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Do conflicts of interest create a new professional norm? Physical therapists and workers compensation

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Do conflicts of interest create a new professional norm? Physical therapists and worker's compensation systems

In their article, Testoni and colleagues (1) argue that sports physicians face unique ethical challenges regarding conflicts of interests (COI), accentuated by the lack of evidence-based standards and the presence of strong financial incentives. Third party systems create powerful incentives that can influence the behavior of health professionals. However, these ethical challenges are not unique to sports physicians. Physical therapists (PTs) treating patients covered by workers' compensation (WC) systems face similar COI when guidance or even pressure from third party organizations (i.e., WC systems or employers) intervene in clinician-patient interactions. While PTs strive to treat their clients using a patient-centered approach, they often have no choice but to obey external rules based on the values of third party organizations. A comparison of the sports medicine and WC situations can help us better understand these issues.

Similarities between WC and sports medicine

Testoni and colleagues show that sports physicians sometimes face ethical dilemmas concerning the disclosure of sensitive information relating to an athlete's condition, situations that can also be encountered by PTs working in the WC system. Should PTs provide all requested information to the WC board (e.g., a patient's perception of their employer, progression of the condition or desire to return to work) which could influence WC benefits? PTs know that their first priority as healthcare professionals is the best interests of their patient, and to maintain their trust (fidelity and beneficence). But is the WC system structured in a way that threatens confidentiality? PTs need to keep patients' information confidential to preserve the fiduciary relationship, but they also must consider societal issues such as equity of service to the WC board. The dilemma is made more challenging when the WC board or WC physicians request detailed information concerning the patient's condition and progression during rehabilitation. In many instances, the patient has not been informed that information shared with the PT may end-up in the WC board's monthly report.

Second, decision-making regarding return-to-work is an important issue in the WC system, echoing ethical issues in sports medicine about return-to-play. In the WC system, no clear guidelines determine when the patient is ready to go back to work. As a result, return to work decisions can be influenced by diverse financial interests. For example, the employer or WC board often pressures the PT and his/her patient for a rapid return-to-work, even if the goals of treatment are not completely achieved. This pressure, even if based on a desire for a faster recovery, also aim to reduce treatment costs. By contrast, PTs and private clinic owners may have a financial interest in prolonging rehabilitation to insure stable income for their clinic. So as with return-to-play, return-to-work can be an important context for various COI.

Third, patient autonomy is of great importance in rehabilitation (and in medicine); this principle can be threatened by the service organization. As for athletes, patients who benefit from the WC system must live with the consequences of decisions made by parties involved in their care and which may have been made with little regard to their values or autonomous decision-making. The employer, physician, PT and WC agent may all have different expectations and convey different messages to patients. A paternalistic approach often dominates and patients must follow the "orders" coming from these different parties. The sports industry and WC board are both

hierarchical organizations that create top-down pressure, with the coach or the WC physician having significant (even predominant) influence in the organization. The patient is stuck between the healthcare professional, the WC board and the employer. On the other hand, PTs involved in the care of patients supported by the WC board also feel pressure from the different parties; and trying to meet these diverse interests can affect professional judgment.

Finally, the authors stress the absence of a universal code of ethics specifying the actions of physicians in COI situations, specifically when working on a sports team. Codes of ethics are an explicit enunciation of professional norms and expected behavior, and therefore play a crucial role in ensuring professional ethical conduct. They articulate a moral framework, provide guidance to members and promote public accountability by elevating standards of practice and protecting patient well being (2). Echoing the situation of sports physicians, PT codes of ethics contain only minimal norms regarding service provision. Determining the parameters of ethical professional practice in relation to third party payers is left to the PT's discretion, judgment, knowledge and moral integrity. Additionally, the PT code of ethics does not take into account particular contexts, nor does it clearly articulate issues of COI in relation to the WC board; this grey zone permits COI situations (and related unethical behavior).

Conflicts of interest leading to unethical behavior

Similarities between sports medicine and the WC system can help us better understand the ethical issues. Using the case of workers' compensation as a comparison, we argue that the COI faced by clinicians working in organizational settings (e.g., sports teams or companies) could potentially impair patient (athlete/worker) treatment. In fact, as is well illustrated by Testoni and colleagues, tensions created by these COI can interfere with the therapeutic alliance between patients and clinicians. These conflicts can also generate increased stress during the rehabilitation process, both for professionals and patients, possibly delaying healing time (3). Under pressure, team physicians make decisions for long-term risks in order to have short-term gains (4). These gains can be dangerous for athletes' health in the long-term (5). Some sports physicians have been accused of hiding important information from athletes; information that was necessary for them to make informed decisions regarding their return-to-play (4). Other cases include repetitive injections of corticosteroids to maintain a player in the game (6), yet, these injections are a threat to tendon health and must be given only with the athlete's informed consent.

COI can also lead to unethical behavior such as fraud. Health insurers, WC boards and other third party payers, media and professional boards have recently questioned the frequency of physiotherapy sessions offered to WC patients (7, 8). The problem is the potential for unnecessary treatment multiplication where a WC patient will receive a greater number of treatments, a number that would have been very different if the client were paying from his/her pocket. Increased treatments beyond what is required by the patient's condition may constitute fraud, or it may be related to the health system and its organizational features (e.g., health policies, pressures and expectations from peers, managers, third party payers) (9, 10). For example, a high treatment frequency is implicitly encouraged to reactivate injured workers where PT becomes their daily "job". Moreover, the payment per treatment is often below the current market price for private PT services. Therefore, an expected behavior may be to reduce the cost of treatment for injured workers (shorter treatments, more frequent and extended for a longer period, with staff that is less costly) in an attempt to even out the income received. The line between a higher number of treatments and unnecessary multiplication of treatment is difficult to

determine. The lack of evidence-based guidelines concerning physiotherapy treatment echoes the dilemmas described by Testoni and colleagues when sports physicians must choose between the best treatment plan for the patient or for the athlete as member of a team. Moral reasoning and ethical orientation of the individual therapists can contribute to this problem. However, therapists rarely work alone, and colleagues are often partners in the decision-making process (9, 10).

Is the unethical behavior solely related to individual behavior or do colleagues, managers and organizations contribute? When only one professional is pushing the boundary, it can be considered an individual unethical behavior. When we let COI permeate the heart of the profession, altering the fiduciary relationship with the patient, we collectively create a new norm, one that leads professionals away from their main goals of providing high quality patient care (beneficence) and respecting societal demands (justice). The context of practice of healthcare professionals and their interactions with third party in sports medicine, like in rehabilitation, needs to be re-evaluated and restructured to avoid the unethical pitfall left by COI. This new norm is drifting away from what we would expect from a good professional, shifting the normal curve to a new standard that must be followed by all. Let's not make business, temptation or profit our professional drive. Let's return to the essence: the relationship established with the patient, one where the patient trusts the professional to provide the best care without following his/her own interest, even if declared! Declaration of interest is definitely a start but those interests need to be managed by an external judge, who is independent and has the public interest at heart. Professional boards, peer-groups, or patient associations could play the role of these judges, as they are aware of the specific context in which these COI take place, they are impartial as not directly involved in the fiduciary relationship.

Healthcare professionals must push for the highest standards of transparency and accountability if they are to continue to be seen by the public as worthy of respect, trust and professional independence. Conflicts of interest can create a new professional norm that runs counter to the public interest, and these situations will inevitably undermine public trust in the profession.

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