What's Unethical About Interprofessional Collaboration?

COMMENTAIRE / COMMENTARY

Lise Lévesque[1]

Reçu/Received: 17 Dec 2014 *Publié/Published:* 10 Mar 2015
Éditrices/Editors: Maude Laliberté & Aliya Affdal

Résumé
Dans ce commentaire, la valeur bénéfique des dimensions relationnelles relative aux collaborations interprofessionnelles est mise en valeur afin de démontrer que les conflits d'intérêts émanant des auto-référencements sont plus complexes que les conflits d'intérêts traditionnels. Un échange entre professionnels de la santé et éthiciens est recommandé afin de mieux comprendre les aspects relationnels, qui sont essentiels au bien-être et à l'autonomie du patient, concernant différents soins et contextes organisationnels qui se produisent dans les secteurs publics et privés. Ceci afin d'éclairer les élaborations politiques quant à la gestion des conflits d'intérêts associés aux auto-référencements.

Mots clés
référencements, collaboration interprofessionnel, équipe de soins, éthique, relation de soins, soins axés sur le patient

Summary
In this commentary, the beneficial value of the relational aspects of interprofessional collaboration is emphasized to demonstrate that conflict of interests arising in self-referrals are more complex than presented in classic cases of conflicts of interest. A dialog involving health professionals and ethicists is recommended to better understand the relational aspects that are essential to patient wellness and autonomy, in relation to the various care and organizational contexts across private and public sectors. The goal is to inform policy making on management of conflicts of interests associated with self-referrals.

Keywords
referrals, interprofessional collaboration, healthcare team, ethics, care relation, patient-centred care

Affiliations des auteurs / Author Affiliations
[1] Lise Lévesque, AXDEV Group Inc., Brossard, Québec, Canada

Correspondance / Correspondence
Lise Lévesque, levesquel@axdevgroup.com

Remerciements
L'auteure tient à remercier ses collègues pour les discussions inspirantes autour de la collaboration interprofessionnelle.

Acknowledgements
The author wishes to thank her colleagues for inspiring discussions on interprofessional collaboration.

Conflit d'intérêts
L'auteure est Éditrice de la section Comptes-rendus pour *BioéthiqueOnline*. Depuis 2014, elle est chercheure et consultante pour le groupe AXDEV, une entreprise privée offrant des services spécialisés dans la recherche relative à la formation médicale. Les opinions exprimées dans le présent commentaire sont celles de l'auteure et n'engagent aucunement d'actuels ou d'anciens employeurs.

Conflicts of Interest
The author is Section Editor of Reviews at *BioéthiqueOnline*. Since 2014, she has been a researcher and consultant at AXDEV Group Inc., a private firm offering specialised services in research on medical education. The views expressed in this Commentary are those of the author and do not reflect the positions of any present or past employers.

Introduction

In 2014, *BioéthiqueOnline* published a Commentary by Anne Hudon on the conflicts of interest [1] that may arise with self-referrals, defined as the act of referring a patient to a professional, a clinic or a service in which the referent has a financial interest [2]. It appeared that such self-referrals correspond to a classic situation of an unacceptable conflict of interest, and so should be avoided and condemned.

Being trained in bioethics, I can appreciate how important it is to manage conflicts of interest and to put in place processes, policies or frameworks to avoid them when possible. Patient autonomy must be respected, and distribution of health resources should be fair, optimal and based on needs. Useless and inappropriate care should be avoided. However, through my professional experience as a researcher in primary care, I have also become aware of the importance of interprofessional collaborative practices (ICP) for patient-centred care, and of the relational dimension of interprofessional collaborative care (ICC).

As stated by the World Health Organisation:

> The interprofessional collaborative practice in health care occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings. Practice includes both clinical and non-clinical health-related work, such as diagnosis, treatment, surveillance, health communications, management and sanitation engineering [3].

In a document informing the development of health policy, the Canadian Medical Association clarified collaborative care and put forward its relational dimension:

> Interprofessional collaborative care entails physicians and other providers using complementary skills, knowledge and competencies and working together to provide care to a common group of patients based on trust, respect and an understanding of each others' skills and knowledge. This involves a mutually agreed upon division of roles and responsibilities that may vary according to the nature of the practice personalities and skill sets of the individuals. The relationship must be beneficial to the patient, the physician and other providers [4].

Referrals are often the initiator of ICC. In that context, the relational dimension is essential and must be preserved.

Anne Hudon proposed establishing a culture of ethics among the clinicians so as to guide them in the management of conflicts of interest in the context of referrals [1]. In this Commentary, I wish to contribute to the ongoing discussion by emphasizing the importance of recognising and maximizing, in this culture of ethics, the relational aspects that are essential to care. To do so, I first clarify why referral occurs in the context of ICP. Then, I emphasize the value of ICC and of its relational dimension. Finally, I briefly outline general points to consider in future policy making, and recommend a dialog between ethicists and healthcare providers.

Referral, interprofessional collaborative care and the relational dimension

Referral is the act of a health professional of recommending a patient to have a consultation with and/or a follow-up of another health professional. Appropriate referral decisions are based on clinical judgment pertaining to patient health, needs, motivation and priorities. Of course, referral is not equivalent to interprofessional collaboration. ICC is much richer than simply sending a patient to another health professional, although it often begins with a referral. Interprofessional collaboration also involves shared follow-up of patients, which requires frequent and rich communications between health professionals. For example, a patient with a stroke could need orthopaedic care to correct walking patterns, which would require several adjustments and close collaboration with a physiotherapist to obtain an optimal result.

Benefits of interprofessional collaborative care. ICC is broadly recognized as highly beneficial to the patient. Its implementation has been recommended by World Health Organisation [3], and by the

Canadian Health Service Research Foundation [5]. Access to appropriate health professional and continuity of care throughout the health system are attributes of quality care, especially primary care [6], and referrals are one of the most important mechanisms for ensuring appropriate continuity of care. It has often been emphasized that team-based care is the basis of patient-centred care [7]. However, ICC challenges current clinical practices because it requires more coordination and communication, and health professionals need to organise their work differently. Generalisable evidence of its superiority and cost-effectiveness is still lacking [8].

Trust relationships. High quality ICC relies on the possibility for and the ability of health professionals to establish communication and dialog between health professionals [9]. It requires a specific skill set, including the ability to establish trusting relationships with patients, families, other health professionals, and teams [10]. Indeed, good interprofessional relationships must be based on long-term trust, which is more easily achieved when professionals work in the same institution [9,11,12]. The basics of interprofessional collaboration – i.e. creating communication channels (e.g., referral forms), having regular interprofessional activities (e.g., case discussions, interprofessional training sessions, work meetings), and sharing health information and resources (e.g., health records, with the patient's consent) – are difficult to implement when different health professionals are in remote locations [13]. Professional codes of ethics allow communication within a care team, but the patient's explicit consent is needed to allow information flow to health professionals outside the clinic or health establishment where care is initiated.

Patient preference. Patients often appreciate being referred to a health professional who is known and trusted by their primary care provider. Many patients have issues with transportation and prefer to return to clinics they already know they are able to access. Geographical and relational proximity are important to patient [14].

Points to consider in ethical reflection on referrals in the context of interprofessional collaboration

Strengthen relational aspects essential to patient-centred care. Considering the preceding text, it is obvious that ethical evaluation of specific referral practices in the context of ICC should acknowledge and address the relational dimension that is essential to effective and appropriate ICC and patient-centred care. The appropriate and desirable aspects of the relational dimension of specific ICC and ICP should first be clarified to avoid throwing out the baby with the bath water by simply forbidding all referrals that are done within the same clinic. In her commentary, Hudon *did not* recommend adopting such a strict approach to managing conflicts of interest. However, she reported that this is the approach currently applied in Saskatchewan and British Columbia [1]. She also noted that there currently is no unique solution to the problem in Canada, and the merits and pitfalls of each approach should be examined. While Hudon proposed promoting a culture of ethics among clinicians, I wish to emphasize that this culture of ethics should be sensitive to the relational dimension of care. However, the common ground and values of this culture still remain to be established. My contribution is to recommend the essential relational aspects of care should be not only tolerated, but enhanced for the wellbeing of patients.

Support health policy making with information on patient needs and context of care. Establishing team work in healthcare is challenging and there are many organisational and systemic barriers to optimal ICC [15]. For example, one of the challenges for members of new interprofessional teams is to learn to balance case load and coordination of care [16]. Policies related to ICP do have a strong influence on ICC [15]. For example, policies that promote governance models where staff can be hired to support the development of the interprofessional collaboration in the clinic (e.g., business development manager, IT support staff) can help the clinic make the most of their resources [16]. Ethical examinations and policy making processes must be informed of the factors and contexts that

are barriers or enablers of ICC, if they are not themselves to become barriers. Professional ethicists should support their recommendations to health authorities with evidence-based, relevant and accurate information on patient needs and context of care.

Empowering patients in shared decision making on referral. Patient autonomy must be maximized at all times, especially in referrals. Respecting patient autonomy generally is understood as respecting patient desire to be sufficiently informed and to take part in shared medical decision making [17]. Patient autonomy also concerns patient involvement in developing the treatment plan, with respect to his/her priorities, needs, and values [18]. When making a referral, the health professional should provide patients with up-to-date lists of appropriate health resources and health professionals available in their area so as to empower patient and engage them in choosing another health professional if they so prefer. Patients should also be encouraged to voice their concerns regarding any aspect of ICC. For example, a patient may have financial difficulties that limit his/her ability to access certain health professionals. Patients might feel discomfort with a particular health professional's communication style, or may not be ready to engage in certain type of care at a certain moment of their life.

It should also be kept in mind that it is always possible in some cases that the trusting patient-health professional relationship may fail to be established, or the experience or quality of care may be poor. In such circumstances, a patient's autonomous choice to terminate a patient-health professional relationship should be respected. Patients should be encouraged and empowered to communicate any concern at any moment of treatment and follow-up.

Carefully examine financial interests in self-referral practices in and across public and private settings. Despite the desirability of the relational aspects of ICC, it is important to acknowledge certain situations that deserve careful ethical examination to prevent or manage conflicts of interest that may limit patient autonomy in decision making. Indeed, when referral to physiotherapists, nutritionists or other health professionals is made within the same clinic, the situation may be similar in many aspects to self-referral as defined above. If referral and follow-up by other health professionals are appropriate and necessary to patient treatment (as opposed to frivolous and/or superfluous), and the patient is also informed of other possible options available outside the clinic, geographic and relational proximity could justify certain self-referral practices if that is what patient actually prefers.

Organizational characteristics of the clinic or health establishment where self-referral may be performed must also be taken into account, as well as the type of professional practice. In primary care clinics in Quebec and elsewhere in Canada, health professionals like physiotherapists and nutritionists are often in private practice, unless they are hired by the public system to serve in a department of a (public) health establishment. Different private health professionals diversify the health service offerings of family medicine clinics, and they also bring financial income for the clinic, e.g., office rentals [19]. Health professionals are often uncomfortable discussing their financial issues with the patient, as these issues may be perceived as a matter of "internal administration".

Little attention has been given to new models of private health service delivery and to the potential conflicts of interest related to self-referrals made in that context. For example, a broad range of professional services (e.g., by nutritionists) are now available within community pharmacies [20], which are private practices and may be franchises of large companies. It is also possible that diverse models of service delivery may be found amongst different pharmacies. Are patients referred? By whom? What is the relationship to the patient and to the pharmacy? What are the administrative agreements? Referrals within these new models deserve greater scrutiny.

Conflicts of interest are often considered as a problem that is typical of the private sector, because health services are sold to the patient. Health providers in public establishments may be reluctant to

refer patients to health professionals in the private sector [21]. Yet, avoiding discussions on care that is appropriate to patient needs because it is offered by nutritionists, physiotherapists or other health professionals working in the private sector limits patient autonomy. Universal access to care is highly valued by Canadians and health professionals [22-24]. However, information flowing to patients regarding services that are available in the private sector should not be restricted because of decisions made by health authorities regarding public resource allocation. I admit that by stating this, I am preaching against my own personal inclination in favour of universal access to public health care. We should be aware of the fact the public system too has financial interests that must be examined.

Conclusions

With an ethicist's eye, it is obvious that conflicts of interest should in general be managed if they cannot be avoided in health care sector, so as to maximize patient autonomy. However, because of the beneficial value of the relational aspect of interprofessional collaboration, self-referral is often not just the classic case of an unacceptable conflict of interest. It is much more complex. Ethicists can bring guidance to professionals regarding referrals, but in so doing, they must strive to maximize the relational aspects that are essential to patient wellness and autonomy in the context of care. Professional ethicists should consider engaging in a dialog with the different health professionals and officials of health establishments concerned in order to have a clear understanding of ICC across diverse settings, various organizational contexts, and private and public sectors.

List of References

1. Hudon A. L'auto-référencement en physiothérapie : la mise de l'avant d'une culture éthique pour encadrer la pratique organisationnelle. BioéthiqueOnline. 2014; 3(12).
2. Morreim EH. Physician investment and self-referral: philosophical analysis of a contentious debate. Journal of Medicine and Philosophy. 1990; 15(4): 425-48.
3. World Health Organisation. Framework for Action on Interprofessional Education & Collaborative Practice. Geneva: World Health Organisation. 2010.
4. Canadian Medical Association. Putting Patients First®: Patient-Centred Collaborative Care - A Discussion Paper, July 2007
5. Oandasan I, Baker GR, Barker K, Bosco C, D'Amour D, Jones L, Kimpton S, Lemieux-Charles L, Nasmith L, San Martin Rodriguez L, Tepper J, Way D. Teamwork in Healthcare: Promoting Effective Teamwork in Healthcare in Canada. Policy Synthesis and Recommendations. Ottawa: Canadian Health Services Research Foundation. 2006.
6. Haggerty J, Burge F, Lévesque J-F, Gass D, Pineault R, Beaulieu MD, Santor D. Operational Definitions of Attributes of Primary Health Care: Consensus Among Canadian Experts. Ann Fam Med. 2007 July; 5(4): 336–344.
7. Wen J, Schulman KA. Can Team-Based Care Improve Patient Satisfaction? A Systematic Review of Randomized Controlled Trials. PLoS One. 2014; 9(7): e100603.
8. Reeves, S, Perrier, L, Goldman, J, Freeth, D, Zwarenstein, M, Interprofessional education: effects on professional practice and healthcare outcomes (update). Cochrane Database Syst Rev. 2013;3:CD002213.
9. Interprofessional Education Collaborative Expert Panel. Core competencies for interprofessional collaborative practice: Report of an expert panel. Washington, D.C.: Interprofessional Education Collaborative. 2011.
10. Donnelly C, Brenchley C, Crawford C, Letts L. The integration of occupational therapy into primary care: a multiple case study design. BMC Fam Pract. 2013; 14: 60.

11. Perreault K, Dionne CE, Rossignol M, Morin D. Interprofessional practices of physiotherapists working with adults with low back pain in Québec's private sector: results of a qualitative study. BMC Musculoskelet Disord. 2014; 15: 160.
12. Chung VCH, Ma PHX, Hong LCH, Griffiths SM. Organizational Determinants of Interprofessional Collaboration in Integrative Health Care: Systematic Review of Qualitative Studies. PLoS One. 2012; 7(11): e50022.
13. D'Amour D, Goulet L, Labadie J-F, San Martín-Rodriguez L, Pineault R. A model and typology of collaboration between professionals in healthcare organizations. BMC Health Serv Res. 2008; 8: 188.
14. Freeman G, Hughes J. Continuity of care and the patient experience. An Inquiry into the Quality of General Practice in England. The King's Fund. London, UK. 2010.
15. Study Team for Research on Interprofessional Collaborative Practice in Champlain Region. Barriers and Enablers to Interprofessional Collaboration in Health Care: A Regional Scan of Interprofessional Collaboration in the Champlain Region. Research Report. Academic Health Council - Champlain region, Ontario.
16. Scott C, Lagendyk L, and CoMPaIR team. Contexts and Models in Primary Healthcare and their Impact on Interprofessional Relationships, Canadian Health Services Research Foundation. 2012.
17. Ende J, Kazis L, Ash A, Moskowitz MA. Measuring patients' desire for autonomy: decision making and information-seeking preferences among medical patients. Journal of General Internal Medicine. 1989; 4(1): 23-30.
18. Kukla, R. Conscientious Autonomy: Displacing Decisions in Health Care. Hastings Center Report. 2005; 35: 34–44.
19. Kijiji, 2014. Québec > Grand Montréal > immobilier > espaces commerciaux, bureaux on line.
20. Fournier MC, Vézina J. Collaboration interprofessionnelle en pharmacie communautaire. Presentation at Colloque sur la collaboration interprofessionnelle en première ligne - médecin, pharmaciens et infirmières, une équipe gagnante. Jan 16 2009.
21. McDonald J, Jayasuriya R, Harris MF. The influence of power dynamics and trust on multidisciplinary collaboration: a qualitative case study of type 2 diabetes mellitus. BMC Health Serv Res. 2012; 12: 63.
22. Shingler B. Charter of rights, universal health care top Canadian unity poll, June 30 2014, Global News, The Canadian Press.
23. Muzyka D, Hodgson G, Prada G. The Inconvenient Truths About Canadian Health Care, The Conference Board of Canada, 2012
24. Snowdon A, Schnarr K, Hussein A, Alessi C. Measuring What Matters: The Cost vs. Values of Health Care, 2012, International Center for Health Innovation