

PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Is clinician refusal to treat an emerging problem in injury compensation systems?
AUTHORS	Brijnath, Bianca; Mazza, Danielle; Kosny, Agnieszka; Singh, Nabita; Bunzli, Samantha; Ruseckaite, Rasa; Collie, Alex

VERSION 1 - REVIEW

REVIEWER	Hasan Erbay Afyon Kocatepe University, Faculty of Medicine, History of Medicine and Bioethics. Turkey
REVIEW RETURNED	18-Aug-2015

GENERAL COMMENTS	<p>The paper addresses an important area that including bio-psycho-socio-ethical issues.</p> <p>The authors provide useful framework for evaluating the (mostly ethical) challenges and dilemmas of refusal to treat on compensable injury cases.</p> <p>It is very interesting, well written and clearly argued paper with all parts. (title, evaluating method, discussion, design with limitations, fundin and other contributions)</p> <p>It will be of interest and relevant to not only Australian medical community but also a wide range of audience from many different areas of medicine all over the world.</p>
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REVIEWER	Carolyn McLeod Philosophy, Western University, Canada
REVIEW RETURNED	23-Sep-2015

GENERAL COMMENTS	<p>Is clinician refusal to treat an emerging problem in injury compensation systems?</p> <p>The title of the paper gives a clear indication of what it is about. The authors suggest that understanding the ethical implications of the relevant refusals to treat requires an understanding of the constraints physicians are under when they are faced with cases of compensable injury. The goal is to identify what these constraints are. The goal, as stated, is not to comprehend the ethical implications of the relevant refusals to treat. However, at times the authors seem to try to accomplish this second goal, particularly in the discussion section of the paper. Their discussion here of the ethical implications of refusals to treat compensable injuries is weak, in my opinion. The relevant ethical concerns are not simply beneficence and non-maleficence, as the authors suggest, but also professional ethical responsibility and the social responsibility of</p>
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	<p>physicians, among other factors. The former type of responsibility would arguably preclude objections made on the grounds that it's "not worth the hassle" (p. 10), I wouldn't get paid enough, or the like. The latter type—social responsibility—would arguably demand that physicians lend their powerful voices to debate about revising current compensation systems.</p> <p>The authors need either to clarify that the point of their paper is not to understand the ethical implications of refusals to treat compensable injuries and that they do not pretend to be describing these implications in depth, or they need to expand significantly on their discussion about the ethics of the relevant refusals.</p> <p>More minor comments:</p> <p>p. 4:</p> <ul style="list-style-type: none"> • Statement in paragraph 2 that doctors "are free to choose who they treat and who they do not" needs to be qualified, since this freedom is limited. (How much so is a topic of significant debate in bioethics.) <p>• Need more citations for notes 3 and 4 in paragraph 2 to substantiate the claim that the relevant reasons for refusals to treat are common. E.g., there is a very large literature on conscientious refusals to treat, and the authors should cite more of it.</p> <p>p. 6:</p> <ul style="list-style-type: none"> • Are race, religion, and gender the only prohibited grounds for refusals to treat in Australia? Is there not relevant human rights legislation that lists more grounds of this sort? <p>p. 10</p> <ul style="list-style-type: none"> • Is "the 'difficult' patient" the right subtitle for the new section started here? Some of the discussion concerns difficult cases, but not difficult patients. <p>p. 12</p> <ul style="list-style-type: none"> • "Difficulties establishing trust also appeared to be a factor influencing GPs reluctance to treat new patients presenting with compensable injuries." This statement should say "some new patients," the relevant ones being patients with problematic expectations. The subsequent discussion does not prove that trust is an issue with all patients. (Overall, in this section, the authors should be careful to say whether the relevant problem they are addressing concerns all patients or only some of them.) <p>p. 14</p> <ul style="list-style-type: none"> • How might RTT "exist on a spectrum"? This claim needs explanation. <p>p. 15</p> <ul style="list-style-type: none"> • "... health providers' frustrations [and biases] ... may be more harmful than therapeutic." How could they be deemed therapeutic? <p>• "RTT and refusal-to-treat may also present a significant challenge to an effective, sustainable compensation system ..." Of course, presumably, if the compensation system were improved, then there would be less RTT and refusals to treat (despite how things turned out in Sweden). It would be worth clarifying the above statement.</p>
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REVIEWER	Michelle Foley Waterford Institute of Technology Cork Road Waterford Ireland
REVIEW RETURNED	29-Sep-2015

GENERAL COMMENTS	<p>The role of the GP in the overall assessment of fitness for work matters is an interesting concept and one of growing concern due to the increase in the reporting of difficulties. Therefore I would welcome greater studies examining this complex phenomenon. This study has its merits, however would need considerable rewriting to bring it up to an acceptable standard and the authors should consider the wider context to make it of interest to a greater audience.</p> <p>Introduction: The introduction lacks a discussion on the role of the GP in assessment of fitness to work. It also fails to explore the actual situation in Australia, for example what are the numbers of claims, how much does it cost (the taxpayer, employer etc). How much is the GP remunerated to take on a case. How does this system compare with other systems across Europe.</p> <p>Methods: The method needs to be made explicit. So the data for this study emerged from the initial interviews but was not the intention of the study is how I am reading it. Is this correct? Also GPs were recruited by use of a database and were then sampled purposively for the purpose of recruiting a diverse sample, yet the study ended up with a specific age and experience profile. What step were used to try and gain the diverse sample and why was this not achieved. It is also mentioned that data saturation was reached, was this the intention to reach data saturation. It is also unusual to enter transcripts in NVivo at the end. Was NVivo used in the data analysis? The method of analysis could be further described here, how was interpretation verified, where there any issues, how were these resolved.</p> <p>Results: Data needs further critique in terms of divergent views, especially in terms of age and years of practice. Words like some and most are used but it may be better to display in terms of numbers of the GPs expressing the sentiment.</p> <p>Discussion: I am not so sure that there is a refusal to treat but rather a reluctance to treat as the author mention and this should form the basis of the discussion. What are the implications in terms of maintaining the Doctor-Patient relationship and managing the business interests. Is there an argument to have a separate assessor trained in occupational health?</p> <p>Design limitations should mention the confines of qualitative research, the use of an incentive should also be mentioned.</p>
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VERSION 1 – AUTHOR RESPONSE

Reviewer Name: Carolyn McLeod, Philosophy, Western University, Canada

2.1. The authors suggest that understanding the ethical implications of the relevant refusals to treat requires an understanding of the constraints physicians are under when they are faced with cases of compensable injury. The goal is to identify what these constraints are. The goal, as stated, is not to comprehend the ethical implications of the relevant refusals to treat. However, at times the authors seem to try to accomplish this second goal, particularly in the discussion section of the paper. Their discussion here of the ethical implications of refusals to treat compensable injuries is weak, in my

opinion. The relevant ethical concerns are not simply beneficence and non-maleficence, as the authors suggest, but also professional ethical responsibility and the social responsibility of physicians, among other factors. The former type of responsibility would arguably preclude objections made on the grounds that it's "not worth the hassle" (p. 10), I wouldn't get paid enough, or the like. The latter type—social responsibility—would arguably demand that physicians lend their powerful voices to debate about revising current compensation systems.

The authors need either to clarify that the point of their paper is not to understand the ethical implications of refusals to treat compensable injuries and that they do not pretend to be describing these implications in depth, or they need to expand significantly on their discussion about the ethics of the relevant refusals.

Thank you for prompting us to be more explicit about the ethics of refusing to treat and reluctance to treat. We believe that a discussion of ethics is relevant in this paper, however we acknowledge that this is an emerging phenomena and further research is required to understand the ethical implications of reluctance to treat in this context. We have elaborated on this in the first paragraph of the Discussion:

"In Australia, as elsewhere in the world, GPs are bound to uphold the core values of medical ethics. These include beneficence – that a clinician should act in the best interest of the patient – as well as non-maleficence: that a clinician must above all, do no harm.[1] GPs, like other doctors, also have professional ethical and social responsibilities, which mandate that they treat compensable injury patients irrespective of the extra burden this places on them as well as advocate for reform of the current compensation system. While many GPs do undertake these tasks, including advocacy [18 29], change is incremental and slow. Meanwhile, it appears that when it comes to patients with compensable injuries in Australia, the moral obligation of GPs "to provide care and do no harm" is challenged by current practice constraints, including the financial, time, clinical and emotional reasons for reluctance to treat".

We have also recognised the need for future research under the heading: Study implications:

"In opening a new avenue of inquiry, we have only touched on the ethical implications of reluctance to treat in an Australian setting. Indeed, our study raises more questions than it answers: How widespread is reluctance to treat? Is reluctance to treat more common amongst some clinician groups than others? What are the ethical implications if a clinician refuses to treat?"

2.2 p. 4: Statement in paragraph 2 that doctors "are free to choose who they treat and who they do not" needs to be qualified, since this freedom is limited. (How much so is a topic of significant debate in bioethics.)

We have qualified this statement and included a reference to this debate in the second paragraph of the introduction:

"Indeed doctors are under no legal obligation to care for all people who require their services and are free to choose who they treat and who they do not. However, this freedom is not limitless and there are significant debates in bioethics as to how much freedom doctors should have.[3]"

[3] McLeod and Downie 2014 Editorial for Bioethics

2.3 Need more citations for notes 3 and 4 in paragraph 2 to substantiate the claim that the relevant reasons for refusals to treat are common. E.g., there is a very large literature on conscientious refusals to treat, and the authors should cite more of it.

Thank you, we have included more citations to reflect the large body of literature on conscientious objections including: Kantymir and McLeod 2014; Card 2007; Shaw and Downie 2014; Kolers 2014.

2.4 p. 6: Are race, religion, and gender the only prohibited grounds for refusals to treat in Australia? Is there not relevant human rights legislation that lists more grounds of this sort?

Thank you for prompting us to include relevant human rights legislation here. We have cited the Victorian Equal Opportunity and Human Rights Commission 2010: Equal Opportunity Act. Please see

additions under the heading: Context of compensable injury management in Australia:
 “The only instance in which a GP cannot refuse treatment is in the case of a life-threatening emergency [13] and legislation prevents GPs from refusing treatment on the basis of a patients’ race, religion, gender, employment activity or political beliefs. [14]”

2.5 p. 10: Is “the ‘difficult’ patient” the right subtitle for the new section started here? Some of the discussion concerns difficult cases, but not difficult patients.
 Thank you for this observation. We have changed the subtitle to: “difficult cases” rather than ‘patients’.

2.6 p. 12: “Difficulties establishing trust also appeared to be a factor influencing GPs reluctance to treat new patients presenting with compensable injuries.” This statement should say “some new patients,” the relevant ones being patients with problematic expectations. The subsequent discussion does not prove that trust is an issue with all patients. (Overall, in this section, the authors should be careful to say whether the relevant problem they are addressing concerns all patients or only some of them.)
 As suggested, we have changed this statement: to ‘some new patients’.

2.7 p. 14: How might RTT “exist on a spectrum”? This claim needs explanation.
 For clarification, we have removed the word ‘spectrum’ and referred instead to the ‘domino effect’ of reluctance to treat:
 “However the reasons for reluctance to treat identified in this study suggest that in the case of compensable injury management, reluctance to treat is likely to have a domino effect towards refusal to treat. The more compensable injury patients that a GP has at any one time, the more likely they are to bear the time and financial costs and experience the clinical challenges that may eventually drive them to refuse treatment. Their refusal to treat will increase the burden on the remaining GPs, who in turn, may also become reluctant and refuse to treat.”

2.8 p. 15: “... health providers’ frustrations [and biases] ... may be more harmful than therapeutic.”
 How could they be deemed therapeutic?
 Thank you for highlighting this, we have corrected our wording of this statement to clarify that we are referring to the clinical encounters, rather than health providers frustrations, that may be more harmful than therapeutic:
 “This finding, also shown in Kilgour et al.’s [15] systematic review, underscores that when health providers’ frustrations with the compensation system biases treatment against injured workers, clinical encounters may become more harmful than therapeutic”

2.9. “RTT and refusal-to-treat may also present a significant challenge to an effective, sustainable compensation system ...” Of course, presumably, if the compensation system were improved, then there would be less RTT and refusals to treat (despite how things turned out in Sweden). It would be worth clarifying the above statement.
 We have clarified the statement above by elaborating:
 “Ultimately, to ensure an effective and sustainable compensation system, it may be necessary to reduce the time and financial burden to GPs.”
 And then:
 “It is likely that in addition to system-level changes, GPs may need more training to better equip them to manage the complex bio-psycho-social factors involved in a compensable injury case”

 Reviewer Name: Michelle Foley, Waterford Institute of Technology, Ireland

The role of the GP in the overall assessment of fitness for work matters is an interesting concept and one of growing concern due to the increase in the reporting of difficulties. Therefore I would welcome greater studies examining this complex phenomenon. This study has its merits, however would need considerable rewriting to bring it up to an acceptable standard and the authors should consider the wider context to make it of interest to a greater audience.

3.1 The introduction lacks a discussion on the role of the GP in assessment of fitness to work.

We have included a discussion of the role of the GP in the assessment of fitness to work in Australia: "The GP plays a key role in diagnosis, providing advice, and facilitating the treatments required for return to work (RTW).[9] In assessing fitness for work, the GP most commonly relies on the patients' own assessment of their functional capacity in relation to the demands of the workplace (Mazza et al. 2015), although safe, appropriate and timely RTW is meant to be jointly coordinated by the GP, the injured person, the injured person's compensation agent and employer."

3.2 It also fails to explore the actual situation in Australia, for example what are the numbers of claims, how much does it cost (the taxpayer, employer etc). How much is the GP remunerated to take on a case. How does this system compare with other systems across Europe.

Thank you for prompting us to include more detail on the current situation of compensable injury management in Australia. We have included additional information under the heading: Context of compensable injury management in Australia:

"The cost of compensable injury in Australia has been estimated at A\$60.6 billion, or 4.8% of GDP. [9] The average cost per case of workplace injury is \$A99,100 and of this, A\$73,300 is paid for by the injured worker themselves. [9] The majority of costs are therefore borne by the injured person; about one third of injured workers receive workers' compensation and about a quarter receive support entitlements from their employer. [10] The most common workplace injuries in Australia are musculoskeletal injuries, followed by an increasing prevalence of work-related mental health issues. [11]

As compensation systems differ between countries, with differences in the role of the health professional in occupational health and different recovery pathways [13-16], a description of the Australian context is provided below."

3.3 The method needs to be made explicit. So the data for this study emerged from the initial interviews but was not the intention of the study is how I am reading it. Is this correct?

Yes, the reviewer is correct in her interpretation that it was not the aim of our study at the outset of data collection to explore reluctance to treat, rather this is a concept that was raised in the interviews and identified as a salient theme through the inductive analysis of interview transcripts by four researchers who independently performed data coding. We have attempted to make this more explicit under the heading Methods:

"This paper seeks to understand the reasons for RTT from the GP perspective, a phenomenon that emerged during interviews with all stakeholders"

Please also see response to reviewers' comment 3.6

3.4 Also GPs were recruited by use of a database and were then sampled purposively for the purpose of recruiting a diverse sample, yet the study ended up with a specific age and experience profile.

What steps were used to try and gain the diverse sample and why was this not achieved.

Thank you for prompting us to be more explicit about how we attempted to purposively sample and to reflect on why we did not achieve the sample diversity we had originally planned for. Please see additional information under the heading Methods:

"All GPs who contacted the researchers in response to the invitation, who met the inclusion criteria, and gave informed consent, were then purposively sampled on the basis of location of practice, gender, age and years of experience as a practicing GP. Participants were recruited until sufficient data had been collected to reach a level of data saturation regarding the knowledge, attitudes and

practices of GPs in Melbourne, Australia regarding compensable injury management.”

And additional information under the heading: Design Limitations:

“Through purposive sampling, we achieved a sample of GPs from different geographical locations but an unequal representation of gender and age with most GPs being male, predominantly in their fifties and highly experienced. However, this demographic breakdown is not unusual as there are more male than female GPs in Victoria, the majority are in their fifties, and because of their age, have been in practising GPs for several years, often decades [30]. Nevertheless, it is unclear how the perspectives of reluctance to treat captured in this study may differ from that of younger GPs with less experience. Future research should address this limitation”

We have also included Table 1. ‘Participant characteristics’, describing the gender, age and years of experience of the 25 GPs who participated:

Table 1. Participant characteristics

Code Gender Age Years of Experience Location of practice

01	Male	62	40	South
02	Male	55	27	South
03	Male	53	35	South
04	Male	58	32	East
05	Male	36	7	South
06	Male	52	30	South
07	Male	33	5	South
08	Female	53	25	South
09	Male	65	40	West
10	Male	66	38	Central
11	Male	64	38	South
12	Male	59	30	East
13	Male	67	41	North
14	Male	53	27	South
15	Male	54	25	West
16	Female	51	22	South
17	Male	31	4	East
18	Male	60	30	East
19	Female	37	13	South
20	Female	47	21	Central
21	Female	39	7	East
22	Female	49	20	South
23	Female	49	6	East
24	Male	49	17	West
25	Male	50	25	South

3.5 It is also mentioned that data saturation was reached, was this the intention to reach data saturation.

We have clarified our meaning of data saturation under the heading Methods – i.e. we were aiming for saturation regarding the knowledge, attitudes and practices of GPs across sociodemographic regions in Melbourne

“Participants were recruited until sufficient data had been collected to reach a level of data saturation regarding the knowledge, attitudes and practices of GPs across sociodemographic regions of Melbourne, Australia regarding compensable injury management.”

We have also included a statement about data saturation in the design limitations:

“Further, as the aim of this study at the outset of data collection was not to explore the concept of reluctance to treat to data –saturation, we can only describe this new line of enquiry, but are unable to

comment on the degree to which we captured the diversity of views on reluctance to treat.”

3.6 It is also unusual to enter transcripts in NVivo at the end. Was NVivo used in the data analysis?

We have included more detail under the heading data analysis to clarify how we analysed this data in two stages. The first stage related to analysis of data from the larger return to work study from which we first identified the reluctance to treat theme. We have included a reference for a detailed description of the data analysis process conducted in the initial study. Following this first stage of analysis, data was inputted into NVivo to facilitate further analysis.

The second stage relates to analysis of data coded as ‘Reluctance to treat’ in NVivo. We clarified this in the manuscript under the heading: Data analysis:

“A detailed description of the data analysis process for this study has been published [18]. Recorded interviews were transcribed verbatim. Transcripts were checked and cleaned prior to data analysis. Thematic analysis was employed.[19] Initial coding schemes were developed by four co-authors using inductive methods. Transcripts were coded by two separate authors and cross-checked to verify interpretation. Any differences were resolved by consensus discussion. The final interpretations were confirmed and agreed on in group discussion. Coded transcripts were entered into NVivo 10 for further analysis.

Data coded as ‘reluctance to treat’ in NVivo 10 was further analysed by two co-authors using thematic coding. We identified four main codes: financial, time, clinical and emotional reasons for reluctance to treat that we grouped into two main themes illustrating the key constraints of compensable injury management that could influence GP reluctance to treat: Administrative reasons for reluctance to treat; and Clinical reasons for reluctance to treat.”

3.7 The method of analysis could be further described here, how was interpretation verified, where there any issues, how were these resolved.

Please see response to reviewers’ comment 3.6 and the referral to a previous publication detailing the method of data analysis employed in this study.

3.8 Data needs further critique in terms of divergent views, especially in terms of age and years of practice.

We have included a further critique of the data and included a divergent view that reflects on the role of age and years of clinical practice. See addition in the final paragraph under the heading: Results:

“It is interesting to note that the emotional impact of compensable injury management described above, was highlighted by two of the younger GPs in this sample. The role that years of experience as a GP may play in compensable injury management was raised by this participant with thirty years of experience who suggested that it may be particularly challenging for younger GPs who do not have confidence in their clinical skills or the industry contacts to help them navigate the compensation system:

“Confidence comes with experience. A younger GP coming out of med school may find it a little bit intimidating. I think knowledge of the local industries and building up a network also helps” (GP#12, m, 57 yo, 30ye)”

3.9 Words like some and most are used but it may be better to display in terms of numbers of the GPs expressing the sentiment.

We would like to stress that the aim of this study was not to explore the concept of reluctance to treat to saturation and this is not a generalizable sample. This study aimed to describe a new phenomenon that has not been described in detail previously in order to inform further research that can explore the extent of this phenomenon in Australia. However we accept the reviewer’s feedback that it may be useful to understand the extent to which the perspectives described were reflected by the sample. Rather than using terms such as ‘some’ or ‘many’ we have given a better indication of how many GPs endorsed the sentiment, using terms such as ‘almost all’, ‘several’ and ‘a couple’. Please see additions under heading: Results e.g.:

“Almost all GPs reported delayed payments for their services because of doubts over the legitimacy of

the claim by compensation bodies and employers as well as administrative delays from compensation agencies”

3.10 I am not so sure that there is a refusal to treat but rather a reluctance to treat as the author mention and this should form the basis of the discussion.

We agree with this suggestion and have changed the focus of the paper to reflect reluctance rather than refusal to treat. For example under the heading: Discussion:

“As GPs play a key role in the facilitation of RTW, their reluctance to treat may delay RTW with significant impacts on the patients’ physical, psychosocial and financial wellbeing”

We have also written ‘reluctance to treat’ out in full rather than using the acronym RTT to prevent any confusion.

3.11 What are the implications in terms of maintaining the Doctor-Patient relationship and managing the business interests. Is there an argument to have a separate assessor trained in occupational health?

This is an excellent point raised by the reviewer and an area that is worthy of further research.

However we are unable to comment on this in detail as we did not seek to explore this in our study.

We have included this as an area for future research under the heading: Study Implications:

“In opening a new avenue of inquiry, our study raises more questions than it answers: How widespread is reluctance to treat? Is reluctance to treat more common amongst some clinician groups than others? What are the ethical implications if a clinician refuses to treat? How do GPs negotiate the impact of reluctance to treat on the doctor-patient relationship and on business interests? What incentives (and disincentives) should be put in place to mitigate reluctance to treat?”

3.12 Design limitations should mention the confines of qualitative research, the use of an incentive should also be mentioned.

Thank you for this prompt. We have mentioned our reimbursement for time under the heading:

Methods:

“GPs were reimbursed \$200 for their lost consultation time a sum which is in line with the hourly rate of GPs in Australia [22] and consistent with previous studies involving the recruitment of Australian GPs. [23]”

We have also included a statement to acknowledge a key confine of qualitative research:

“Further, as the aim of this qualitative study at the outset of data collection was not to explore the concept of reluctance to treat to data saturation, we can only describe this new line of enquiry, but are unable to comment on the degree to which we captured the diversity of views on reluctance to treat.”

VERSION 2 – REVIEW

REVIEWER	Dr Michelle Foley Marie Curie Research Fellow School of Health Waterford Institute of Technology Cork Road Waterford Ireland
REVIEW RETURNED	12-Nov-2015

GENERAL COMMENTS	This has been significantly improved and with a few minor changes may be improved further. Table 1 should be arranged as a breakdown on demographic rather than showing each participant. Page 20 line 3, please reword first sentence. Page 20 line 45, please change word scarcity to a paucity or simply lack of literature..
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VERSION 2 – AUTHOR RESPONSE

Reviewer Name: Michelle Foley, Waterford Institute of Technology, Ireland

Table 1 should be arranged as a breakdown on demographic rather than showing each participant.

We would like to retain Table 1 in its original format, showing the demographic data for each participant as we have already provided a breakdown on demographic in the written text and believe it would be repetitive to present this breakdown in Table 1.

If the editors would like, we can remove Table 1 from the main document and present it as an appendix or supplementary file.

Page 20 line 3, please reword first sentence.

We have reworded the first sentence to:

“To address limitations of the present work, future research should include the experiences of GPs from other states alongside the views of specialists and allied health professionals.”

Page 20 line 45, please change word scarcity to a paucity or simply lack of literature.
We have replaced the word scarcity to paucity as suggested.