If they do not like it, they can choose another specialist. (Interview 5) (6.42)

The assessment above may illustrate the tendency to incorporate the goal of informed consent into compliance-based discretionary evaluations in treatment. Legislative regulations concerning side effects, as specified by the Directorate on its internet portal (W2), encourages discretion-based practices. Strategies of information provision in treatment are a well-established tool for achieving compliance in practice.

#### *6.3.2.5. Motivating to self-responsibility*

Assessments of the regulations focusing on patients' self-responsibility tend to be associated with the process of motivating the patients to accept treatment. It may also be seen as another way of manipulating the patient to comply:

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We have to work to motivate patients... I always start very carefully. It happens that during the first stay [of the patient at the treatment institution], we work only with motivation. I tell them, "If you were my sister, my daughter, or my mother, I would absolutely recommend you to try this medication... what do you think?" And then they very often agree to do it. (Interview 6) (6.43)

Motivation is understood as the next stage after building up an alliance and trust. Using trust, the specialist manipulates the patients to accept particular aspects of treatment, especially medications, by withholding information about the risks and convincing the patient to comply. The clinicians tend to speak on behalf of the patient's family members to make the patients believe that they (the clinicians) are making decisions based on the patients' best interests.

Another strategy to convince patients to comply is to provide them with information about the positive effects of treatment only, as follows:

...They (the patients – A.S.) are motivated by the doctor and the psychologist to use medications... They are also informed about how the medications work... the most important is to inform about the advantages of using medications. (Interview 7) (6.44).

In most of the interpretations, patients' acceptance of the application of treatment is seen as a pre-condition of health help. Examples of it are as follows:

The patients must take responsibility for their own treatment... we make them aware of that... They must contribute to the treatment by following the

assignments they get from us. There are so many people who think that we have a magical way to make them healthy, but this is not the case. It doesn't function like that in psychiatry. (Interview 7)

The patient does the entire work of following treatment... Our job is to make them see themselves as responsible actors... They sign the plan... it is always the patient's name that comes first... which means they are responsible for following the treatment. (Interview 8) (6.45)

I must make it clear to the patient... if you do not want to follow the treatment that I think is the one you need, I cannot offer you any treatment at all. I must reject their referral for treatment, unless they are extremely sick and depressed. (Interview 9) (6.46)

The expectation of the patients' active approach to take responsibility and follow the treatment as defined by the specialists is in accordance with the legislative regulations of self-responsibility. Experienced clinicians seem to incorporate self-determination into the different versions of the norm of compliance. They recommend certain methods and tend to expect the patients to contribute to the process of recovery. Furthermore, these expectations tend to be registered as the goals for the treatment are accepted by the patients.

Legislative regulations that allow practices based on norms are preferred. The legislative regulations that contradict the norm-based practice influence the practice as well, but in a different way. They appear to be adhered to when patients cannot avoid

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it but not accepted voluntarily by the clinicians, as is the case with, for example, providing the information about rights in advance of treatment.

## **6.4 Data analysis**

### ***6.4.1 Introduction to the analysis of the interview data***

The interview material presented above illustrates the differences between the assessments made by the clinicians. In most cases, the interviews with the experienced practitioners revealed that self-determination and informed consent tend to be institutionalized into compliance in various ways. Institutionalization of the regulations into the norms tends to dominate the assessments made by the experienced practitioners. The variations in the assessments concern mainly the matter of matching the norm of compliance to different stages of treatment. Three stages were found relevant in their assessments of the RTIP: trust building, motivating or convincing the patient, and transferring the responsibility for applying the treatment. In most cases, clinical norms overpower legal goals, which then become integrated into established ways of thinking.

As in the practice of the experienced clinicians, the assessments made by the inexperienced specialists working on their own included a combination of the legal goals and clinical norms; the difference was that in their case, the legal goals tended to dominate. They literally implement the legal goals of self-determination and informed consent. The transparency of information and the possibility to choose the method of treatment are seen by them as important aspects of the recovery process. These



assessments of the RTIP suggest that the legal goals become an integral part of treatment strategies. Inexperienced clinicians who work in teams tend to institutionalize the legal goals into the norm of compliance, similarly to the experienced specialists. In this case, however, the legal goals were often assessed as important legal standards and seen as necessary to follow in practice. This process, according to the clinicians, ensures the legitimacy of practice.

Clinicians tend to reject or accept the legislative regulations depending on whether they perceive them as normatively appropriate or not. The explanatory factors that are likely important in this case are the clinicians' experience and education. This chapter also shows that precise rules bind clinical practice stronger than vague ones. This issue may also be related to the clinicians' experience or education. The arguments above suggest the support for the main hypothesis that proposed stability of unified clinical practice. There seem to be common norms that can to some extent unify clinical action. The other hypothesis that presupposed variations in clinical practice embedded in experience seems to be supported as well. Differences in the amount of experience seem to lead to differences in the outcomes of regulation through the RTIP. Furthermore, this study suggests that the regulations through the RTIP do not lead to differences in the assessments made by the professional groups of psychologists and psychiatrists, as had been expected. In the following section the variations embedded in experience are discussed.

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## **6.4.2 Legal goals and clinical norms in clinical practice**

### *6.4.2.1. Literal adherence to the legal goals*

When analyzing the influence of goals and norms on practice, the main point is to identify how clinicians assess their practice of co-determination in relation to the legal goals of informed consent and self-determination. The context of clinical practice tends to be regarded by practitioners as both well-known in general and as rather unpredictable with regard to individual cases, especially by newly educated practitioners. Inexperienced practitioners tend to assess informed consent and self-determination against the theoretical and scientific knowledge they have obtained through education. Clear and more or less unclear situations call for different choices of regulations. When the situation is new to the practitioners, their assessments tend to vary more. This could suggest that the situation at hand can play an important role when clinical reasoning takes place. A lack of experience can lead clinicians to follow either the leadership of the experienced colleagues or, if they work on their own, precisely defined legal goals that diminish the need for discretionary evaluations. It can suggest that clinical reasoning can be to some extent steered and in a way also enabled through the process of establishing local standards for treatment practices.

Compliance with legal goals can provide inexperienced specialists with a feeling of reliable practice. Thus, the legal goals become the major aspect that structures the clinical discretion of newly educated clinicians working on their own. Their interpretations are characterized by little flexibility, which is demonstrated by the low degree of acceptance of traditional norms in their assessments. These assessments are therefore considered to be close to the subject perspective.

Quotation 6.17 offers an example of a different type of rigidity among inexperienced clinicians. They tend to follow procedures that aim at the standardization of clinical treatment directly. These procedures often give little consideration to individual adjustments of treatment. The ultimate goal in this case is to provide the same treatment service to all patients.

As illustrated by quotation 6.21, inexperienced clinicians who work on their own often implement the legal goals of self-determination and informed consent precisely as they are defined by the legislators. Quotation 6.18 suggests a tendency to institutionalize the assessments close to the subject perspective. In this case, self-determination becomes an integral part of the clinical way of thinking. Another example of it concerns the information about rights. It is assessed as the basis for alliance building and is an important background for information delivery and self-determination in treatment.

Explicit knowledge of the legal regulations in practice is illustrated by quotation 6.16. This example may offer an explanation of why inexperienced clinicians who work on their own tend to hold closer to the subject perspective in their assessments.

Institutionalizing the legal goals in clinical practice literally, as done by inexperienced practitioners who work independently, is a clear case of the legislators' influence upon the clinical practice.

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*6.4.2.2. Withholding information and the legal goal of increased information*

The interviews with the experienced practitioners illustrated that the provision of information tends to be adjusted with regard to previously encountered situations. First of all, the experience and the legislative regulations are based on norms that create a set of tools applied by experienced clinicians. As one outcome, experienced clinicians (together with inexperienced ones who work with them) have a tendency not to provide information about the possible risks of treatment. This trend suggests assessments close to a subject anomaly perspective. The patients seem to receive information based on a compliance strategy called “motivation to treatment.” The interviews suggest that experience, as well as individual thought and judgment, could be seen as a source of variations in the assessments of the practice of informing the patients.

Clinical practice typically allows space for accepting a variety of different assessments. This can be regarded as a strategy chosen to handle the inconsistency of legislative regulations. Interpretations given by the leaders represent the strongest example of incorporating both legal goals and clinical norms simultaneously which, in some cases, leads to inconsistent understandings within the scope of the same statements (see quotations 6.22–6.24).

In norm-based interpretations, a provision for legal information regarding patients’ rights is enforced in some cases (see quotation 6.35). Furthermore, clinicians could protect patients from the registered information about their health conditions in two ways: scarce registration and rejecting patients’ requests to access it. In general, the danger of revealing “too much” of the information about the patient directly to the

patient is perceived as a possible factor that could lead to endangering the clinical goal of recovery (quotation 6.29).

This logic illuminates the institutionalization of informed consent into the professional norm of protection. There are some exceptions from the main tendency, which suggest that clinicians may have a more flexible approach and allow access to information regarding the patients' health condition and recommended treatment. The provision of these two types of information can represent compliance with the legal goal of informed consent as well as the traditional practice of information delivery.

The rigidity in practice based on norms could be exemplified by providing access to information when patients explicitly ask to avoid being given this information (quotation 6.30). Thus, in cases where information is assessed as a tool in treatment, it tends to be used by experienced specialists without considering patients' wishes. It can suggest manipulating the information in order to achieve patient compliance. Incorporating information process into the clinical norms of protection and discretion suggests that experience and established ways of thinking are the primary drivers of clinical action in this case.

The arguments presented in the two sections above suggest that the following hypotheses developed in chapter 3 have been confirmed: *Experience is a source of knowledge that could to some extent explain variations in professional action in clinical practice.*

Furthermore, the following hypothesis seems to have been confirmed to some extent as well: *Precise regulations leaving practitioners little chance to re-define them*

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*in practice*. This is discussed in the following section.

#### *6.4.2.3. Self-responsibility and the norm of compliance*

One of the main tendencies found in the assessments made by the experienced clinicians is that the concept of self-responsibility is associated with different aspects of compliance, thus leaning towards a subject anomaly perspective in treatment (see section 6.3.2.5). The main trend is to focus on convincing patients to take responsibility for the application of treatment that the specialists recommend. This practice may be seen as contradicting to some extent the legal goal of self-determination, seen as establishing an equal decision relationship between the specialists and their patients. Such assessments reinforce the traditional compliance-based practice. For experienced clinicians, clinical norms tend to be the stronger drivers for clinical action than legal goals.

The legal goal of self-responsibility also tends to structure the clinical discretion of inexperienced clinicians who work as part of a team. This behavior is especially clear when the development of an IP in clinical practice is assessed. Clinicians tend to incorporate various aspects of the Directorate's goal of self-responsibility into the norm of compliance. This is illustrated by quotations 6.13–6.15. In clinical practice, self-responsibility may be understood as, for example, expecting the patients to comply with a particular treatment methodology. In this case, it requires the clinicians to motivate the patients to accept the methodology. One of the strategies of such motivation is to allow the patients to define the goals for the treatment. In this way,

self-determination in practice becomes the means to achieve compliance. Clinicians tend to be inflexible about this in their assessments, emphasizing that this method of interpreting the RTIP is in accordance with the Directorate's interpretations. Co-determination is therefore close to a subject anomaly perspective in these cases (see quotation 6.45).

The concept of *help to self-help*, which was developed by the Directorate, tends to be applied directly in the practice of compliance. It is noteworthy that the specialists are familiar with such expressions as *help to self-help*, which are used by the Directorate in the guidelines. This concept is usually applied by the practitioners during the development of an IP. Most clinicians then associate *help to self-help* with motivating patients to comply with a reliable treatment (see quotation 6.13). Self-responsibility has also been related to the Directorate's concept of self-mastering. It is understood as a mobilization of the patients' own resources to achieve compliance (see quotation 6.14).

It may be suggested that some of the concepts developed in the guidelines that seem to be easily applied to the existing norms, can be directly followed in the clinical practice.

#### *6.4.2.4. Alliance building and the legal goal of increased information*

One of the main strategies that clinicians have developed within the logic of clinical action is the clinical procedure of alliance building (see the data presented in

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section 6.3.2.1). This method tends to be achieved first of all through withholding particular types of information that could undermine compliance (e.g., limiting the available information about patients' rights (see quotation 6.35). This type of information tends to be seen as endangering the patients' trust in treatment and tends not to be provided.

Establishing a good relationship with the patient is strongly connected to achieving patient compliance. Patients' trust tends to be the means to a manipulation strategy to convince the patients to apply a particular treatment. The practitioners tend to state that trust is necessary to achieve a good outcome in treatment (quotation 6.31).

Inexperienced clinicians assess information delivery based on their goal to develop an alliance with their patients differently. They have a tendency to build trust based on the transparency of all the available information (see quotation 6.21). This suggests that both the experienced and the inexperienced specialists have different strategies intended to achieve the same goal of establishing an alliance. In both cases, trying to build an alliance, which may make it easier for the patients to accept treatment (quotations 6.32; 6.33).

Experienced clinicians have a tendency to focus on information that concerns the best methods embedded in experience (see quotations 6.39, 6.41). The strategy of manipulating information suggests that the clinicians focus on positive information about reliable methods when seeking the patients' compliance. Inexperienced specialists tend to include the criterion of practical availability that can be seen as "you get what we have to offer," (see quotations 6.8, 6.9). Inexperienced clinicians have a



tendency to accept suggestions from the patients concerning treatment (see quotations 6.1 or 6.4).

The variations described above may be seen as the main outcome of regulation through the RTIP. There is a close relationship between the legislative regulations and clinical action. Clinicians tend to incorporate the guidelines into the clinical action based on both clinical norms and legal goals. Legal goals tend to either be followed directly or incorporated into clinical norms.

#### *6.4.2.5. Combining the legal goals and the clinical norms – the practice of the leaders*

The leaders interviewed in this study are clinical practitioners as well. Contrary to their experienced colleagues who do not currently hold leadership positions, most of the time leaders tend to directly adopt the legislative regulations based on legal goals as appropriate in clinical action. Thus, they tend to be familiar with the exact wording of the law concerning the RTIP and consider it appropriate to define their practice accordingly. They also choose to follow these guidelines for clinical practice, which support a subject perspective. The leaders encourage the expansion of the patients' insight into treatment, as well as their influence on it. This suggests that the patients may choose the method of treatment whenever possible, and that should be kept informed about their health conditions and treatment options. The patients are provided with a good understanding of the content of available health care services. They are thus made aware of the premises for the treatment and can make a conscious decision about accepting the offer. This interpretation suggests, in line with the hypothesis

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developed in chapter 3 that the leaders may align clinical actions with the organizational strategies to a larger degree than other professionals.

Leaders also tend to admit and accept that the practices of experienced clinicians may differ from the ones encouraged by the RTIP. In some cases, when leaders assess their own clinical practice, they also lean towards subject anomaly perspective. It is therefore reasonable to conclude that they accept practices embedded in both legal goals and clinical norms. It could be therefore concluded that leaders may to some extent buffer an external influence on clinical practice (decoupled organization structure).

The leaders are thus the only group that assesses practice in such a way that it is difficult to conclude whether the legal goals or the clinical norms dominate the assessments. Within the same group, most of the interpretations are based on the combination of legal goals and clinical norms. This is particularly true with regard to self-determination in treatment (see 6.25, 6.26). This might be explained by the fact that the leaders have it among their major tasks to limit the differences between *de facto* practice and regulations (see quotation 6.19). It may be seen in line with the assumption that the hierarchy could furnish organizational members with a guide for actions (see chapter 3.7.)

#### *6.4.2.6. Discretion structured by clinical norms*

The legal goals are to some extent institutionalized into clinical norms, as illustrated by quotations 6.8 or 6.9. The regulations embedded in the legal goals tend then to be seen by the practitioners as being imposed upon clinical practice, as shown

by quotation 6.19, suggesting that the legal goals are political and detached from clinical reality. They become empty descriptions of ideas not institutionalized in practice. Illustrations of this point may be found among experienced clinicians as well as inexperienced ones (see, for example, 6.36). This may explain why they often choose the practically available treatment methods rather than adjust them to the patients' preferences. In this rather practical approach, the possibility to influence the choice of methods is rather limited. These assessments are characterized by little space for individual adjustments. A clinical meeting with the patients is carried out in a rather different way than the one encouraged by the legal goals. This line of interpretations suggests that norm-based practice allows the patients' only a small degree of influence on the choice of methods.

Some of the interpretations (made by inexperienced practitioners) go even further and show that if the patients do not accept what they are offered, they will get no treatment offers at all (see quotation 6.10). Experienced clinicians may be much more flexible on this point, especially if the patients are interested in some specific treatment methods (see, for example, 6.23). This example shows that more experience does not necessarily suggest more rigidity in clinical practice.

In case of information delivery, the space for discretion is structured through vague interpretations found in the Directorate's recommendations, allowing a norm-based approach. Clinicians tend to assess information delivery using a discretion-based process. This method leads to a variety of practices ranging from withholding information to providing it against the patients' will. It may suggest that vague regulations leave practitioners large possibility to re-define them in practice.

The information that is provided is limited to the description of the treatment that is considered to be the easiest to provide practically, which is not necessarily the best treatment for the patients' particular diagnosis. Thus, practical availability is more important than the reliability principle (see quotation 6.23). This line of interpretations suggests that practical considerations may overpower the reliability of treatment as well as the patients' preferences. Specialists tend to incorporate informed consent into the norm of compliance by providing only information regarding the available methods.

Clinical discretion is structured both through the vaguely defined legal goals, such as the goal of expansion of information, as well as through the clinical norms, such as the norm of compliance (see quotation 6.30). This interpretation is different from all the other interpretations, since the information is provided against the patients' will.

Clinicians want to motivate patients to agree to treatment using information delivery. In this case, individual considerations are not encouraged in practice. This approach to information is very different from the one suggested by the inexperienced clinicians working in a team (see section 6.4.2.7.)

#### *6.4.2.7. The legal goal of more extensive information*

The discretionary evaluations of inexperienced specialists working in a team tend to be structured using vague legislative regulations so that clinicians have the freedom to decide which information to provide and how. As in the case above (section

6.4.2.6.), the clinical norm of compliance drives the action when information is delivered. It takes place, however, in a very different way. Clinicians are not flexible when the patients ask for access to information. The information registered in the record tends to be regarded as having the potential of endangering compliance with treatment (see, for example, quotation 6.20). It may suggest that the organization of work can guide the actions.

The interpretations of the experienced clinicians seem to be much more flexible in this matter. Their discretion tends to be structured in a similar way (see quotation 6.29), but not in all cases share this structure. Some clinicians give the patients the opportunity to get access to the information, especially in cases when the patients specifically ask for it (e.g. quotation 6.38). In this case, the legal goal of expanded information can be seen to be subjected to the clinical norms in a more flexible way. Withholding information is rather perceived in this case as a possible way to motivate the patients to compliance in treatment (6.39). These interpretations tend to be a matter of discretion in each case. Not revealing particular premises for the treatment makes it difficult for the patients to influence the choice of it.

Work in teams usually results in interpretations made by inexperienced clinicians that are norm-based and quite rigid. It becomes most clear in those interpretations where co-determination may suggest the increasing clinical power in decisions (e.g. quotation 6.9.). Withholding relevant information may lead to a decrease in the patients' abilities to self-determine and give informed consent to treatment.

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Inexperienced clinicians who did not work as a team focus first of all on providing patients with all the information that is in accordance with the legislator's goals of increasing the patients' possibilities to influence the treatment. These interpretations also agree with precise legislative regulations, which include information about rights, possibilities of treatment, its advantages or disadvantages, and health condition. Thus, these practitioners comply in practice with the legislative regulations that are precise and embedded in the legal goals, as illustrated by quotation 6.21.

Co-determination may be seen in this case as providing all the information about treatment and giving the patients the chance to define their own treatment according to their preferences based on the information that they have received. Practitioners allow the patients a choice of treatment, which suggests assessments close to subject perspective. One explanation might be that reliable treatment has been redefined as a treatment that is mainly based on patients' preferences.

#### **6.4.3 *The flexibility of clinical practice***

Clinical practice is flexible in adjusting to the guidelines, which are manifested by the numerous variations found in the assessments. The question posed at the beginning of this chapter concerned the variations in the way the guidelines structure clinical discretion. As discussed above, discretion is the most important mechanism driving clinical action. The way the regulations are matched to the choice of treatment methodology is individually adjusted to the patients and cannot be always the same.

The space for discretion given by the regulations and institutionalized in clinical practice allows for flexibility when the regulations are assessed with regard to a concrete treatment situation. Such flexibility contributes to variations in the individual assessments made by clinicians in general.

At the same time, similar patterns are found among certain groups of clinicians. This may be related to the area of co-determination. Both information delivery and the way to involve the patients in treatment are to some extent standardized by the organization of work in teams and through standard treatment methods.

Cases of clinical reasoning being steered through the process of establishing local standards for treatment, i.e. by the structures and established practices within the scope of specific organizations or teams (local rationality) have not been found in this work. It is rather team- or individual organization of work in general that seems to affect the outcomes of regulation through the RTIP.

Furthermore, the interview data suggest that the observed variations in the assessments of the regulations could hinder the reliability of clinical practice when patients' preferences are considered to be more important. This is particularly true when the reliability-based treatment choice is not compatible with the one suggested by the patients.

The legal goals may in some instances be an integral element of clinical evaluations. However, most of the time, clinical norms dominate the legal goals. Thus, the legal goals are recognized and accepted as guidance but do not dominate the practice. Nevertheless, a continuous re-interpretation of both clinical norms and legal

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goals is an integral aspect of clinical practice leading to what can be seen as local forms of juridification, i.e. accepted in practice assessments of the regulations.

The newly educated specialists who work on their own have a tendency to institutionalize the legal goals that are filled with precise content. This is true particularly when questions concerning self-determination in treatment are evaluated. The expected outcome of following legal goals is that the patients may choose which methodology they prefer in treatment. Furthermore, in some cases, clinicians may recommend treatment methods based on the criterion of reliability, but only if the patients ask for a recommendation.

Patients' self-determination in treatment could also be seen as a strategy to achieve compliance with treatment. Even though the patients have a fair amount of influence on the treatment, clinical reasoning follows the logic of providing a treatment that is effective. However, "effective" is here assessed as not merely acceptable to but also clearly preferred by the patients. These assessments therefore suggest that clinical discretion is strongly structured through precise interpretations embedded in legal goals. Inexperienced specialists who work on their own do not have a readily available team of experienced clinicians with which to discuss treatment strategies, which may make them more preconditioned to apply the theoretical knowledge obtained during their education in their discretionary evaluations. This tendency also may explain their unwillingness to accept the interpretations of the RTIP alternative to those embedded in the legal goals.



The specialists who work on teams tended to emphasize that legal goals are detached from the clinical reality (see 6.9). In this way, clinical discretion tends to be structured through the clinical norms, so that the patients' possibility to influence the choice of treatment is limited and is driven by compliance with the one treatment method chosen by the doctor. The possibilities to achieve informed consent of individual patients may also be seen to be embedded in compliance, since the information regarding other treatment possibilities is withheld.

In general, the practices of inexperienced clinicians are described by different kinds of assessments due to various perceptions: for example, who (the patient or the specialist) decides upon the most reliable choice of treatment methods. The assessments of reliable methods vary as well.

The variety of interpretations within clinical practice may be seen as a mechanism of adjustment to the corresponding differences existing in legislative regulations. Based upon the interview data, many examples suggest that when a large variety of legal regulations exist, specialists look to education and experience as the sources of their assessments. This fact may be one of the reasons for the variations found in the assessments.

There are, however, also cases when the clinical interpretations of inexperienced specialists go beyond the Directorate's definitions. For example, when choosing a treatment, the criterion of reliability seems to be of less importance than the patients' preferences because the reliability of treatment is considered to be of lesser importance than the patients' preferences when the clinicians assess their practices (see 6.2). In

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such cases, juridification does not take place at all, since it is neither within the scope of legal goals nor clinical norms to influence the reliability of treatment when co-determination is occurring. This situation may be suggested to be a case of no juridification at all and is the example of juridification not occurring in practice, which may be seen as theoretically possible.

Regulation through the RTIP thus has different implications for clinical practice. One implication is an increase in the flexibility of regulations, which seems to make a diversity of interpretations in clinical practice possible. This flexibility is far greater than what might be expected based on the theoretical assumption that clinical norms could unify the practice. Such flexibility of legislative regulations enables practitioners to adjust to changes in legislation; this adjustment of practice to society's desire to create a more egalitarian relationship in clinical practice is currently taking place, although signs of thinking patterns that are embedded in clinical norms, autonomy, and discretion still dominate clinical practice.

## **6.5 The influence of the legislative regulations on clinical action**

The interview data show that both the legal goals and the clinical norms may be perceived as conducive to clinical practice, which leads to a variety of interpretations within the same group of clinicians. Most of the interpretations seem to be embedded both in legal goals and in norms, and one of these has a tendency to be dominant. An exception has been found in the case of leaders that may follow both the clinical norms and the legal goals (see 6.22). The assessments of other experienced clinicians most

often represent the dominance of the clinical norms, while those of inexperienced clinicians illustrate the stronger dominance of the legal goals. It may suggest support for the main hypothesis within the professional dimension, i.e. that clinical practice may have common characteristics institutionalized in the clinical norms for practice. Thus, professional norms in the field of psychiatry may be viewed as contributing to the stability and unification of practices.

The pattern found in the interview data differs from the one in the legislative guidelines, where the influence from the clinical norms and legal goals often take place at the same time, but the hierarchy relationship between them cannot be established.

A variety of concepts describing self-determination, which was introduced by the Directorate, has been institutionalized directly into the practice of experienced practitioners. These concepts of *self-responsibility*, *self-motivation*, and *help to self-help* can in practice be seen as assessed within the scope of the norm of compliance because the concepts of patient responsibility and motivation have been used by the practitioners in relation to compliance with treatment in clinical practice. *Help to self-help* is understood as giving advice about how to apply the best treatment in the most effective way, which may suggest that the concept of *help to self-help* is easily incorporated into the norm of compliance.

An initial assumption in this work has been that the less specific the legislative regulations for the choice of treatment, the stronger the process of reasoning based on discretion. Furthermore, it has been assumed in this study that the strength of the wording in the regulations establishing the RTIP may influence clinical practice. Weak

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wording was assumed to allow deviation from the main principle in practice to a larger extent than the strong ones.

Data from the interviews show that discretion is the main mechanism and is independent of the content and forms of the regulations that structure it. As discussed in chapter 5, the Directorate also leaves clinicians plenty of room for discretion in the case of precise interpretations. Furthermore, variations in the understanding of the RTIP with regard to the guidelines and the clinicians' autonomy to choose among them strengthen these practices based on discretion. There are no examples in the data material that could suggest variations in the outcomes of weak and strong wording of the legislative regulations. The clinical norms tend to be largely at work in clinical practice. In particular, the norm of compliance is critical for the assessments of clinical action. It is also applied in combination with other norms, such as the norm of reliability of treatment. This primarily concerns the experienced clinicians and those who work as part of a team. Clinicians who work on their own seem to regard the goal of compliance as the most important one in treatment. It suggests support for the hypothesis about members of teams institutionalizing the RTIP in a different way than the specialists working on their own.

The way these clinicians achieve this goal differs, however, from the other groups of specialists. Their logic is that focusing on the patients' preferences is a good strategy to achieve compliance. Therefore, even though the clinical goals are the same for all the groups, the inexperienced clinicians implement the legal goals of self-determination and informed consent directly in order to achieve compliance. Experienced specialists and those who work on a team both apply manipulation

strategies with regard to information, as well as convince the patients using their trust. In this process, legal goals are incorporated as a means to achieve the desired clinical outcomes. Thus, experience is a source of knowledge that could to some extent explain variations in professional action in clinical practice.

Even though legal goals are rather vague and general, in many cases they can lead to largely precise assessments of clinical action. Most of the clinicians are able to decide if and how they choose to relate to them in practice. The interpretations made by the leaders and the inexperienced clinicians who work on their own suggest a direct incorporation of the legal goals into everyday treatment. Thus, they allow practices that are based on the logic of expanded possibilities to self-determine and increased information in treatment.

An interesting way to practice these regulations is by transferring the responsibility for making decisions regarding treatment to the patients to some degree. In this case, practitioners make different assessments with informed consent being a precondition for the patients' decisions. Allowing the patients to take responsibility for making all the decisions is called a consultant form of treatment (see 6.23). This interpretation assumes, as a precondition for the treatment, the patients' ability and willingness to decide on and take responsibility for treatment.

Transferring the responsibility for treatment decisions to the patients may be regarded as a new way to understand self-determination, which could influence the reliability of treatment. Using this method, leaders can reduce the possibility of compliance-based practice with regard to their practices but still retain it in practices

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of other clinicians. It can be therefore concluded that hierarchy matters for the outcomes of the regulations through the RTIP. The leaders may align clinical actions with the organizational strategies to a larger degree than other professionals. They may buffer an external influence on clinical practice and in this way support existence of the practices based on clinical norms and the legal goals.

This suggests that the leaders allow flexibility of interpretations. A similar degree of flexibility was also found in the practice of other experienced clinicians and may be illustrated by the internalization of various interpretations with regard to informing patients about the side effects of treatments (6.42). This action illustrates discretion of interpretations as well as flexibility of existing practices.

It is noteworthy that the regulations institutionalize the reliability and compliance of treatment as one of their major goals. Most of the time, the Directorate's guidelines are based upon traditional clinical norms. Therefore, any possible friction between practice and legislative regulations may to some degree be avoided through the process of regulation.

Thus, the practitioners accept various understandings found in the legislative regulations, which suggests that the one-thousand-year-old clinical practice is characterized by a large degree of flexibility. The methods used to organize clinical work are an important factor influencing the practice of legislative regulations.

Furthermore, free choice among legislative regulations in clinical action makes the relationship between those two indeterminate. The more interpretations exist, the more possibilities there are to follow those that are most convenient. Clinical norms

have become an integral part of the legislative regulations that structure the clinical practice of clinicians. As we have seen, clinical norms that are internal within the clinical practice may also be interpreted differently and lead to a separate course of action.

It is not only inexperienced clinicians but also the experienced ones who integrate the new regulations embedded into the legal goals into their practice. It is even more interesting that the same experienced clinicians who act based on reliability and compliance are willing to conform to information types defined by the legislators. This action suggests a new balance between legislative regulations and clinical practices that does not seem to diminish but instead restructures the space for discretion-based implementation of the regulations.

The aspect of treatment in which information transparency still seems to be closer to the traditional authority-based practices concerns the information about treatment methods. Some types of information follow this tendency more closely than others. For example, in many cases, clinicians may not inform patients about side effects, while information regarding recommended treatment method tends to be given. These tendencies suggest that the discretionary space should also be restructured in the case of experience-based, well-established practices.

The results presented in this chapter suggest that the assessments of *de facto* practices of co-determination may differ substantially from what is formally prescribed for the components involved in the process of treatment. Therefore, one needs to study the actual, and even the perceived, forms of co-determination to understand the effects

of the regulations on clinical action. Even then, many other mutually affecting, intervening factors may come into play, like leadership and organizational structure, the nature of the task at hand, the presence of clear rules, etc. A major challenge for empirical research is to systematically study the interplay of these intervening factors upon which the performance of practices is contingent.

This study does not seem to provide data that could support the assumptions about the differences between the professional groups. It has been anticipated that the psychiatrists and the psychologists may engage in emphasising the differences between them. The differences between professions do not seem to influence the outcome of the regulation through the RTIP. Similarly, the anticipation concerning variations being the outcome of the local standards for treatment or specific organizations called local rationality cannot be supported by the data presented in this work. The differences between different teams and DPCs do not seem to influence the outcomes of the regulations through the RTIP in this work.





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## 7. Implications of the RTIP for professional practice

### 7.1 Introduction

The following research questions were posed in this study:

1. How is the content of the RTIP interpreted by the Directorate of Health? What are the characteristics of these interpretations?
2. How do the legislative regulations (the RTIP and the Directorate's guidelines) influence the assessments of the RTIP and clinical action made by the clinicians?

In order to answer these questions, I have analyzed the following:

- Legislative regulations (chapter 5);
- Clinicians' assessments of *de facto* practice and of the legislative regulations (chapter 6);
- The relationship between the legislative regulations and the clinicians' assessments (chapter 6).

In this chapter, the goal is to synthesize the findings and analysis of the current study in order to offer some final conclusions. The extent of the influence that the legislative regulations may have on the clinical practice is discussed. The answers to the research questions are given in the light of the theoretical framework of the institutional approach and the results of the analysis. I first summarize the general assumptions of the institutional theory and, within its scope, the chosen legislative, organizational and professional dimensions of the analysis. The precise/vague and

strong/weak legislative regulations are called the legal dimension. The professional norms, experience and profession are called professional dimension and the organization of work, local rationality and hierarchy are called the organizational dimension. Each dimension is presented separately and the hypotheses related to each of them are discussed.

The next step is to introduce the analytical constellations that represent combinations of the three dimensions. A further goal is to discuss how the constellations might contribute to explaining the findings in this work.

Furthermore, the analysis presented in chapter 5 seems to demonstrate that ambiguity is inherent to the legislative regulations. Answering the research question about how the ambiguous guidelines may influence the clinical work of professionals I discuss the findings of this work against the conclusions in the other scholarly works on the outcomes of juridification. Applying the general framework of the institutional theory, the goal is to explore how the ambiguous regulations could influence clinical discretion. Clinicians may face a variety of possible treatment situations and their choices among action alternatives could likely be influenced by different factors.

Finally, the aim of this chapter is to take a step aside from the results of this study by means of asking the question about the power of discretion in clinical practice. The most pessimistic scenario from the legislator's point of view is then proposed based on the results of this work. Could clinical discretion and the best practice at all be regulated? This question is suggested for further scholarly endeavors.

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## **7.2 The three dimensions of the analysis and clinical action**

Within the general approach of institutional theory, I chose to focus on three particular dimensions that are relevant within the context of this study, the legislative one, the organizational one and the professional one, and their explanatory power with regard to clinical action. The legislative dimension comprises the legislative regulations, the organizational one includes the hierarchy and the organization of work, while the professional one covers clinical experience, profession and general clinical norms.

### ***7.2.1 The characteristics and the content of the legislative regulations***

The RTIP is a legally binding framework for clinical action that belongs to the category of procedural health rights. The Directorate has expanded the content and developed more extensive understanding of the RTIP in the guidelines for clinical practice.

The most general assumption made in this work is that the legislative regulations may influence clinical action. The results of this study support this assumption. More specifically, clinical action seems to be influenced by the content of the regulations in itself, as well as by the way they are worded; vaguely or precisely and weakly or strongly.

While vague regulations comprise inconsistent words, general concepts, and non-specific wording, precise ones are characterized by specific, clear, and concise

concepts. Vague wording may allow deviation from the main intention of the regulations to a larger extent than precise wording. If the legislative framework for action is vague, discretionary evaluations of clinical situations define the outcomes of the RTIP to a large extent. Strong and weak regulations state an obligation and recommendation.

### ***7.2.2 The organization of work and hierarchy***

In the context of this study, clinical reasoning is bounded by organizational structures. Organization members are taught to adopt locally prescribed practices. Based on this fact, local rationality, defined as local standards for treatment resulting in variations in the practice at different organizations, has been anticipated in this work.

In clinical practice, professionals become part of organizational hierarchy. District psychiatry centers, DPCs, having flat structure, low degree of hierarchy, and no strictly defined division of work among the professions, furnish organizational members with a normative and consequence-based guidance for actions. In DPCs tasks tend to be organized either in teams or as individual work so that clinicians may work individually with the patients or they can be members of working teams. Teams tend to be interdisciplinary consisting of different professionals having various experience and background as well as one team leader.

Furthermore, working groups can affect the framework of individual work with patients. Teams may develop their own rules, values and norms, which in turn exert an independent influence on clinical decision-making. There are differences with regard

to the number of teams within DPCs. The current study provides a good illustration of the differences that may arise between clinicians who see themselves as team members and those who rather work independently on their own. These differences concern their understandings of the regulations, as well as the way in which they perform clinical work. Teamwork is characterized by a collective process of decision-making and collective responsibility for the treatment of patients. Individual work takes place in a one-to-one relationship between the clinician and the patient.

This study has additionally focused on the issue of combining leadership and clinical responsibilities. Having a leadership role has an impact both on the professional's understandings of the RTIP, and on their clinical practice. The leaders tend to be more strongly engaged in or more concerned with introducing new regulations into clinical practice than the other practitioners.

Organizational theory provides different hypotheses about the relationship between the organization and the leadership, and how they affect the outcomes of reforms. It has been argued that, particularly in the clinical context, clinical managers may buffer external influence of the regulations on clinical practice. This has been called a "decoupled organization structure" (Meyer & Rowan 1977). In this work, however, the opposite seems to be the case. The leaders tend to identify with the legal goals and act as their conductors in clinical practice at their respective organizations. This finding seems to support previous studies suggesting that organizations are open to the environment and adaptive to its changes (Thompson 2008, p. 11).

The leaders tend to see themselves as being responsible for the relationship between DPCs and the legislative framework with regard to information and

participation as well as clinical treatment. The leaders' assessments are often motivated by securing the legitimacy of clinical practices through expressing support for the legal goals. The leaders may challenge the established practices by providing the information about the legal goals and developing strategy documents embedded in them.

### **7.2.3 *The field of practice: norms, experience and profession***

The main hypothesis with regards to the professional dimension, as described in chapter 3, has been that the clinical practice has common characteristics institutionalized in the clinical norms for practice. This work shows that the professional norms in the field of psychiatry contribute to the stability and unification of practices.

While the main hypothesis is based on the stability and unified clinical practice, the two other hypotheses proposed in chapter 3 assumed variations within clinical practice. Variations in professional background and experience were expected to lead to differences in clinicians' understandings. Professionals with different backgrounds were assumed to be preoccupied with marking the differences among them, however, this was not found to be the case

A further anticipation has been that the length of experience could explain variations in professional action in clinical practice. As shown elsewhere, the less experienced professionals tend to have different occupational ideas, identities, and dedications than the more experienced ones (Dreyfus and Dreyfus 2005). This work

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has shown that both clinical norms and experience do influence the clinicians' interpretations of practice, of the RTIP and of the guidelines.

The legislative regulations, organization of work, the leadership positions as well as length of experience and the professional background have the influence on how the clinicians assess the RTIP and their own practices. This study shows that especially the different combinations of these properties affect the outcomes of regulation through the RTIP. It is further explored in the following section.

### **7.3 The analytical constellations**

I apply an institutional approach in order to capture the complexity of clinical decision-making. According to the discussion of the interviews with the clinicians provided in chapter 6, clinical action depends on a combination of situational knowledge, personal identity, individual strategizing, rules and pragmatic reasoning. The institutional context may shape clinical action to some extent, but the creative judgment of the actors who reason may lead to large differences with regard to the outcomes in the reasoning process. This creative judgment can be based on the expected future consequences, individual experiences, profession, organizational context, membership in a team, as well as a combination of these. Furthermore, this work suggests that the three theoretical dimensions mentioned above are central to understanding important aspects of the decision process. I chose to include these dimensions in this study through a discussion of legislative regulations, organizational theory and theory of professions.



The relationship between the dimensions result in different combinations of their properties, further called constellations. Within the scope of the institutional approach I have developed three types of constellations of the legislative, the organizational and the professional dimensions that seem to capture the main tendencies in the interpretations of the RTIP and clinical practice found in this work.

It may be suggested that the constellations described in this section are not exhaustive, but sufficient to understand the outcomes of regulation through the RTIP and answer the research question posed in this work. The main analytical logic is that each constellation leads to different types of outcomes of the regulation through the RTIP as well as in the clinical action, as follows:

1. Working alone combined with long experience and vaguely and weakly worded regulations may result in reasonably strong compliance with the traditional norms and a rather strong detachment from the legal goals.
2. Working alone combined with short clinical experience and strongly worded regulations may lead to compliance with legal goals and detachment from the traditional norms. This constellation may have a high probability of supporting the legal goals.
3. This type of constellations represents ambiguity. It includes the findings suggesting that the same constellation may strengthen either the professional norms or the legal goals. One example of such constellations is the combination of vaguely and weakly worded regulations together with clinicians who have long experience in the profession and work together in teams. This constellation

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may lead to reasonably strong compliance with the traditional norms, but may also result in the opposite, promoting the legal goals. Thus, in this category the outcomes are not as clear as in the two previous categories.

The constellations are used to synthesize the findings and comprise both the relatively clear tendencies in clinical understandings and those that may be seen as ambiguous. While the first two types of constellations are homological, i.e. they represent an agreement between the properties of the three different dimensions, no such agreement may be found for the third type of logically inconsistent, ambiguous constellations. This third type, ambiguity, captures unclear outcomes of the regulations. Ambivalent responses to legislative regulations are a common phenomenon that is rather difficult to interpret (Halvorsen & Michelsen 2002). All of the elements in the analytical structure of these findings cannot be logically combined into one, unified structure. This kind of constellations cannot be clearly placed within the scope of either organizational, professional or legislative field.

The above classification includes two homological constellations that allow clear, straightforward interpretations (points 1 and 2 above). The two constellations seem to point to the opposite outcomes with regard to the implications of the RTIP. The organization of work is the critical point affecting the clarity of the implications. Specialists who work alone tend to lean clearly towards either the legal goals or the clinical norms. This seems to be true independent of the amount of experience they have. The clinicians working in teams, on the other hand, do not show such clear tendencies. Clinicians working alone may have both long and short clinical experience.

In case of the second constellation the precision and strength of the regulations as well as short experience lead to assessments which are close to the legal goals. Working alone makes the individual assessments clear and logically consistent. This category captures practices embedded in following the legal goals directly without considering the established conventions in clinical work. Under such circumstances the traditional norms and practices may be weakened due to the outcome of the changing regulations. These developments might at some point lead to local organizational rationalities within specific DPCs deviating from the traditional approach to treatment and the practices based on it.

The analysis in this study is based on a broad scope of clinicians' actual understandings, not *a priori* anticipations of organizational structures, professional background or responses to the regulations. The analysis of de facto practice in complex clinical situations suggests that no single, direct relationship between organizational context, occupied positions, profession and clinical reasoning may be established.

The analysis is furthermore based upon subjective interpretations made by actors placed in the specific clinical context, i.e. upon their individual evaluations. Their responses to regulations may be rather difficult to predict.

In my analysis, I investigate the relationships between clinical action, legislative regulations, professional background and organizational structures separately, as well as the relationship between the three and clinical action. Thus, the actors' understandings of the professional roles and organizational framework, when they

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practice discretion, are as important as their approaches towards the legislative regulations.

In the following section I discuss the implications of regulation through the RTIP in the clinical practice and the possible explanatory factors related to them.

#### **7.4 Complexity of the outcomes of regulation through the RTIP in clinical practice**

Various empirical and theoretical studies show that juridification is a highly complex and diverse process. Based on empirical and theoretical discussions, scholars agree that, as a result, juridification often leads to different outcomes and inconsistencies among them (Magnussen & Banasiak 2013; Aasen et al. 2014; Loick 2014). Within the broad scope of institutional approach, a combination of the three dimensions described above allowed capturing a variety of outcomes of regulations through the RTIP in clinical practice. The implications of the regulations depend upon the complexity of different factors such as rules, situational factors and pragmatic reasoning.

This study suggests that the outcome of regulation through rights is a coexistence of practices embedded in legal goals and clinical norms, which are in constant flux, forming different constellations. This knowledge could contribute to an ongoing dialogue about how to regulate well-established clinical practice.

The complexity of the outcomes of regulation through the RTIP found in this work may further be summarized in accordance with the three dimensions of the analysis, as described below.

#### **7.4.1 *The regulations***

Based on the results of this study, it is reasonable to suggest that the regulations do not have a standardizing effect on clinical practice. Interpretations found in the guidelines are neither consequent nor unified. Different actors were involved in the development of each guideline. Each of the documents has a different target group. Furthermore, the content of each guideline consists of different understandings. There are inconsistencies and tensions within the scope of, not only each document, but also among single paragraphs. These extensive variations make it reasonable to suggest that ambiguity is the main characteristics of the regulations. This leaves much room for interpretation, which, in its turn, makes the achievement of the legislator's goals rather challenging.

All the recommendations have the same status. They are not ranked in relation to each other. The clinicians who look for guidance in specific clinical situations tend to look for the strongest, most precise guidelines that would give the clearest definition of good practice. Thus, strong wording strengthens the effect of specific regulations. Therefore, the strength of wording has implications for the outcomes of regulation through the RTIP. The weak and vague combination tends to be preferred by the specialists who have long experience and choose rather traditional understandings. This

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combination strengthens the established traditional conventions in clinical practice. The specific answers to how to involve and inform in clinical practice are then left to be decided upon by the clinician.

The experience and socialization into clinical work may explain these outcomes. The less experience on the job, the stronger the perception of the legal goals as being the synonym of best practice. The two above-mentioned combinations of strong versus weak, and precise versus vague regulations make different frameworks for discretionary action, structuring and affecting it in various ways.

Magnussen & Brandt (2014) concluded that the weak and vague wording of the rights to healthcare could lead to heterogeneity in clinical action among the medical professionals who implement the law. This study in the fields of orthopedics and cardiology showed that the vague and weak wordings of the right to health care services do not lead to unified clinical action. Patients with the same diagnoses were treated differently, and there were differences among the clinicians' assessments of whether their actions are at all affected by the regulations.

This suggests that the legal concepts of rights may lead to various understandings, different practices, and not necessarily equal opportunities to participate in treatment for all the patients (Magnussen & Brandt 2014). This is in line with the results of the current study. Combining professional norms and legal goals in the regulations of practice may lead to significant variations in how the practitioners relate to patients' involvement in treatment. The outcomes of the regulations may significantly deviate from the legal goals.

Within the regulations, concepts describing co-determination that clinicians easily identify with, tend to be internalized in practice. These concepts are used by clinicians when they develop their understandings of how to inform and involve patients in treatment. It is common among the clinicians to refer to the concept of self-responsibility introduced in the guidelines. Experienced clinicians tend to understand this as the patients' obligation to comply with any treatment that was chosen for them. The inexperienced specialists also apply this concept, although their understanding of self-responsibility differs from the more experienced clinicians. In contrast to more experienced clinicians, less experienced specialists tend to view self-responsibility as the patients' responsibility to apply the treatment that they have either chosen themselves or were involved in choosing. In this case, the explanation could be that since the inexperienced clinicians prefer the precise regulations, they tend to internalize well-defined and specific concepts. Inexperienced specialists often know the exact wording of the Directorate's definitions of self-help.

The characteristics of the regulations described in this work contribute to the differences found in clinical action. This is to some extent in line with other works suggesting that clinical practitioners tend to be able to keep a large degree of their discretionary power in spite of the legal changes (Bentsen 1999, p. 221; Blomgren 1999, p. 171; Lindholm 1999, p. 117; Sahlin-Andersson 1999 pp. 209, 304).

The characteristics of guidelines might have been different if the Directorate had, for example, presented unified interests of one target group in every source, but this is not the case with regard to the RTIP. The analysis in chapter 5 shows that the legal goals and the various interests of target groups (patients' organizations and

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clinical specialists) have been incorporated into the guidelines all together. It is reasonable to suggest that consensus building among the understandings embedded in different values have contributed to the ambiguous wording of the explored in this study regulations.

#### **7.4.2 The organization**

This study suggests that local practices, organization of work, and hierarchical relations influence the outcomes of regulations and clinical reasoning. Clinical practice based on collective or individual forms of decision-making affect the outcomes of regulations. Both a low degree of hierarchy and an inclusion of leaders in decision processes results in following the legal goals in clinical practices. Collegial decision-making seems to have a unifying effect on the team participants, i.e. it contributes to fewer differences in the interpretations of the regulations among the specialists. Team members tend to share the understandings that dominate in the team.

Clinicians working alone do not normally have as frequent possibilities to share and expose their opinions at the collective, professional arenas as their colleagues who work in a team. The professionals who work alone seem to have perceptions that could differ and sometimes contrast strongly with the understandings of other specialists working in teams.

It may be suggested that in the context of DPCs, individuals working in teams may be affected by the legal goals stronger than individual clinicians working on their own. An explanation might be that the teams relate to and comply with the



organizational routines and procedures to a larger extent than the clinicians working on their own. This is especially true with regards to specialists who are used to discretionary practices and individual judgments.

Furthermore, the leaders' understandings may differ significantly from non-leaders. Their clinical practice with the patients tends to often reflect legal goal of increased patients' involvement. In some cases, leaders suggest the primacy of patients' right to choose the treatment over all the other considerations in treatment while emphasizing clinicians' responsibility for information delivery. These understandings differ to a large degree from the assessments of experienced specialists in non-leadership positions. Leaders often underline the necessity of aligning clinical actions with the organizational strategies to a larger degree than all the other professionals. They also seem to be aware of the control evaluations from the authorities and emphasize the importance of their outcomes. In this regard they often underline the necessity of transparency and documentation of patients' involvement in decisions about their treatment and information delivered by the clinicians. Mirroring the goals promoted by the RTIP in practice is often seen by the experienced non-leaders as being rather detached from the reality of the clinical treatment.

The leaders are often aware of and accept the existence of traditional practices in general. They admit that the technical core, i.e. other clinicians, may perform based on the clinical norms, but the leaders tend to identify with the legal goals in their own practice and when leading the teams. The explanation may be seen as a pragmatic approach, i.e. it is difficult to change the established pattern of traditional practices and,

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therefore, it is better to accept it as it is. Clinicians who work on their own are the ones most resistant towards the legal goals.

It is reasonable to suggest that the leaders contribute to co-existence of traditional understandings and the RTIP-based ones in the clinical practice. It may be explained by the low vertical division of labour decision hierarchy of teams, in which leaders are an integral part of the collegial decision process in clinical practice?, and the aim is to achieve a decision consensus. This finding seems to disagree with the buffering hypothesis mentioned above.

Leaders have a representative role and are expected to comply with the Directorate's recommendations and governmental strategies. The pragmatic approach focusing on the need for a good flow of day-to-day operational practice might explain to some extent the acceptance of the traditional and paternalistic approach to the RTIP.

Practices specific to particular DPCs and teams, and which are reproduced by them, are interpreted as local rationality. Local practices tend to influence the clinicians' preferences with regard to, for example, specific methods of treatment, such as medical or therapy-based procedures. These preferences seem to influence the way clinicians interpret the regulations. Particularly therapy-oriented local practices seem to have a rather strong degree of openness towards regulations of the RTIP. Treatment practices have then a strong focus on engaging the patients in the choice of treatment. The perceptions of clinicians seem to also be bound by the local availability of specific treatment methods. It is well illustrated by the process of information delivery which most often is based on available treatment.

Different local rationalities may also contribute to the perception of data as ambiguous.

### **7.4.3 *The profession and experience***

The differences in the length of experience and profession were expected to explain the variations in clinical assessments. The psychiatrists and psychologists were expected to be keen to point out the differences between these two professions. This study shows that the profession does not necessarily lead to differences between the assessments made by medical doctors and by psychologists. This may be due to the fact that the regulations are the same for all clinicians, and both professions have been involved in the process of their development. Through the education process specialists learn about the legal framework for clinical work that can contribute to the common understandings of the legislative regulations. Furthermore, the clinical norms have the unifying effect for the field of practice. Socialization into clinical practice is a long process that can contribute to the common assessments of good practice with regard to informing and involvement in treatment.

Organizing task-solving in teams comprised of both psychiatrists and psychologists can also explain the existence of shared assessments. One of the goals of teamwork is to develop common treatment strategies. Furthermore, it is reasonable to suggest that common treatment strategies, internal standards and procedures (i.e. local practices within DPCs) could to some extent coordinate common assessments of the RTIP that influence individual practices. The team leaders tend to define the overall

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treatment strategies and introduce organizational goals to the teams. The collective goals and strategies in teams could also have a unifying effect on the clinicians' assessments.

This study shows that there are a number of norms that tend to be perceived by clinicians in a similar way. The longer the experience, the stronger the influence of clinicians' own authority and judgment, rather than that of the written rules and recommendations for best practice. The experienced specialists may support or discard the regulations, but they have a tendency to adopt the concepts introduced by the legislator. Thus, a strong focus on the traditional norms promotes activation policies that focus on the idea of patient's self-responsibility. But it is often internalized into the norm of compliance. Self-responsibility is understood as patients' obligation to participate and gain information. Patients' responsibility then becomes the central aspect of involvement in treatment. This is in line with the argument that regulations which do not deviate from existing practices tend to be more readily accepted in clinical work. Such a scenario may be seen as re-institutionalization of clinical norms through the practice of the RTIP.

However, the legal goals tend to be incorporated into the regulations as well. Clinicians with short experience tend to reject traditional thinking and follow the legal goals. The length of experience seems to be the major explanation of clinical assessments found in this work. An easier adoption of legal goals into practice by the inexperienced clinicians may be explained by the fact that new legal regulations have become an integral part of professional educational training. In this way, legislative regulations and legal ways of thinking are brought much closer to clinical working

methods learned by the clinicians. Inexperienced specialists often identify legal goals as best practices and apply it directly in their clinical evaluations. Introducing legislative regulations in the education program for the clinicians is one professional platform through which the RTIP enters practice, and it represents a very different way to institutionalize legislative regulations into practice than through top-down regulation directed externally on the practitioners.

An alternative explanation of the assessments made by the inexperienced clinicians may be that some of the regulations embedded in legal goals are more precise than those embedded in norms and, therefore, somewhat more preferable in practice to vague and general statements. This is particularly important in the case when experience-based norms are not institutionalized as a legitimate background for professional practices. Other studies (e.g. Bygnes 2014) support this explanation. These authors suggest that for rights and laws to be effective, they have to be operationalized and contextualized in specific situations. Therefore, one could argue that the larger the number of regulations and the more precise they are, the more effective the legislative regulations seem to be for inexperienced clinicians.

The influence of experience on clinical action is strengthened by the dimensions of organization and regulation. Long experience, work alone, and vague and weak regulations contribute to older norm-based understandings. Short experience, work in a team, as well as strong and precise regulations support understandings driven by the legal goals.

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## 7.5 Juridification and ambiguity

As such, the ambiguity of the regulations could be the outcome of mutually reinforcing elements: a long history of norm-based clinical action and clinical experience, the new societal understanding of human rights and the society's commitment to social values embedded in the RTIP, as well as the organization of work and hierarchy. The regulations, organizational structures and professional background represent different normative platforms for the evaluation of the legislative framework and the clinical action. Clinical practice may be seen as a crossing point for these normative platforms. Accordingly, the assessments made by the clinicians are embedded in the regulations, organizational structures and professional background. This may contribute to ambiguity being one of the outcomes of the legislative regulations.

The traditionally scarce regulations of practice through rather vague clauses allowed a large degree of discretionary understandings in the past (see chapter 2). The traditional practices may influence the assessments made by the clinicians in this study, and the form of regulations regarding the RTIP. It may be suggested that their present form may both enhance discretion as well as bind practice. The question that is beyond the scope of this work, is then what would happen if the ambiguity of regulations were to be reduced? Co-existence of the variety of practices seem to a large extent depend on the ambiguity of the rules. The one case, discussed above, concerns experienced clinicians working on their own in combination with the vague and weak regulations. It may be seen as the most pessimistic scenario from the legislative point of view. It may be challenging for the legislator to influence the experienced clinicians and make

them comply with the legal goals behind the RTIP. The ambiguity of the rules may be seen to support the existence of the traditional practices.

## **7.6 Regulations and the clinical discretion**

Through the legislative regulations explored in this work clinical discretion is structured in a new way as compared to traditional regulation through norms. This does not, however, suggest that the scope of so-called epistemic discretion (i.e., the content of discretionary action based on, for example, scientific knowledge, practical knowledge, or values) becomes narrower. Magnussen & Brandt (2014) reported that limiting discretion does not necessarily take place through the regulation of individual rights. In accordance with the results of this study, the authors argue that significant variations in the interpretations of the individual right may undermine the actual legislative content of the regulations. The conductive power of the vague and weak regulations is limited, and compliance in this case may be difficult to evaluate.

It could be suggested that the regulations that are partly embedded in clinical norms become more professionalized, which could make the resistance to their application weaker.

This study suggests that the relationship between structural discretion (i.e., the regulations) and epistemic discretion (i.e., clinical assessments) is not antagonistic and that the regulations affect the assessments of the clinicians. This finding is in accordance with some earlier studies that explored the relationship between

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juridification and professional discretion (e.g. Bærøe & Bringedal, 2014). Some degree of discretion will always be necessary to make the clinically sound and legally appropriate decisions; thus, legislative regulations and discretion are interrelated.

This study shows that the re-institutionalization of clinical norms through the regulations of practice has taken place to some extent. However, the legal goals of the RTIP tend to be incorporated into the regulations as well. Thus, the response to regulations from outside could be to some extent described as “the protection of the traditional values of professions” (Sahlin-Andersson 1999, p. 299). The professionals tend to some extent keep their autonomy.

This work suggests that the question of the outcomes of regulation through the RTIP is not about limiting or expanding clinical discretion but instead it is about restructuring it. This process reflects the ongoing institutionalization of different combinations of legal goals and clinical norms.

Broad and weak wording may enable variety of discretionary assessments. The regulations may also to some extent limit the discretionary understandings of the RTIP. Regulations seem to equip the practitioners with the idea of the best practice that frames and places boundaries on the professional evaluations in the areas that have traditionally been reserved for the discretionary judgment. By being obliged to relate to the regulatory framework professionals may lose a reasonably large degree of control and autonomy.

The binding force of the regulations is especially strong with regard to collective forms of decision-making. The best practices seem to be incorporated into the



regulations, passed on to the leadership and become embedded in organizational strategies and learning. Best practices at the organizational level provide the requirements and standards for practice that are expected to be followed. These expectations are enforced through the requirements of transparency and the regular controls from the external authorities. It might therefore be challenging to sustain practices in a way that deviate from these standards.

In order to increase the possibility to influence *de facto* clinical action, it could be suggested that regulation through the RTIP should be implemented either via educational processes or as early as possible in the process of socialization into the clinical practice. Furthermore, it could be suggested that patient rights should be shaped as specific statements, which can be applied in a particular context. Thus, from the legislators' point of view the most optimistic scenario comprises the specific regulations, inexperienced professionals working on their own. This constellation could expand the possibility of influencing the clinical practice. The inexperienced professionals tend to be strongest devoted to following the legal goals when they work alone. The inexperienced specialists working in teams are influenced by the legal goals but the clinical norms tend to affect their assessments as well. The membership in teams makes the assessments influenced by the variety of combinations of legal goals and clinical norms. All of the inexperienced specialists know the wording of the RTIP but those working alone distinguish themselves by assessing the wording of the law literally as the best practice.

The major point in this work is that it seems to be possible to influence the clinical practice through the regulation in the form of guidelines. The outcomes of it can vary and seem to differ from clear to more ambiguous and differentiated.

Nowadays, there is an agreement among scholars that this picture has changed as compared to the traditional regulations of clinical practice (Kjønstad 2007). The various forms of laws and administrative regulations, such as patients' rights, acts addressing professional conduct, and international human rights, have affected the structure of clinical action. Additionally, these laws are given more specific interpretations by public administration, which may further be expanded by the scope of institutionalized practices. The latter could furthermore become regulatory for the administration together with the laws and their interpretations. However, the variety within the existing regulatory framework and its implications for the outcomes of the regulations have to be further explored in order to understand the complexity of the outcomes of the legislative regulations.

## **7.7 Legislative regulations and best practice**

This study shows that well-established 'best practices' can be regulated. The regulations lead to large differences in what is understood to be "best practice". These understandings may be based on the clinical norms, the legal goals, or both. Furthermore, this study has shown that the properties of the three analytical dimensions, especially the organization of work, as well as the hierarchy and the professionals' experience, influence the outcomes of regulations.

Actions of both the experienced and the inexperienced professionals tend to be affected by their membership in a team. The assessments made by experienced specialists working in teams tend to become more positive towards legal goal as compared to the experienced clinicians working on their own. The assessments made by inexperienced specialists working in teams, tend to be more positive towards clinical norms as compared to the inexperienced clinicians working on their own. Furthermore, the clinical practice of the experienced professionals taking leadership responsibilities seems to be influenced by the leadership role. The leaders seem to have rather strong focus, as compared to the other experienced specialists, on extensive information delivery to their patients and adjusting treatment offer to the patients' preferences.

It seems reasonable to suggest that the answer to the research question of how practice is influenced by legislative regulations can vary depending on the context, and also within the same context. DPCs are characterized by the flat organizational structure, working tasks divided into interdisciplinary teams and focusing to a large degree on the patients with rather mild disorders. The outcomes of the legislative regulations within the context of DPCs may differ from how the other types of organizations such as hospitals would respond to the regulations.

One of the challenges in achieving the legal goals that may be indicated in this study, seems to be an intrinsic resistance towards losing the control and professional autonomy by the traditional clinical practice with regard to the area regulated by the RTIP.

This study attempts to contribute to the knowledge regarding the implications of regulations on the administrative practices. It has been argued that equal opportunities in traditional welfare provision are unlikely to be achieved through the application of legislative tools in the field of welfare. The field has traditionally been dominated by considerations other than clients' influence (Aasen et al. 2014). This point is elaborated upon in the following section.

### **7.8 Juridification and the patients' possibilities to act**

There has been significant international interest among scholars regarding the consequences of addressing social challenges with the use of legal instruments (Hirschl 2004). One important debate has focused on regulation within the framework of health care. Various possible consequences of the increased exercise of individual legal rights in health care services for democracy have been of particular interest. This work supports the general impression of great complexity of the implications of regulation through individual rights expressed elsewhere (Magnussen & Banasiak 2013).

This study of regulation through the RTIP calls for a discussion of the tension between treatment based on specialized knowledge and the encouragement of patients to influence the treatment and gain information about it. The results of the study suggest that the content of the regulations, as well as the organizational structures and the professional background, may all lead to both discarding and following the legal goals in clinical practice for different reasons.

To analyze the practices in the area regulated by the RTIP, the concept of co-determination has been employed. As described in chapter 3, this concept applies to the various degrees of involvement in decisions concerning the treatment, as opposed to compliance.<sup>32</sup> From a clinical normative perspective, co-determination may be related to the clinical obligation to exercise discretion and provide reliable treatment as well as some form of involvement in decisions.

The case of this study shows that the weak, procedural rights may both enlarge and limit the patients' possibilities to influence their treatment. The regulations are followed differently, with some patients being allowed to decide upon their treatment while the others are expected to accept the standard offer with much less possibility to participate in the choice of treatment offers. The opportunities to participate in the choice of treatment method depend on whether the clinicians perceive the regulations to be useful or as detached from *de facto* practice. When the legal regulations are assessed as useful, they influence the practice directly. In the opposite case, clinicians would preferably delegate the implementation of the regulations to other administrative bodies.

By enabling such variations, regulation through procedural rights has limited its influence on the structure of clinical discretion. Thus, for some patients, the procedural regulations may serve as a foundation of increased influence on service provision, while the others may enjoy no change in the way they are treated. Therefore, it may be

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<sup>32</sup> This concept is different from self-determination, which is applied in this study as a more general legal goal based on the principle of respect to individual choices and the patient's autonomy.

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argued that individual legal rights per se may not necessarily result in strengthening the patients' position in health care services.

It could easily be taken for granted that the RTIP warrants the possibility to co-determine in one's own treatment. One could, however, easily imagine the situations in which the power to influence the decisions about one's own health might be troublesome in practice and, therefore, restricted. One example could be the considerations given to cost-effective treatment overpowering the patients' possibilities to co-determine. Therefore, regulation through the RTIP may not always reduce such arbitrariness in practice.

## **7.9 Final conclusions**

This thesis explores how Norwegian clinical practitioners and health care authorities assess and interpret individual rights. It provides an analysis of how and why certain clinical practices and legislative regulations are developed. The major focus is on clinicians' understandings of their practice and the regulations.

This study shows that clinical practitioners subjected to legislative regulations may find themselves at an intersection of various rules, which may influence the interpretations of the regulations differently. Furthermore, the situational factors as well as pragmatic and consequence-oriented thinking may influence the clinical action.

In order to capture the variety of the outcomes of the legislative regulations, institutional theory has been applied in this work. Within the broad scope of

institutional approach, the legislative regulations, organizational structures and professional background are found to have explanatory power for the outcomes of regulation through the RTIP in practice.

Each of these dimensions encompasses a different normative platform for evaluating the questions concerning the RTIP and de facto treatment. The extent of the influence of each dimension separately as well as how the certain constellations of these dimensions influence clinical action have been explored. As it has been argued throughout this chapter, the answer to the research question of how regulation through the RTIP may influence clinical practice is not straightforward.

The complexity of clinical context in study shows that constellations of the three dimensions define the principles of action in practice to a larger extent than each of the dimensions separately. Depending on the constellation, the outcomes may be more or less clear. Each constellation could suggest rather different outcomes.

The room for differences seems to be the major mechanism that could contribute to enabling the coexistence of practices based on tradition and on the legislator's idea of co-determination in a similar manner as discretion. Otherwise, the regulations that allow the discretion-based practice could under some circumstances reduce the antagonism between norms and legal goals by allowing the existence of different practices. Discretion-based practices may promote a culture of consensus as well as result in splitting the practitioners. The lack of hierarchy among the different guidelines and the coexistence of various clinical assessments could explain a rather friction-free relationship between the legislative regulations and the assessments made in clinical practice.

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Ambiguity seen as an intrinsic characteristic of the regulations and their outcome in the clinical practice seems to originate from the vague wording and differences in the content of the regulations. It also seems to be derived from the lack of clear rules embedded in the professional background and organizational structures that frame the clinical action. These findings have led to the adoption of ambiguity as the one of the empirically derived category to classify the observed variations in the outcomes of juridification through the RTIP.

In the context of this study where all of these dimensions co-exist the possibilities to reduce ambiguity, seen as lack of clarity, could be to some extent rather limited. It is reasonable to agree with studies that suggest that policies with ambiguous goals and means may often be expected to enhance a wide range of flexible practices (Cohen et al. 1972; Lowi 1979). Considering the aim of the legislator with the RTIP and the context of institutionalized practice it could be suggested that the legislator using individual rights attempts to reconcile legal goals, organizational context and professional background in the clinical practice. Thus, the regulations through the RTIP in the field of institutionalized practices might enhance flexibility of practice, perceived as acceptance for differences, rather than be an instrument for its reduction and standardization of practice.

The characteristics of the regulations, their content, organization of work, hierarchy relations as well as, the education process, socialization into practice, and individual adjustments of treatment are critical for understanding the complexity of implications of legislative regulations for clinical practice.



From the legal normative perspective, the RTIP may be seen as concerning the questions of reducing inconsistencies in regulated practices. This study has shown that the RTIP calls for different interpretations, which do not always support the established clinical practices. This is a rather different approach to the regulation of clinical practice than the one based on clinical discretion and social trust. It could be expected that various forms of laws and administrative regulations addressing professional conduct, such as patients' rights, might meet with a certain resistance in the professional environment. Based on this work, however, it may be suggested that the institutionalized clinical practice may to some extent accept the legal goals promoted by the RTIP. This may be an outcome of the general social inclination towards encouraging treatment practices based on patients' autonomy and respect for the patients. This is in spite of the fact that traditionally the regulation of medical practice has been based on the principle of clinical autonomy, while normative questions were to be based on individual judgments of ethical conduct. Nowadays, there is an agreement among scholars that this has changed and clinicians have lost a significant degree of their power (Kjønstad 2007).

It is reasonable to suggest that the relationship between the legal goals and clinical norms found in this study is not antagonistic, because the regulations support the variety in practices rather than suggest ranking between the legal goals and norms. This may also be due to the fact that the relationship between the law and clinical practice in the field of psychiatry was established a long time ago through the institution of the Control Commissions in coercive treatment (see chapter 2).

There are methodological limitations in this work, which do not, however,

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prevent from answering the research question. They could nevertheless be considered in the studies that will build upon this work. For example, investigating the patients' perspective could contribute with their understanding of participation and information and the perception of its regulation through the RTIP. It could provide insight into why there have been no litigation cases based on the RTIP at this time, despite the fact that recent evaluations of psychiatry show that patients and their families are not satisfied with the information they typically receive (Bjertnæs et al. 2005.)

As to other limitations, a repetition of interviews with clinicians (a longitudinal study) would provide a more stable and reliable data set. It could give a better understanding of the mechanisms of institutionalization of legislative regulations into the professionalized organizational context. These concerns involve particularly characteristics and content of the regulations, experience-, profession- and education-based understandings as well as organization of work and hierarchy relations. Thus, future work should explore under what circumstances the bearers of certain types of socialization into practice may change their behavior, (e.g., novices gaining more experience and ceasing to follow legal goals in the recommendations). It has been shown a number of times that socialization into a profession in general tends to make a strong influence on professional practice (Sahlin-Andersson 1999, p. 306).

It would be interesting to explore if the observed pattern of the leaders' behavior would change when they come back to their exclusively clinical responsibilities. With regard to novices working on teams, a possible question for further studies is whether their behavior might change if the number of inexperienced clinicians on working teams is increased.

Furthermore, one could explore the precise and the vague regulations more extensively in the professionalized context, with the focus on the specific clinical profession. The data gathered in this study do not provide generation-based information, which could allow more extensive conclusions on this matter. It does not seem either from the gathered data that specific professional backgrounds might play a role in outcomes of juridification through individual rights.

How to interpret the findings in this work? Could it be suggested that precise and clear regulations could influence the one thousand year old practice? From the legislator's point of view, the scenario might be more optimistic in some cases than in the others. Young clinicians working on their own might yield the outcomes closer to the legislator's aims than the experienced specialists who work alone. Nevertheless, the practice will always be to some extent loyal to the traditional norms. Still, this is not to say that professional discretion cannot be influenced through regulations. The best practices need to be regulated and the standards should be possible to establish. The legislative regulations will always be influenced by the rules their administrators will apply in the process of interpreting them.

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## Appendix 1. The interview guide

The purpose of the interviews was to:

- gain the information about the practitioners' assessments of informing and involving the patients in the treatment process;
- grasp the changes in the procedures, routines, ways to think and do things since the introduction of RTIP;
- obtain the assessments of the regulation of clinical practice through the APR and the RTIP, as well as the outcomes of these regulations for the process of informing and involving the patients in treatment.

The same set of questions was posed to all 30 clinical specialists.

The guide is divided into six parts. The first one concerns general information about the professional background and age of clinicians. The second and third parts comprise the questions regarding information and participation (involvement) in clinical practice. Part four comprises the questions about the possible changes in the practice after the RTIP. Part five includes the questions about individual practices regulated by the RTIP (i.e. the way the clinicians inform the patients and what kind of participation they allow the patients in treatment). Part six includes the questions about the implementation of the requirements defined by the RTIP in clinical treatment in general.

The questions were asked in Norwegian. They are presented here in English (my translation).

1. General information

What is your professional background?

Age?

Professional group?

How long have you been working with psychiatric patients?

2. Information delivery in clinical practice

When you meet a patient for the first time, what do you inform about?

Do you say anything about the treatment methods available here? Type of treatment, the methodology available?

Do you say anything about the possible and optimal treatment methods – considering also other places the optimal treatment could be offered?

Are there other things you also inform about?

What factors do you consider when you evaluate which information to provide in every particular case?

What do the patients ask about?

Is there any standard information that you give to more or less everyone?

Have there been any changes in the way you inform? The type of information or how extensive it is – more or less information?

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What are the most challenging situations with regard to the information process? For example, when do you not provide all the information you usually do?

What do you do if the patients' understanding of the best treatment is not the same as yours?

Do you say anything about the possibility to complain?

How do you inform about medications?

What do you do if they do not accept the medical treatment?

Can they choose?

Do you register the information you provided? Are there any standard routines with regard to it?

Can the patients get access to their medical record? Does it have any consequences on how you work?

### 3. Participation (involvement) in clinical practice

How do you involve the patients in the treatment? Are there different strategies to do it?

How do you keep the patients involved throughout the treatment process?

Are the patients involved in decisions about the treatment? Can you give any examples of it?

Which decisions are they involved in?

Are there any situations when involvement/interaction with patients is especially difficult?

Have you always worked in this way? Have you noticed any changes in your practices with regard to involving the patients in decisions about their treatment?

Have these changes had any consequences for how you work with your patients?

#### 4. Changes in the practice after the introduction of the RTIP

Have your patients changed? For example, with regard to their expectations to treatment procedure and its outcomes? Or the way they involve themselves in treatment?

What could be the reason for it?

Has it influenced the way you work?

#### 5. Individual practices regulated by the RTIP

The patients have the right to information and participation – how do you understand this right?

Has the right changed the way you treat your patients?

How has it influenced your work? Do you work differently now than before the right was enforced?

Do the patients use the right to enforce their requirements?

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Is it clearer for you now how you are supposed to inform your patients? Has the right brought about some clarity with regard to information process?

6. The implementation of the requirements defined by the RTIP in general

The RTIP, as it is presented in the APR, says that the patients have the right to *choose between the available and medically sound methods of examination and treatment.*

How does it happen in clinical practice?

Furthermore, the law says: *Health personnel shall as far as possible ensure that the patient has understood the contents and the meaning of the information that has been passed on to him – how does it take place in treatment?*

The law specifies as well that: *The patient shall have the information that is required in order for him to gain insight into his health condition and the contents of the treatment given to him.* How does it take place in treatment?

Do you inform about the patients' rights in the treatment setting? How? How do the patients get his information?

Are there any circumstances when the information about rights is especially important?

Which aspects of the law do you inform about?







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