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CONFLICT OF INTEREST AND PHYSICAL THERAPY

Mike W. Martin & Donald L. Gabard

Most philosophical attention to health care ethics has focused on physicians and nurses, neglecting the moral issues faced by physical therapists and other members of allied health care fields. The neglect is compounded by misperceptions that physical therapists are technicians rather than professionals, that they do not have fiduciary relationships with patients, and that they lack all discretion in allocation matters. In fact, physical therapists possess discretionary power in treatment selection, advising, and duration and intensity of therapy—all areas in which trust and trustworthiness are paramount. In addition, their work tends to make possible longer time spent with patients. And their contributions to health care are distinctive in terms of the techniques used in restoring persons to a more functional, pain-free, independent life, as well as in preventing injury and pain. For all these reasons, the neglect of physical therapy ethics fosters a lack of vigilance that sometimes masks abuses, such as those arising from conflicts of interest.

The definition of conflicts of interest is itself contested, quite apart from physical therapy ethics. We begin by proposing a definition and providing a rationale for it, using examples from several professions. Then we make a few general comments about evaluating conflicts of interest. The remainder of this chapter discusses issues of current interest in physical therapy under six headings: (1) advising and providing, (2) physician referral, (3) equipment and supplies, (4) gifts, (5) inappropriate sexual behavior, and (6) teaching and research. The categories are not exhaustive, but they suffice to illustrate an array of recurring problem areas.

Defining Conflicts of Interest

Conflicts of interest have always arisen in all forms of work, but the expression "conflict of interest" has somewhat recent vintage, as Neil R. Luebke (1987) points out. Only since the 1930s did the phrase acquire currency in law and then spread to other professions. Its original usage targeted relationships of trust in which a fiduciary acquired interests in property (money, jobs, etc.) or persons (family, friends, etc.) inimical to meeting duties to clients, employers, or the general public. Thus, judges should not try cases involving their own children, and attorneys should not accept two clients whose financial interests directly clash. Luebke (1987) contends that we should retain this original meaning. In his view, conflicts of interest involve (1) fiduciary relationships and (2) "objective interests" (rather than mere subjective biases), such as "some material right, benefit, asset, or share possessed by the fiduciary or by others with whom he/she is legally or closely associated (family members, business partners, employer, benefactor, client, or the like)" (p. 69).

Other philosophers broaden the definition by expanding the range of interests that threaten responsibilities; simultaneously they narrow the definition in other ways. Thomas Carson (1994), for example, expands interests to include altruistic desires, such as a company official's desire to help a nonprofit charity by donating corporate funds and also malicious desires such as to harm someone by not awarding their company a contract. At the same time, he also restricts conflicts of interest to employees, thereby excluding self-employed professionals. Again, Michael Davis (1982, 1998) expands the relevant interests to include virtually any desire or duty, attitude or aim, bias or benefit having a tendency to adversely affect judgment within a role. Yet he restricts conflicts of interest to situations involving the exercise of judgment or discretion, apparently ruling out occasions when one's responsibility is entirely obvious and requires no exercise of judgment.

We share Luebke's worry about losing the usefulness of the concept by stretching it too far. Nevertheless, his attempt to limit interests to material matters, "objective" relationships, and fiduciary relationships is needlessly restrictive, as is Carson's restriction to employee status and Davis's limitation to matters of judgment—even though these factors have great moral significance in the cases we discuss. In particular, we agree with Davis that most conflicts of interest involve matters of judg-

ment, where judgment is "the capacity to make correctly decisions not as likely to be made correctly by a simple clerk with a book of rules and access to all the facts" (Davis, 1982, p. 27). Yet, conflicts of interest also arise in routine matters when sophisticated judgment is not required, and when by-the-book decisions straightforwardly indicate one's obligation in the situation. It can be entirely obvious what should be done, even to the agent who through weakness of will or outright greed fails to do what is right.

Regarding motives, we note that typically professionals have mixed motives in all areas of their work: compensation motives (income, recognition), craft motives (commitment to excellence), and moral concern (caring, integrity). (Martin, 2000). These multiple motives interact in complicated ways, usually reinforcing each other but occasionally pointing in opposing directions. In most conflicts of interest, compensation motives threaten responsibilities within professions and organizations, although occasionally altruism conflicts with professional responsibilities, as Carson points out. Complete explanations of any ensuing wrongdoing need to be contextual and to make reference to motives linked to both social influences and personal character. (Martin, 1999).

In our view, the crux of conflicts of interest resides in significant threats to role responsibilities, where role responsibilities are well-delineated duties attached to formal assignments within organizations or social practices, such as professions. Accordingly, we adopt the following definition: "Conflicts of interest are situations in which individuals have interests that significantly threaten their role responsibilities, or would do so for a typical person having their role." Although the definition is simple, thereby adding to its usefulness, we offer the following comments by way of further clarification and rationale.

Areas of vagueness in a definition can actually be helpful by identifying areas in which practical controversies are likely to arise. Consider the word "interest." Ordinarily, we might not speak of a conflict of interest when professionals' duties are only somewhat threatened by interests centered in personal life, such as family difficulties, desires for illegal drugs and excessive use of alcohol, or sundry bigotries. Our definition allows for this by speaking of "significant" threats (dangers, hindrances) to duty. We reasonably expect and demand professionals to maintain *professional distance*, that is, to avoid allowing personal biases and interests to distort their work (Martin, 1997). Some conflicts of interest arise when distance is placed at risk, as when individuals know (or should know) that their prejudices or addictions are beginning to significantly threaten their work, perhaps by tempting them to issue biased rulings (judges, referees) or to steal drugs from a hospital (health professionals).

Why does the definition refer to both individuals and typical persons? Consider a judge of such exceptional integrity that we know she would be fair in adjudicating a dispute involving a family member. The judge is still in a conflict of interest in cases involving family members because, according to ordinary usage, a typical judge in that situation would be at risk of failing to properly fulfill his or her role responsibilities. Conversely, some professionals are inclined to lose distance in particular areas (perhaps a specific religious matter) in which a typical professional would not, and hence the definition also refers to the individual involved.

The term "formal role" also deserves comment. We intend rule-structured activities with assigned responsibilities within social organizations—understood broadly to include professions, corporations, and voluntary organizations—that assign responsibilities and authority. Do families involve formal roles? We do not think of them that way, at least given their great variability within contemporary Western societies, but others might. For example, others might speak of a conflict of interest when Christian Scientists or Jehovah's Witnesses withhold essential medical care (on religious grounds) from their young children. In a similar vein, Davis (1993) suggests that parents face a conflict of interest when their desire to take a weekend trip threatens their judgment about their child's medical care. We consider these applications of conflicts of interest a bit expansive, but our definition helps us pinpoint the source of disagreement.

Again, is citizenship a formal role? We do not think so, because the role delineations and duties involved are too diffuse and disputed, but others might disagree. Consider Antigone, who has conflicting obligations (and conflicting interests): a citizenship duty to obey King Creon, who forbids the burial of her brother, and a religious duty which requires burying her brother. In our view, Antigone faces a conflict of duty (a moral dilemma) but not a conflict of interest. There would be a conflict of interest, however, if Antigone had been the King's Deputy of Burials. If others disagree, our definition at least helps explain why the disagreement arises.

Evaluating Systemic and Episodic Conflicts

Joseph Margolis (1979) suggested that Antigone is not caught in a conflict of interest for a different reason. In his view, conflicts of interest are restricted to situations in which it is morally wrong to follow the conflicting interests together. We disagree: Some conflicts of interest are inevitable or otherwise tolerable, and hence permit pursuing both interests (cf. Davis, 1982). This leads us to offer a few general comments on the moral evaluation of conflicts of interest.

Why do conflicts of interest have such great moral significance? Part of the answer is clear from the definition: They threaten responsibilities. Another part of the answer is that even the appearance of conflicts of

interest can endanger the trust which is so important in professional relationships. However, to say that conflicts of interest are morally problematic, especially in raising issues of trust, does not settle how to resolve them. For there might be additional moral considerations, whether additional responsibilities or rights, that override the threat to role responsibilities and permit pursuing the (conflicting) interest. To illustrate that point, let us distinguish between episodic and systemic conflicts.

In this chapter we are interested in recurring conflicts of interest, ones that arise with frequency rather than by occasional happenstance. Recurrence takes two forms. *Episodic* conflicts of interest arise in particular situations as a result of voluntary choices (beyond simply choosing to serve in a formal role), yet they can be recurring in the sense of widespread. Giving and accepting personal gifts is a familiar example we will discuss. By contrast, *systemic* conflicts of interest arise from the very structure of formal roles. For example, there is an ongoing temptation in all professions to provide unnecessary services to clients in order to increase profits.

The last example, which we discuss in the next section, illustrates how systemic conflicts of interest can be inescapable, short of overthrowing or radically modifying social practices and economic systems (which often generates new systemic conflicts). As a second example, it is cost-effective for the Federal Aviation Agency (FAA) to select some employees of airline manufacturers to serve as government inspectors. (Martin & Schinzinger, 1996). Here the conflict of interest is internal to the individual's professional roles: professional duty versus professional duty, rather than duty versus personal gain. The dual roles of government inspector and corporate employees constitute a conflict of interest, but when individuals are carefully selected, the practice saves taxpayers the costs of a wholly independent set of inspectors for complex technology (or risking public safety by doing without inspectors).

In general, systemic conflicts of interest are *tolerable* when the relevant systems (institutions, economic structures, etc.) are morally permissible and when effective procedures of overseeing abuses are in place (laws, self-regulations within professions, consumer-group publications). We will largely take for granted the economic systems of Western democracies that combine capitalism (free enterprise), government regulation, and professional self-regulation currently established in the United States. Nevertheless, we are less sanguine about current substructures in health care, in particular many aspects of current managed health care. Capitalism takes many forms, and the rapid changes currently under way confirm that the United States has yet to achieve anything like an ideal form with regard to health care.

Calling a conflict of interest tolerable or inevitable does not banish moral concern. Such conflicts continue to be of concern because responsibilities continue to be at risk. Inevitable and inescapable conflicts of interest call for moral vigilance and conscientiousness by committed professionals and equally vigilant disciplinary structures. Notoriously, these things are in short supply in long-established professions, and difficulties are compounded in still developing professions such as physical therapy.

Regarding episodic conflicts, alternative moral responses include the following options: (1) escape from them, typically by relinquishing the conflicting interest that threatens the role responsibility; (2) avoid them in the first place; (3) disclose them to appropriate parties (e.g., employers and clients); or (4) take other steps, as appropriate, if only exercising special caution to ensure that role responsibilities are properly met (Davis, 1998). As we proceed, we will discuss which option is appropriate in a particular situation. We add a prefatory caveat about disclosure, which is too readily taken to be sufficient.

Health care exists because someone is vulnerable and in need of care. Furthermore, harm caused by mistakes frequently cannot be undone, unlike financial or legal matters. As a result, disclosure of conflict of interests is generally not enough. To undermine the trust on which care is built is to diminish the care, regardless of whether professionals profit. Unlike a profession such as law or banking, where it is desirable for all parties to be vigilant and where full disclosure helps ensure that vigilance, in health care the primary concern and focus are to achieve better health or function. To minimize the threat to trust, there is a strong presumption that therapists and other health care professionals should do everything possible to avoid conflicts of interests as they relate to patient care.

In short, to call something a conflict of interest is to raise a (moral) red flag, but it does not indicate how the flag is to be waved. As an analogy, consider the word "deception." All deception raises moral questions, but the questions are sometimes easily answered and other times sharply contested. Deception is permissible in a game of poker; it is obligatory when it is the only way to defeat a tyrant in order to save many innocent lives; its moral status is subject to debate when it is used to conceal personal sexual matters (as recent debates about President Clinton revealed). Exactly when and why conflicts of interest are morally objectionable needs to be explored contextually, a task to which we now turn.

Advising and Providing: Intervention, Outcome, and Payment

In physical therapy, as in other professions, the most basic systemic conflicts of interest center on the primary good served. Described in general terms, this good is shared within all health fields: to promote health while

respecting patient rights. Described more specifically, the good served by physical therapy is to restore persons to a more functional, pain-free, and independent life, and also to prevent injuries and pain. Three interwoven questions arise immediately:

1. When is health care intervention warranted and at what level?
2. Who defines acceptable outcomes—patient, provider, or reimbursement organization?
3. What is the cost, and who pays?

Most of us, healthy and functional within the expectations of others, our age, and our level of activity, could profit from physical therapy services in prevention (proper body mechanics) or even improvement in such things as balance and gait. Who defines the threshold for services? If left to patients, all will draw a different line in the sand. Even when there is obvious disability, some patients are quickly resigned to a life of needless dysfunction; others want not mere average abilities but athletically competitive skills. Needs for physical therapy can be highly specialized, even within the specialties recognized by the national organization and achieved through extensive specialized training and monitored clinical experience. For example, within sports medicine, some physical therapists have specialized in treating only professional dancers due to the unique injuries and risk in that profession.

As with physicians, therapists' primary conflict of interest is inherent in the entrepreneurial method of reimbursement and acquisition of medical services. All health care providers have one foot in an ethic of equality (serving all patients to the best of one's ability) and another foot in an ethic of equity (service according to ability to pay or a plan's prenegotiated equity format). In addition, each of the methods of reimbursement carry with it potential conflicts of interest between whatever service is provided or denied and the financial well-being of the provider.

Again, as in most professions, physical therapy generates systemic conflicts of interest centered on the therapist's dual roles of adviser and provider (Green, 1990; Kipnis, 1986; May, 1996. McDowell, 1991; Rodwin 1993). Thus, most professionals advise clients about options, help decide the best course of action, and then provide the services. The implications of adviser–provider conflicts differ according to the payment systems within which health professionals function, and those systems are in the midst of turmoil on a historic scale. Many options are being experimented with, but two main categories are fee for service and managed care.

In traditional fee-for-service systems, the provider role is a systematic incentive to advise for unnecessary services, thereby raising costs dramatically. As a general tendency, fee for service brings higher costs for patients, unnecessary tests, and unnecessary procedures. Under fee for service, the therapists' self-interest is to set goals and timetables that will harvest the maximum payment, yet patients' desire to restrict cost as much as possible.

By contrast, in managed health care systems, the costs of providing services constitute a systematic incentive not to advise patients of all needed services (to minimize usage of services, given that capitation pays according to numbers of members rather than usage). In a managed care environment, the conflict of interest is between a duration of treatment which is in the best interest of the client and what is permissible under the managed care plan. The move to managed care has generated many adviser role conflicts for physical therapists: Should therapists inform and counsel clients about the true potential and risk in the minimal care they are being asked to provide? How about informing clients of options that might produce beneficial results but at extra cost for the provider? Or, should therapists proceed to limit client expectations to meet standardized pathways and time frames?

The current system encourages providing a minimum level of care rather than an optimal level. Economic realities cannot be ignored, but concern for the patient must remain paramount. When patients would probably profit from additional treatment, they should be so informed. Defending the adequacy of a managed care pathway, which is not accurate regarding the individual, is dishonest even if the employer is embarrassed. Therapists should not sign contracts that forbid them to express professional opinions ("gag orders") any more than physicians should.

The primary responsibility of physical therapists is to clients: to provide quality services and products at reasonable costs within the constraints of respect for autonomy. In addition to issues of cost, quality, and control, there are related considerations about honesty and maintaining the public trust, which often require avoiding even the appearance of objectionable conflicts of interest. In addition, there are responsibilities to employers, to other professionals with whom one works, and to the general public. Exactly when these responsibilities are sufficiently threatened requires examination of the dangers arising in particular types of situations, informed by an understanding of human propensities and historical settings.

Finally, the American Physical Therapy Association (APTA) Code of Ethics sounds the right note, although it leaves specifics to the judgment of individual practitioners. The accompanying "Guide for Professional Conduct" explicitly forbids certain types of conflicts of interest (without using the expression) (APTA, 2001). For example, section 7.1.B states that "A physical therapist shall never place her/his own financial interest above the welfare of individuals under his/her care," and 7.1.F states that "A physical therapist shall not directly or indirectly request, receive, or participate in the dividing, transfering, assigning, or rebating of an unearned fee."

Physician Referral

Physician referral constitutes one of the most discussed issues surrounding conflicts of interest in physical therapy, partly owing to historical reasons. At one time physical therapists worked more directly under physicians' supervision. As physical therapy became increasingly professionalized (a process still continuing), with greatly augmented skills required in both diagnosis and treatment, there was a strong move toward therapists working privately. As a result, referral arrangements began that allowed physicians and physical therapists to profit when physicians were paid simply for making referrals.

By the early 1980s there was increasing awareness that the practice had serious potential for abuse, and in its grossest forms it constituted kickbacks that significantly increased costs to patients, potentially affected judgments about quality of services, and threatened a loss of public trust. A consensus arose that referral is not itself a service from which physicians should be allowed to profit but essentially a type of kickback arrangement that invites numerous abuses. In 1983, the APTA forbade physical therapists from entering into arrangements that allowed physicians (or other referring practitioners) to profit simply from making a referral.

Philip Paul Tygiel (1989) cited many illustrations of instances in which patient rights were abused when physicians were allowed to profit from referrals. The cases included physicians and therapists alike providing unnecessary services, low-quality care resulting from physicians not focusing on adequate specialization of the therapists they used, and denying patients the therapist they prefer, either individuals or those in convenient locations near their home. In one case study, an orthopedic surgeon employed a physical therapist who, although well trained in treating spinal conditions, did not have an expertise in hand therapy—even though hand surgery was a primary component of the surgeon's practice. Hand therapy and the custom splinting frequently required by patients is a highly specialized area of practice for both physical and occupational therapists. The surgeon still referred his patients to the therapist in his employment, even though patients frequently had to be referred again to one of four qualified hand therapists in the community for resplinting because the therapist employed by the surgeon lacked the special skills needed. The resplinting by a qualified therapist was an additional cost to the patient.

The APTA Code of Ethics has since been clarified and strengthened to forbid physical therapists from entering into many problematic referral relationships. Regardless of how carefully a code is constructed, however, it is not possible for a single document to anticipate all possible variations on a common theme. For example, we know of a case in which the husband is a physician and the wife is a physical therapist. Although legally their practices are separate, and therefore withstand the APTA definition of conflict of interest, the private and personal perspective clearly defines a conflict in which their joint income is enhanced by referrals from the physician husband to his therapist wife. The physician responds that he wants his patients to receive the best physical therapy care available, and he believes that is provided by his wife. In this case, there is clearly a possibility for abuse. Disclosure to patients by the physician or therapist should be supplemented with a listing of other therapists in the area with similar training prior to the first appointment.

A general reading of the intent of section 7.3 in the "Guide for Professional Conduct" appears to support the spirit of this recommendation. The section states that "A physical therapist shall disclose to the patient if the referring practitioner derives compensation from the provision of physical therapy." (APTA, 1997).

Referral issues have become somewhat more convoluted with managed care where the senior physicians in the health maintenance organization (HMO) hold ownership of the HMO. Profit is still the concern, but this time underuse rather than overuse poses the more serious offense. The dilemma is compounded by the dependent role the physical therapist experiences in practice. Although in some states, such as California, the physical therapist can treat a patient without a physician's referral, the vast majority of insurance carriers will not reimburse without the referral. As a result, therapists are financially wedded to physicians, even though they have professionalized themselves to the point to which many make independent evaluations and treatments of disabilities. This financial tether is somewhat unique, and although it may disperse liability and accountability, it has the potential to bind the professional judgment of the therapists to a menu of physician-acceptable options.

Referrals to therapist-owned facilities might not be ethically resolved by a simple disclosure of interests. Patients trust therapists as they do physicians to act and recommend in the best interest of the patients. The trusting relationship is itself diminished if the patient has to monitor the provider. To maintain the more comfortable trusting relationship, patients ignore confessed disclosures as a required process that may be pertinent to others but certainly not to their relationship.

Equipment and Supplies

Frequently physical therapists make equipment for patients, such as splints and seating inserts. Usually only the therapists who work with the patient know their specific needs and have the specialized knowledge to order equipment. In private practice it is usual for the therapist to charge patients for materials and sometimes the time used to construct

the equipment. Frequently these therapists supply equipment cheaper than that available through specialized vendors, but not always.

Therapists who fabricate equipment for patients often cite patient benefit as the primary motivation. Because equipment, especially splints, has to be custom made in many cases to the specification of the therapists, they argue that it is both time efficient and ultimately contributes to a better product when therapists do the fabrications. Doing so, they do not have to bring another person into the clinic and take the time to communicate in detail the patient needs. They also point out that while fabricating a piece of equipment, they are free to respond to unanticipated variables and to change the specifications of the equipment and implement those changes immediately.

Many therapists charge only for the cost of the materials and their customary practice rate, or some fraction thereof, to generate the equipment. There are, however, companies strictly dedicated to the creation of these appliances and they are quick to point out that this practice robs them of needed income for the task for which they are specifically trained. Perhaps, however, there is the greater problem of the appearance of a conflict of interest. Therapists can easily fill any downtime with equipment fabrication, thereby securing a secure and steady income in private practice. Thus, there is the temptation to create a market for equipment with a population that could not possibly get the exact appliance without going to another therapist who also manufactures appliances. The appliances are so uniquely a blend of the patient's need and the therapist's goal of correction that without the therapist's input, an outside vendor would be unable to adequately meet the patient needs.

Therapists should not have major financial interests in the company that supplies them with products they use in practice. However, there is an interesting dilemma inherent in this advice. People are advised to invest only in areas in which they know the products and the markets. If therapists are also good business persons intent on securing extra financial security through investments, their fiscal manager might advise investing in companies whose products they know to be better than the competition's. Thus even though therapists may own stock in those companies from which they make purchases, they are driven by the commitment to provide the best supplies. Only if the company supplies inferior products, offers direct kickbacks, or becomes excessive (as defined by reasonable guidelines within organizations and the profession) is the stock ownership inherently objectionable.

Gifts

The importance of context and of appearances enters into thinking about gifts. Principle 4.4 of the APTA's "Guide for Professional Conduct" states: "A physical therapist shall not accept or offer gifts or other considerations that affect or give an appearance of affecting his/her professional judgment." This is a good, clear statement, but even so it leaves some areas of vagueness. The intent is not to forbid all gifts. That prohibition may become necessary in some professional settings, such as the defense industry. But in physical therapy, as in many other professions, hard and fast rules on gifts can cause unexpected negative consequences.

Many gifts by vendors are "reminder items" that have negligible monetary value. But as a tool to enhance a relationship, their value cannot accurately be measured in dollars. Instead, it must be considered relative to the subtle influence on the relationship and related decisions. The American Medical Association (AMA) allows small gifts, and anyone who has attended a health profession conference in this nation has experienced how widespread this practice has become. At APTA conferences, as well as at other health-related conferences, the trend has been away from promotional gifts which can be used with patients and instead toward gifts specifically for the therapists, often without any relationship to the products the vendors sell.

Other gifts raise different concerns, in both their acceptance and their rejection. In most physical therapy settings, the therapist is engaged with the client for significant lengths of time, and the quality of that time is enhanced by collaborative goal setting and assessment that frequently builds a social as well as professional relationship. Clients often see the therapist as their primary advocate and sometimes their primary hope for restoration of function. As a result, gifts from clients to therapists are common, especially in pediatric settings and often insignificant in their cost—drawings, homemade cards, and so on. Whereas with vendors small gifts may be objectionable because they build a relationship that will influence products purchased and used, in this case they appear to actually strengthen a component of care and caregiving that is advantageous for the client.

It is also true that in some cultures gifts are given to health care providers out of custom and appreciation, without any intended influence to acquire more or better services. In those cases, to refuse such a gift is considered an insult. It symbolically states that the giver and the gift are unappreciated and thereby disrupts the client-therapist relationship. Because the type of work that the therapist perform requires maximum effort and cooperation from the patient, any action that diminishes the trust with the patient potentially diminishes the effectiveness of the intervention.

At the same time, no therapist is immune to attempts by clients to influence them to provide more services in appreciation of a gift. Patients sometimes try to influence therapists to continue treatment after the point at which, in the therapist's judgment, the patient has the capability of benefiting from treatment. As long as the therapist continues to treat

the patient, many believe that hope for significant recovery or restoration of function exists. No one wants patients to abandon realistic hope, nor should patients and loved ones cling to false hope when doing so undermines efficient use of services or equipment. In these ways, gift giving and receiving are caught in the nuanced interplay of hope and honesty in ways that call for good judgment rather than fixed rules.

Cost of the gift is one guide to its intent, but surely it is a fallible guide. Gifts must be assessed against the background of the economic situation of patients rather than the value relative to the therapist. What may appear to be a large gift to one therapist may be an inexpensive expression of appreciation by a client, whereas for another client it would be a considerable sacrifice. In all these cases one must assess the intent based on the history of the relationship and what is known of the client.

Despite these and other moral nuances of gift giving and receiving, in practice the difficulties are not insurmountable. Claudette Finley (1994) offers several criteria that handle most cases. Gifts should be expressions of gratitude, not manipulation or coercion; they should have minimal monetary value; they should not significantly shape relationships with vendors; they are best when they benefit people in need; the cost of gifts must not be passed on to clients; most important, one should be willing to have the gift disclosed to interested parties.

Inappropriate Sexual Behavior

Mentioning inappropriate sexual behavior immediately brings to mind misconduct initiated by professionals, but in fact patients are also initiators. If not dealt with properly, inappropriate sexual behavior by patients creates conflicts of interest for the therapist and threatens performance of their responsibilities as health care providers.

Physical therapists are especially at risk for these behaviors because of the close physical contact and prolonged private communication with patients. In addition, because of their physical disability and complex psychological states triggered by medications, feelings of isolation, and damaged self-esteem, patients are frequently in need of reassurance that they are desirable and lovable. Usually the therapist intervenes at a time in patients' lives when they lack their usual degree of power at work, within families, and elsewhere.

Inappropriate sexual conduct by patients expresses itself on several levels (McComas, Hebert, Giacomin, Kapla, & Dulberg, 1993). Mildly inappropriate sexual behavior by patients, characterized as suggestive stories or solicitations for dates may, depending on the setting, best be handled by the therapists ignoring or being nonresponsive to the behavior, thus in effect escaping from the conflict. Moderate (deliberate touching, direct propositions, etc.) and severe (forceful fondling and attempts to secure sexual intercourse) inappropriate sexual behavior by patients present the therapist with difficulties as well as temptations.

According to a study conducted in Canada, 92.9% of surveyed practicing physical therapists had experienced some level of inappropriate patient sexual behavior in the work environment (McComas et al., 1993). Of those, 32.8 percent of female physical therapists and 37.5 percent of male physical therapists had experienced severe inappropriate sexual behavior by patients. More than 66 percent of students in physical therapy, by the end of their training, had experienced inappropriate sexual behavior by patients. In the United States, a national study published in 1997 found that 86 percent of physical therapists had experienced some form of inappropriate sexual behavior by clients and 63 percent reported at least one incident of sexual harassment by clients (DeMayo, 1997). The problem is recognized as sufficiently prevalent that some educational institutions are implementing instruction on this subject in their curriculum.

The role of power is one of the most frequently discussed components of sexual harassment, of which sexually inappropriate behavior is a component. Paradoxically for therapists, the relevant question is whether there is truly a power differential between therapists and patient and, if so, who has the power? The patient is dependent on the delivery of service by the therapists, but dependency alone does not mean there is a power differential in favor of the provider. In restaurants we do not assume that the server has an elevated position over the patron even though the patron is dependent on the server for the delivery of food. In our health care system, the patient is empowered as a consumer. Indeed, within the managed care environment in which companies openly compete for patients, even the doctor's position of power has been usurped, at least in the eyes of many consumers of health care. The third-party payer or its spokesperson, the health care administrator, is seen by many as the one with ultimate authority over the dispensation of care. Although therapists have significant discretionary power, the general public perception is increasingly that the business manager controls the physician and the physician controls the therapist.

Clearly no one should be forced to compromise his or her personal or professional ethics in the performance of his or her job as health care provider. In these cases, it would seem that disclosure to appropriate parties would better secure a just outcome. However, when power is perceived to be with the consumer, it is feared that administrative efforts will downplay the offense or even blame the therapist for contributing to the situation. Administrators are concerned about keeping patients happy with the services provided in order to keep the market share necessary

for survival and profit. Being portrayed to the public as repressive, lacking a sense of humor, or just being plain hard-nosed does not increase subscription rates or ensure continuing contracts.

In addition, not wishing to bring their own integrity into question, many therapists ignore the behavior and fail to report it to supervisors. Avoidance of the problem may include requesting another therapist to assume the care of that patient for fear that if rejected, the patient may retaliate with false charges of inappropriate sexual behavior toward him or her. More often, however, therapists who complain about patient behavior to supervisors are awarded the status of a whistleblower concerning an institutional secret. The therapist is left alone without any realistic means of protecting him- or herself or achieving fairness.

The institutional response should focus on the long-term survival of the organization. That means recognizing that the health care worker should be afforded the same protections from patients that are already assured legally to coworkers. Substantial numbers of therapists simply will not stay in an employment setting in which their personal integrity is sacrificed for the business of health care. When therapists are harmed by patient behaviors, the quality of care is diminished, either through avoidance or through stringent risk-reduction efforts. To meet expectations of quality care delivery and to maintain a stable work force, health care organizations must make it clear to patients and staff that sexual harassment policies extend to patients as well as to staff.

Regrettably, on occasion therapists solicit sexual favors from patients. These patients may perceive that the quality of care is dependent on their compliance with inappropriate requests. Beyond issues of coercion, there is the far more troubling matter of maintaining trust. Patients typically assume that professionals are obligated to set aside personal opinions and self-serving motivations to provide optimal and objective care. When the therapist diminishes the trust built on that assumption, all who share the assumption are damaged to the extent that they are aware of the violation. There is an unanticipated and unacceptable cost to the patient for the services requested.

What about situations in which sexual attraction is mutual and appreciated? Is there harm to the patient, the therapist, or the institution that provides the care? One troublesome part of this situation when there is no easily defined victim is the issue of the genuineness of a relationship. Formal roles (therapist, patient) can eclipse important values that support lasting committed relationships often desired by the parties. But even if we have no interest in protecting the genuineness and duration of relationships, we have concerns when the purpose of the organization is subverted by personal interests. A health care service environment is by necessity tightly focused on the services and equipment linked to the delivery of care. It has nothing to gain but potential problems and liabilities by allowing behaviors unrelated to its mission.

Teaching and Research

Physical therapists who are also professors of physical therapy have new roles and hence new conflicts. Like other professors, professors of physical therapy have enormous demands from their research, consulting, and family that can threaten teaching responsibilities. Exactly how much time, effort, and skill are morally obligatory in the teacher role is contestable, thereby inviting temptations to give more attention to prestige-promoting publication at the cost of students. But there are threats to research as well, and in general the compensation motives of personal income, job security, and prestige present threats to role responsibilities in academia, as they do in serving patients.

There are also episodic conflicts of interest shared with other professors, such as having sexual affairs with students in their classes. Are they threatening their ability to grade fairly—threatening it sufficiently to call for university policy in the matter? In our view, decidedly yes, and that applies not only to the university environment but also to instructors in the clinic setting who teach students as a part of the university program. But others disagree, and many schools continue not to have policies forbidding such affairs. Values of freedom, sexual and otherwise, are invoked to prevent anything stronger than legally mandated sexual harassment policies.

Additional conflicts of interest arise in accepting, rejecting, and supervising student internships. Physical therapy students must complete a number of months in the clinic treating patients under the supervision of a licensed physical therapist in an employment setting approved by the educational institution. The intent is that the student will be taught many clinical skills, designated by the APTA accreditation standards as part of the eligibility requirements to take the state licensing exam. Especially in a managed care environment, many therapists are simply refusing to take students because of productivity standards that leave little or no time to supervise students, thereby adding to universities' difficulties in finding internship sites. In other cases, students are treated as revenue-generating personnel with little if any instruction. Because the latter is the only situation in which the educational facility has governance, schools regularly interview students and conduct onsite visits to ensure that students receive instruction and are not used solely to increase revenue at the expense and safety of patients. However, as clinical sites continue to diminish, educational institutions will be increasingly tempted to rationalize inadequate supervision as better than having to create new university-sponsored clinics to supply the experiences necessary for completing the educational program.

Currently, an area of great concern is the selection of candidates for educational programs. The number of applicants to schools of physical

therapy have recently decreased, secondary to cost-saving measures in managed care. Simultaneously, the number of accredited physical therapy programs in the United States has increased, rendering some schools unable to fill their class quotas. Like most businesses, university departments are staffed and funded on the basis of anticipated enrollment and accompanying tuition revenue. Compounding the dilemma, academic programs are encouraged by the APTA, or even required, as by the California chapter of the APTA, to convert existing programs to award a doctorate in physical therapy as the entry-level degree program. This is a transition with considerable costs in terms of labor and material resources.

Taken together, these pressures intensify commitments to select only competent students who with education will be able to pass licensure examinations, at the same time keeping enrollment levels adequate to ensure the survival of the department. In addition, the educational institutions serve as the gatekeepers to the profession and have a duty to the profession to populate it with competent professionals. Some schools have responded to these financial threats by increasing their recruitment programs, but it is feared that as competition increases for a diminished pool of applicants, compromises in admission standards are inevitable.

Even the method of selecting candidates is controversial. Basic academic abilities and skills needed to complete the academic program are clearly needed, but what additional standards are needed? Should the educational institutions focus only on the recruitment and training of future clinicians when there are other areas of the profession such as research that are seriously deficient? Given the extremely diverse areas of specialization within clinical applications, combined with the employment opportunities in teaching, supervision, and case management, the task of defining valid admission criteria in addition to academic standards is daunting. Restricting the student population too narrowly, through rigid entrance requirements of voluntary clinical experience, does a disservice to the profession, but to apply no standards invites inappropriate academic recruitment to fill revenue needs.

In all university teaching, research responsibilities are important in their own right, as well as their general contribution to teaching. Physical therapy is criticized for failing to provide documentation that treatment methods pass accepted standards of scientific inquiry for efficacy, and professors share a responsibility toward the profession to help remedy that. Practitioners also have this duty but the conflicts are significant. Especially in a managed care environment, therapists' first obligation is to provide the best care to the patients who depend on them. The patient loads and time allotted typically eliminate any hope of conducting valid scientific enquiry in the true experimental model. Even quasi-experimental models require more time and planning than most therapists in clinical practice can be expected to accommodate. In the university, typically physical therapy faculty carry heavier teaching loads than most other faculty and have limited resources to finance efficacy studies either at a public or a private level. The focus of research dollars remains, and one could argue rightly, on the most expensive elements of health care, namely, pharmacy and surgical interventions.

Even when funds and opportunities are available, there has been a reluctance to engage in double-blind studies on the grounds that it is unethical to deny treatment. That would at some level be correct if it were known that the treatment had an effect. Controlling for bias is essential given the placebo effect of treatment and researcher bias in therapy. In the absence of that knowledge, one has to question the ethics of providing care that may be of no benefit to tens of thousands of patients and the consequential opportunity cost to the patient of alternate care that may provide some benefit or simply avoiding the costs incurred. Thus the most meaningful conflict is the one between current beliefs and the reality of unsupported promises. There is also the suspicion that research is neglected because it might show procedures to be inefficacious, possibly eliminating some components of practice in physical therapy.

Conclusion

The topic of conflicts of interest is a prism for exploring both the core commitments and historic variations of professions. We have highlighted examples of enduring issues centered on the public goods served by physical therapists, such as provider–adviser conflicts and also issues arising from historically contingent institutional structures and economic settings, such as managed health care. Although we commented on possible solutions, our discussion reflected our conviction that the primary moral challenge is to identify and render salient areas in which conflicts of interest are recurring and especially likely to cause harm.

In addition, the topic of conflicts of interest is a prism for exploring areas of shared and distinctive features of professions. Thus, some conflicts of interest in physical therapy are shared with all professions (gift accepting), some are shared with other health professions in particular (adviser–provider conflicts within managed health care), some are shared with other allied health care professionals (physician referral), some have special relevance to physical therapy (patient-intitiated sexual overtures), and some are akin to other professions but have unique variations in physical therapy (equipment and supplies). These prism effects are not surprising given that conflicts of interest, by definition, involve threats to role responsibilities.

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