CONFLICT OF INTEREST, PHYSICIANS AND PHYSIOTHERAPY

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In Brief • En bref

Since Ontario introduced auto-insurance legislation that guaranteed extensive physiotherapy treatment for people who have been in car accidents, the cost of outpatient claims to insurance companies has skyrocketed. However, there has not been a measurable improvement in patient outcomes. At the same time, the average in-hospital stay for patients receiving hip and joint replacements has decreased greatly. Dr. Murray Waldman thinks these divergent trends in rehabilitation can be attributed to physician self-interest.

Depuis que l'Ontario a mis en œuvre une mesure législative sur l'assurance automobile qui garantissait des traitements de physiothérapie prolongés aux victimes d'accidents de la circulation, le coût des réclamations pour services externes présentées aux compagnies d'assurance a grimpé en flèche. Il n'y a toutefois pas eu d'amélioration mesurable des résultats chez les patients. Par ailleurs, la durée moyenne de l'hospitalisation des patients qui ont subi une arthoplastie de la hanche et d'autres articulations a diminué considérablement. Le Dr Murray Waldman pense que ces tendances divergentes au niveau de la réadaptation peuvent être attribuées à l'intérêt personnel des médecins.

The past 3 years have witnessed two major divergent trends in rehabilitation. On the one hand, the cost of inpatient rehabilitation for people with serious injuries or who have undergone major surgery has been declining annually as lengths of stay decrease. At St. John's Rehabilitation Hospital in Toronto, the average length of stay for a patient with a fractured hip has decreased from 56 days in 1992 to 24.2 days in 1995. This has been done with no decrease in the quality of care or patient outcomes, because the criteria for discharge have remained the same.

On the other hand, the cost of outpatient rehabilitation, especially for people who have been in motor-vehicle accidents, has been skyrocketing. According to data from the Insurance Bureau of Canada, the average cost per claim for rehabilitation has risen from $2108 in 1989 to $25 305 in 1994, but there has been no change in the amount of time an accident victim is off work.

The reason for both trends is clear: physician self-interest. On the inpatient side, hospitals face declining funding and are looking at new costing formulas based on "case costing." In its most basic form, case costing means that a hospital receives a fixed amount for treating a patient based on diagnosis, regardless of length of hospital stay. Under this formula, it is in the best interests of the institutions and the doctors who work there to treat patients in a way that will minimize their length of stay. By doing this, beds can be turned over more rapidly, more patients can be treated and money can be saved. At St. John's Rehabilitation Hospital, where I am the medical director, the length of stay for total joint replacements has decreased from about 31.8 days in 1992 to 17.5 days in 1996.

The exact opposite is true in the treatment of patients who have suffered relatively minor injuries in automobile accidents. In these cases, the cost of rehabilitation has almost doubled in 2 years. The reason for this is Bill 164, auto-insurance legislation that was enacted in Ontario in January 1994.

One of its provisions is that anyone injured in a motor-vehicle accident is entitled to up to $1 million in medical and rehabilitation costs. Furthermore, the insurance companies are obliged to pay whatever is billed; if they disagree with the bill's amount

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they can challenge it — after it has been paid.

This legislation arrived at the same time as the fees paid to physicians through the Ontario Health Insurance Plan (OHIP) were being capped and clawed back. The new bill meant there was no ceiling nor any control over what could be charged for the delivery of rehabilitation services, because these bills went directly to insurance companies; they had nothing to do with OHIP or any other government agency.

Some physicians who also owned rehabilitation facilities quickly realized that as gatekeepers who decided which patients required physiotherapy they could refer patients to their own facility, and earn money that was exempt from government caps and clawbacks.

The practice of referring patients to facilities in which a physician owns an interest is a major ethical concern.[1]

According to the University of Toronto's Presidential Commission on Conflict of Interest, "a conflict of interest arrives when one (i.e., a physician) is placed in a position where one's personal interest, often a financial interest, conflicts with one's obligation to, or the interests of, the institution (or one's patient)." [In February, the College of Physicians and Surgeons of Ontario announced that it was moving the issues of self-referral and conflict of interest to the top of its agenda. Its actions are described in the article on page 1744. — Ed.]

This situation was eloquently described by George Bernard Shaw in the introduction to *The Doctor's Dilemma*: "That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg is enough to make one despair of political humanity, but that is precisely what we have done. . . . It may be necessary to hang a man or to pull down a house. But we take good care not to make the hangman or house breaker judges of that. If we did, no man's neck would be safe and no man's house stable."

I believe that the medical profession should take a firm stand against self-referral clinics. Section 45 of the CMA Code of Ethics states that an ethical physician "will avoid any personal profit motive in ordering drugs, appliances or diagnostic procedures from any facility in which the physician has a financial interest."

Are doctors' treatment decisions really influenced by their own financial concerns? The answer, sadly, is yes. There are numerous examples: the ordering of medications from pharmaceutical companies that provide free trips or other perks, the ordering of tests from laboratories in which doctors have a financial interest, or the referral of patients to therapy centres that are owned by physicians.

How widespread is this practice in Ontario? Since Bill 164 was introduced, the number of doctor-owned rehabilitation facilities has increased significantly and new facilities continue to open.

What about the cost of treatment? Before the advent of Bill 164, patients could be treated in either private or OHIP-funded clinics. The private clinics had appeared because for the last 20 years there has been a moratorium on issuing new licences to open OHIP-funded clinics. However, those clinics did very well financially — so well, in fact, that whenever one was sold the price often exceeded $1 million. In 1994, a clinic in Burlington, Ont., was on the market for $1.4 million.

These clinics bill OHIP about $15 per session for rehabilitation services. In the clinics that bill insurance companies, session fees range from $37.50 to $65. In a clinic that bills OHIP, a physiotherapy assessment done by a physiatrist — a physician with 5 years' postgraduate training in physical medicine — is billed at $53.60; consultations by a neurosurgeon are billed at $84.50. Clinics billing the insurance industry charge $150 to $290 for a physiotherapy assessment.

According to industry sources, the higher costs and numbers of rehabilitation services have not resulted in less time off work (or time on claim) for patients treated in these centres; patients may even be receiving longer treatment than they would have before Bill 164.

The *Toronto Star* (Jan. 2, 1996) reported that a local organization was encouraging doctors to join a venture to share the cost of setting up a rehabilitation centre. The physicians would refer patients to the clinic, and the operator and physician-investors would split the profits. The *Star* said physicians would expect a return on investment in the range of 185% per year.

It is clear that these clinics create a conflict of interest that results in much higher costs to the insurance industry and ultimately to everyone buying auto insurance. Can anything be done about this?

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In the US this problem has been solved by legislation, which states in part: "A physician may not refer Medicare or Medicaid patients to a facility where the physician has either an ownership interest or a financial relationship." It is worth noting that physicians can own these facilities in the US;[2,3] however, if they refer patients to them the insurer, either Medicare or Medicaid, will not pay.

If the College of Physicians and Surgeons or the government doesn't legislate against these practices, what can the insurance industry do? First, it should demand that a certain standard of care is met. This could be done by having all facilities that bill the insurance industry meet certain standards that could be set and overseen by an impartial expert in the field, such as experts from a rehabilitation hospital.

Second, the industry should set fees that are reasonable and pay only according to this schedule.

Third, the industry should provide clients with a list of preferred providers — centres that demonstrate excellence in rehabilitation and involve no conflict of interest.

Shaw summed up the extremes to which conflict of interest can lead this way: "I cannot knock my shins severely without forcing on some surgeon the 'difficult question': Could I not make better use of a pocketful of guineas than this man is making of his leg?"

If we get rid of conflict of interest in rehabilitation medicine physicians will not be faced with this sort of difficult decision, and we will all be better for it.

References

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