This is an Accepted Manuscript of an article published by SAGE Journals in ***Qualitative Health Research*** on October 2018, available online: Hudon, Anne*, Debbie Feldman, Matthew Hunt. (2019). Tensions living out professional values for physical therapists treating injured workers. Qualitative Health Research. 29(6): 868-875.DOI: 10.1177/1049732318803589

Title: ***Tensions living out professional values for physical therapists treating injured workers***

Authors: Anne Hudon, PT, PhD
Postdoctoral fellow
School of Public Health and Health Systems, University of Waterloo
Faculty of Law, Civil Law Section, University of Ottawa
a2hudon@uwaterloo.ca

2) Debbie Ehrmann Feldman, PT, PhD
Full Professor, Department of Physical Therapy, School of Rehabilitation, Faculty of Medicine, University of Montreal
Centre for Interdisciplinary Research in Rehabilitation of Greater Montreal (CRIR)
Institut de Recherche en Santé Publique de l'Université de Montréal (IRSPUM)
debbie.feldman@umontreal.ca

3) Matthew Hunt, PT, PhD
Associate Professor, School of Physical and Occupational Therapy, McGill University
Centre for Interdisciplinary Research in Rehabilitation of Greater Montreal (CRIR)
matthew.hunt@mcgill.ca

Abstract

Healthcare services provided by workers' compensation systems aim to facilitate recovery for injured workers. However, some features of these systems pose barriers to high quality care and challenge healthcare professionals in their everyday work. We used Interpretive Description methodology to explore ethical tensions experienced by physical therapists caring for patients with musculoskeletal injuries compensated by Workers' Compensation Boards. We conducted in-depth interviews with 40 physical therapists and leaders in the physical therapy and workers' compensation fields from three Canadian provinces and analyzed transcripts using concurrent and constant comparative techniques. Through our analysis, we developed inductive themes reflecting significant challenges experienced by participants in upholding three core professional values: equity, competence and autonomy. These challenges illustrate multiple facets of physical therapists' struggles to uphold moral commitments and preserve their sense of professional integrity while providing care to injured workers within a complex health service system.

MANUSCRIPT OF THE ARTICLE

INTRODUCTION

Work-related musculoskeletal injuries are a major public health problem (Lippel and Lötters 2013). These injuries impact the physical and mental health of individuals and can lead to prolonged disability and absence from work (Patrick Loisel and Anema 2013). In Canada, injured workers who require healthcare and income replacement services are supported by a workers' compensation system through which they may receive disability benefits (i.e. income replacement), healthcare services (e.g., physical therapy (PT), occupational therapy, chiropractic) and vocational rehabilitation (which aims to help injured workers find different employment if they cannot return to their previous position) paid by their workers' compensation board (WCB). In 2015, 206 112 Canadian workers have made a lost time claim for a traumatic injury or a musculoskeletal disorder (Association des commissions des accidents du travail du Canada 2015). The majority of Canadian workers suffering from musculoskeletal injuries receive care from a physical therapist and most will be treated in private for-profit PT clinics with only a small proportion receiving PT services in hospitals[i].

Although healthcare support offered by workers' compensation systems aims to facilitate workers' recovery, some features of these systems can pose barriers to the provision of high quality care and have mixed impacts on recovery (Kilgour et al. 2014b; Lippel 2007; MacEachen et al. 2010). Compensation systems for injured workers have been identified as sources of recurring frustrations and difficulties for health professionals in the United States, Australia and Canada (Friesen et al. 2001; Kosny et al. 2011; Pergola et al. 1999). These issues include the complexity of administrative structures, magnitude of professionals' workloads, potential for conflicts of interests, lack of clarity

of roles and expectations for stakeholders, and diverse communication challenges (Baril et al. 2003; Kilgour et al. 2014b; Kosny et al. 2011). When looking specifically at PT care, ethical and organizational tensions arise for physical therapists working with compensated injured workers, potentially hindering quality of care, and raising questions related to distributive justice and professional autonomy (Hudon et al. 2015; Kilgour et al. 2014a). Considering that PT care for injured workers is mostly provided through private for-profit clinics in Canada, this particular setting places physical therapists in a context of economic efficiency and resource scarcity where they must respond to predetermined financial imperatives while continuing to provide care in a way that is satisfactory for them and their patients (Praestegaard et al. 2015; Whiteside 2009). Aligned with this neoliberal framework (i.e., universal free trade market, privatization of services, focus on economic growth) (Smith 2018), WCBs and private physiotherapy clinics often put implicit values of effectiveness, self-responsibility, profitability and predictability at the forefront of the provision of care (Parrish and Schofield 2005), which may conflict with health professionals' values of justice, empathy, trust, and honesty (Aguilar et al. 2012). Physical therapists' institutional roles and demands may also conflict with their professional and personal values and result in "value dissonance" (Bruhn 2008). These value conflicts may lead to changes and strains in the therapeutic relationship with patients, affect clinicians' work satisfaction and emotional state and ultimately hinder the provision of equitable and adequate care for injured workers.

Professional values play fundamental roles as anchors for accepted standards of practice. These values underlie common normative guidelines such as codes of ethics and are therefore inherent to the concept of professional ethics. From an ethical perspective, although they are not always explicit, professional values allow physical therapists to make judgments that are coherent with the identity of their profession, and to guide their reasoning toward decisions that are clinically and

ethically meaningful for themselves and their patients (Jensen and Greenfield 2012). Difficulties for professionals to uphold their professional values in practice can cause ethical tensions. These tensions arise when professionals identify a gap between what they can do in a given situation and what they would like to do (Kinsella et al. 2008). Tensions can also be experienced when values conflict with each other, or when the professional is uncertain of the ethical action to take in a particular circumstance (Cohen and Erickson 2006). Ethical tensions are often perceived by professionals as a moral discomfort or by a feeling of "being torn", uncertain or distressed (Bushby et al. 2015).

In an attempt to deepen understanding of the challenges encountered in the return to work and rehabilitation process, researchers in the field of work disability have sought the perspectives of diverse stakeholders such as injured workers and employers (Beardwood et al. 2005; Dionne et al. 2013; Lippel 2007; Roberts-Yates 2003), healthcare providers (Cote et al. 2001; Guzman et al. 2002; Hellman et al. 2015; Lippel et al. 2016; P. Loisel et al. 2005; Pergola et al. 1999; Russell et al. 2005; Soklaridis et al. 2011) and workers' compensation case managers (Newnam et al. 2016; Robichaud 2016). Although some studies have included physical therapists, (Baril et al. 2003; MacEachen et al. 2010; Pincus et al. 2010; Soklaridis et al. 2010; Wynne-Jones et al. 2014), no study has conducted an in-depth examination of the ethical challenges encountered by physical therapists when treating injured workers compensated by a WCB. A thorough exploration of the challenges experienced by physical therapists (key healthcare providers for workers with musculoskeletal injuries) could help improve the process of care for this clientele, including identifying sources of ethical tensions and opportunities to address these challenges in the care of injured workers.

The objectives of this study were twofold. First, we sought to elicit perceptions of physical therapists, along with leaders in the PT and WCBs fields (e.g. from professional associations and WCBs), regarding ethical tensions arising in the care of patients with musculoskeletal injuries supported by a WCB, in three Canadian provinces. Second, we aimed to identify innovative strategies to address these ethical considerations.

METHODS

We used *Interpretive Description* methodology to guide this inquiry (Thorne 2016). It is grounded in a constructivist approach to inquiry and aims to develop knowledge about a domain of human experience related to health and address the "so what?" of the health disciplines (Thorne 2016). Interpretive description aims to develop "a coherent conceptual description that taps thematic patterns and commonalities believed to characterize the phenomenon that is being studied and also accounts for the inevitable individual variations within them." (Thorne et al. 2004, p. 4)

Choice of provinces and policy context

We included the three most populous Canadian provinces in our study: British Columbia (BC), Ontario and Quebec. Physical therapists are the second most frequently consulted healthcare providers, after physicians, for injured workers with musculoskeletal disorders in these provinces. All three have "cause-based" compensation systems designed to compensate injuries attributable to work regardless of fault. These systems have the mandate to adjudicate the claims they receive and, once a claim is accepted, to provide medical benefits and income support based on pre-injury earnings.

There are also important differences among the three workers' compensation systems, including for PT services. In 2014, the BC WCB instituted a "block-care model" provided by contracted PT clinics. Physical therapists receive a fixed remuneration amount and have one week to initiate the worker's evaluation. Treatment duration is fixed at 6 weeks. The Ontario WCB has a hybrid PT model. Patients presenting specific criteria receive care under one of three injury-specific programs (low back, shoulder or musculoskeletal) or through regular fee-for-service arrangements. Injured workers can choose their primary care provider: physician, physical therapist or chiropractor. In BC and Ontario, a physician's referral is not needed to access PT for injured workers, case managers are responsible for making final decisions (e.g., for granting PT extensions, or for starting or modifying the return-to-work process), and professional recommendations from health professionals are not binding. In Quebec, the WCB pays for PT care following a referral from the injured worker's treating physician and treatments are on a fee-for-service basis, in private PT clinics or in public hospitals. There are no fixed limits for treatment frequency and duration of PT, but the recommendations of the physician are binding for health professionals and the Quebec WCB.

Sampling

We interviewed two groups of participants. The primary participants were physical therapists working with injured workers (in Quebec this included physical therapists and PT technicians). PT technicians are healthcare professionals who are included under the category of PT professionals. They have a diploma-level training, in contrast to physical therapists who have a master's-level training[ii]. A second group of participants was interviewed in order to better understand systemic features in each province and gain insight into the current context of PT provision of care for injured workers. This group included leaders and administrators from PT associations, professional

colleges or WCBs. We used a purposive sampling strategy to recruit participants between December 2013 and March 2015. We sought a diversified set of participants based on the following characteristics: type of professional (physical therapists, leaders and administrators), gender, practice setting (private vs. public), clientele (acute vs. chronic patients), clinical experience, experience treating injured workers, and location of practice (urban vs. rural, regional distribution within province).

We used four strategies to recruit participants. First, information was distributed through the listservs and online bulletins of the three provinces' PT associations and/or professional colleges. Second, we used the professional networks of the research team to identify additional potential participants. Third, we employed a snowball sampling strategy whereby at the end of some interviews we asked participants to suggest others who might be interested to participate. As the study progressed, a fourth strategy was employed to guide recruitment. We used theoretical sampling to guide our recruitment of additional participants who could help us better understand aspects of the phenomena that remained underexplored. More specifically, we sought out additional participants who could speak to the influence of the clinical setting on physical therapists' experiences of care provision, including large private clinics that were more corporate in their orientation, as well as the perspectives of physical therapists working in interdisciplinary settings (Charmaz 2006). Individuals interested to participate in the study were invited to contact Anne Hudon by email and were sent a short demographic questionnaire to assess their eligibility for the study and to facilitate the purposive recruitment of participants. The questionnaire collected information about their gender, age, geographic location, current work, and professional experience. We then sent an email to selected individuals inviting them to pick a time and date for the interview.

A total of 30 physical therapists and 10 leaders and administrators were interviewed. Information about physical therapist participants is presented in Table 1. Demographic data from the 10 leaders and administrators are not presented in order to preserve their anonymity. The participants in the three provinces were similar in terms of age and location of practice (urban or rural). Participants' characteristics broadly reflect the male/female ratio and mean age of physical therapists in Canada (in 2015, 75% of physical therapists were women and the highest proportion of professionals were in their 30s (Canadian Institute for Health Information 2015). The majority of participants were working in private for-profit clinics. In 2015, 51% of Canadian physiotherapists were working in the private sector (Canadian Institute for Health Information 2015). The proportion of injured workers within their caseloads ranged from 2% to almost 100%. The median years of practice experience was highest in the province of Quebec.

Table 1. Demographic information about PT participants

Information / Province	British Columbia	Ontario	Quebec
N =	9 physical therapists	9 physical therapists	9 physical therapists 3 PT technicians
Gender	Male: 3 Female: 6	Male: 3 Female: 6	Male: 3 Female: 9
Median age*	31 Range: 28 - 52	30 Range: 26 - 44	39 Range: 25-58
Participants working in private practice	8	6	10
Participants working in public settings	0	2	2
Participants working in both private and public settings	1	1	0
Participants with an adjunct administrative position (e.g., clinic owner/manager/leader)*	3	3	3
Median years of practice as a physical therapist*	3 Range: 0.6 - 28	3 Range: 0.6 - 28	14.5 Range: 2.5 - 31
Median years of practice with injured workers*	3 Range: 0.6 - 22	6.5 Range: 0.6 - 18	13 Range: 2.5 - 29

* Demographic info excludes one participant from Ontario who did not complete the demographic questionnaire

Data collection

All participants took part in an in-depth, semi-structured interview. The interview guide was developed based on issues identified through two focus groups with PT professionals from Quebec (Hudon et al. 2015) and was pilot tested (see Supplementary file). A different guide was developed for the interviews with PT leaders and administrators. The interviews with both groups were conducted at a time and location that was convenient for each participant. Most interviews were conducted by phone or Skype due to the wide geographic dispersion of the participants. The

remaining interviews were conducted face-to-face. Interviews were conducted in French or in English depending on the preference of the participant, and lasted between one and two hours (mean: 1.5 hour). All interviews were digitally recorded and professionally transcribed. Anne then listened to the recordings while reading and correcting each verbatim. Subsequently, a one to two page synopsis of each interview was prepared.

Data analysis

Anne used a recursive approach to data collection and analysis; she began analysis after each interview was transcribed so that early analysis could be tested and help in conducting and refining later interviews (Thorne et al. 2004). She also used constant comparative methods to create links and better see patterns across the whole set of data. Initial coding of the transcript involved categorizing segments of data using labels prompted by questions such as "what's going on here?" and "what does this mean?" This was done by Anne and organized using NVivo 10 software. Ten pages of three different transcripts were coded by the first and last author to discuss coding choices and potential issues with coding. As a result, we refined the coding structure. The codes were then mapped to help visualize the data. Anne created conceptual maps and diagrams, and discussed this process with Debbie Feldman and Matthew Hunt (Charmaz 2006). While conducting this analysis, the team sought to be attentive to variations amongst the participants' work contexts, including province, clinical milieu (public vs. private) and location (rural vs. urban). Recurrent and common patterns were identified using comparative tables that allowed Anne to aggregate codes into broader analytic categories. These categories were then placed together under higher order themes that emerged through the interpretation. The team met at regular intervals to discuss the process of data analysis.

Memos written during the research process were also used as a supplemental data source to help contextualize and enrich the ongoing analysis. Throughout the project, Anne paid attention to her own professional background (she is a physical therapist who has treated injured workers in a private PT clinic in Quebec) and to her preconceived ideas about the topic (Morse 2010). She reflected on her own ontological, epistemological and methodological commitments (Carpenter and Suto 2008; Hunt 2009; Thorne et al. 1997) and how these might affect the direction of the analysis. Preliminary results were presented and discussed with a group of seven physical therapists and PT technicians during a focus group held in March 2016 in Montreal. Participants in this focus group said that the preliminary themes and presentation of results echoed their clinical experiences and resonated with the ethical challenges they experienced in their practice.

Ethics approval

The study was approved by Research Ethics Board of the Centre for Interdisciplinary Research on Rehabilitation of Greater Montreal (CRIR-794-0113). All participants signed a consent form prior to participating in the interview.

RESULTS

Participants encountered ethical challenges (i.e., value conflicts or feelings of being torn, distressed, uncertain, morally uncomfortable or unable to do the right thing) while seeking to uphold three core professional values as they provided care to injured workers. These values and associated challenges are presented below (Table 2) and described at length in the following paragraphs. Solutions proposed by the participants to respond to these value conflicts and improve the provision of PT care are also presented. Selected verbatim quotations are included to illustrate

aspects of the analysis. French verbatim quotations are presented in English in this article and were translated by a native English-speaking member of the research team.

Table 2. Professional values that were in tension and associated challenges

Professional values	Main challenges in living out these values
1. Equity	- Providing access to care - Witnessing inequalities in PT services - Resisting stereotypes - Advocating for appropriate care
2. Competence	- Addressing psychosocial issues, patients' anxieties and expectations - Navigating workers' compensation systems
3. Professional autonomy	- Sharing duties and responsibilities - Looking for greater autonomy in decision-making - Seeking recognition of the value of PT

1. Equity

The narratives of the participants reflect a commitment to individuals being treated fairly and provided access to care in an impartial fashion. However, the ethical value of equity was challenged in many different ways in participants' examples of their everyday practice with injured workers. Four distinct challenges were revealed regarding this value. The first challenge arose due to barriers for *providing access to care,* which participants considered ought to be a universal characteristic of workers' compensation systems. Participants from all three provinces discussed concerns that patients with some forms of injury, such as repetitive movement or overuse injuries had less access to PT treatment.

"So it's more of a repetitive strain, let's say a thumb tendonitis or thoracic spine strain, and it's from the worker having to do the same thing day in and day out but because there wasn't

one specific day where they fell or they injured themselves, their claim gets denied because there was not really a clear date of accident."

Others discussed how some clinical settings categorically refused to treat injured workers, suggesting that the low fees provided by WCBs were viewed as "too much work for too little money" to treat patients who were often "more complicated" from a clinical standpoint, in addition to the additional paperwork and phone call requirements of the WCB. Several participants from BC and Ontario also identified limited options for interprofessional care as a barrier to access needed care for patients, since these WCBs do not reimburse other professionals (e.g. massage therapists, psychologists) while the patient is receiving PT treatment. Participants did identify some areas where injured workers had faster access than the general population, such as imaging (e.g. magnetic resonance imaging, electromyography testing) and referral to medical specialists.

A majority of participants also discussed a second challenge: *witnessing inequalities in PT services.* Participants gave a range of examples that illustrated these inequalities. Many described a tangible tension between offering the best care possible to patients and ensuring the financial viability of their clinic. For example, several participants reported differences for evaluation and treatment times, such as injured workers being scheduled for one-on-one treatment times of 15 to 20 minutes, compared to 30-minute sessions for other patients. A participant expressed:

"Because I think that they're um…I think that every person deserves the same quality of treatment and I don't think that we're encouraged to give them the same quality of treatment because of […] the amount of time that we're expected to see them for […]."

Several participants also reported that, if they were running late, they would be more likely to reduce the treatment time for an injured worker than for a patient with private insurance:

> *"[…] like I said, if I was running late I might only treat a WCB patient for 10 minutes and then send them to the gym versus 15. It's just…we have to sacrifice a WCB patient sometimes for the other patients to stay on time or to do my thing and stuff…because at least the WCB patients aren't paying out of their own pocket […]."*

Most participants also experienced tensions between completing administrative tasks and providing patient care. They reported that administrative tasks associated with treating injured workers were often much more time consuming than for other patients (e.g., initial, mid-term and discharge reports, progress notes to physicians, and phone calls to stakeholders). As a result, they had to choose to perform these tasks during patient treatment time or on unpaid personal time. Several participants explained that schedules and expectations in their clinical setting did not align well with these additional tasks and that therapy time was cut as a result:

> *"All of these things are things that private clients just do on their own and ethically when we have all of these other demands it can be sometimes hard to give the care that we're required to give when we have a whole lot of other demands that we're not getting paid for on top of it so then I think care gets lost…appropriate care gets lost."*

Moreover, injured workers were identified as more likely to receive treatment from PT assistants, PT technicians, kinesiologists, or support personnel. While most participants recognized that these inequalities negatively impacted quality of care for injured workers, several expressed that there

were few options for clinic owners: they saw these decisions as necessary for the financial integrity of the clinic under the present funding system. In that regard, several participants mentioned the need for higher reimbursement fees for PT by WCB:

> *"I understand there are some clinics because the pay is so low they work on high-volume so that it makes it worthwhile, and that provides sort of substandard care to patients and then that gives physio sort of… a bad name."*

Discussing the tension between equality of care and PT clinic finances, one participant said:

> *"As I am telling you, I do not wish to create two types of citizens in my clinic, that should not be. For me, it is not professional. But, it is clear to me that it's not adequately paid."*

Participants also complained about clinic owners who remunerate PTs differently according to the revenue they generate for the clinic, which is always less for injured workers compensated by the WCB. They stated that this approach did not take into consideration the effort and dedication PTs devote to the treatment of these patients, and that this was a form of discrimination against injured workers that could ultimately push PTs to alter the quality of care given to them.

A third challenge regarding equity in care that was discussed by participants was the importance of *resisting stereotypes* about injured workers. They talked about the social stigmatization that exists and how this perspective can be an impediment to care. They noted that society at large, their entourage, and even the university where they studied, labeled injured workers on different occasions as "malingerers", "scammers", "fakers" or people "not wanting to get back to work". However, participants reported that these judgments rarely matched the reality they observed

working with their patients. They stated that they often had to remind themselves, however, to reject such stereotypes in order to remain impartial and provide quality care. On the other hand, the discourse of some participants reflected some stereotypes towards injured workers. For example, a participant described the motivation of injured workers thus:

> *"Normally we're seeing people that are healthy and want to get better and, uh…you know…um… sometimes they're athletes and so there can be that contradiction between the injured worker and our sort of regular clientele."*

Participants expressed views about injured workers including that they are more "demanding" than other clients, many do not like their jobs, and that they were often different than the "normal, high socioeconomic clientele" they were used to seeing in their clinic. So while many participants spoke of resisting stereotypes, it is apparent that some physical therapists continue to see injured workers in ways that echo these perceptions/stereotypes.

Finally, in light of the inequalities they experienced, many participants expressed the need to *advocate for appropriate care* for injured workers. For example, they advocated when they felt that insufficient justification was offered by the WCB or physician for stopping PT treatments. This could happen when dealing with a "block care model" which rendered it difficult to extend care for a patient. Their advocacy role also arose when patients regained their capacity to complete work tasks but remained unable to perform leisure activities, still had considerable pain, or experienced work as exhausting. In these cases, participants stated that it was their duty to help their patients in other spheres (e.g., such as functional participation in family tasks or leisure

activities), and not just to regain their function at work, which they try to do by advocating these rights to case managers (mostly in Ontario and BC) and to physicians (mostly in Quebec).

> *"So […] I think case managers can sometimes be misguided in what they are expecting from an injury and they don't take into account all of the other factors that go along with an injury and you try to advocate for them at times […]."*

As this quote suggests, several participants also felt that some compensation case managers downplayed their patients' injuries or need for care, thus requiring physical therapists to position themselves as advocates for their patients. In sum, participants explained that advocating on behalf of patients to WCB case managers, physicians or employers was important and necessary given the numerous challenges experienced by injured workers throughout their rehabilitation process.

2. Competence

Participants emphasized the importance of providing competent care to all their patients. They sometimes felt that they were insufficiently equipped to address the needs of some injured workers. Several participants felt that they lacked training in areas that were relevant to their patients' care. Several participants described challenges *addressing patients' psychosocial issues* and *their anxieties and expectations*. They noted that their professional training did not adequately prepare them to support patients with these difficulties. A majority of participants expressed the desire to receive better training on how to help patients with psychosocial issues. Some others disagreed, however, about whether PTs should expand their competence in this area, believing that the physical therapist should focus on patients' functional limitations and that psychosocial issues are better handled by other professionals specifically trained in this field. Participants acknowledged

that injured workers supported by a WCB often experience feelings such as fear, distrust, frustration, or a sense of injustice.

> *"I think my ability to actually…uh…de-escalate them…this fear of avoidance response…is, is pivotal in the speed of their recovery…in their ability to return to normal activities of life and occupational activities."*

In Quebec, eight participants mentioned that injured workers often experience stress and anxiety during their WCB medical evaluation. Participants described their role in trying to alleviate patients' fears that their treatment would be discontinued or reduced following the evaluation. In these instances, a solid trusting relationship was seen as fundamental. A participant described the importance of talking with and reassuring his patients:

> *"Yeah, I'd say I would spend… I would say 75 percent of my time talking to clients and about 25 percent of the time treating, and I'd say that's probably being optimistic in terms of the treatment."*

Participants described these counseling interventions as challenging due to their lack of training and because of the energy it required.

> *"I think in our clinical training in university there is not […] it is musculoskeletal rehab, it's exercise therapy but there's no formal training in this kind of area. We got maybe one or two lectures on chronic pain, we don't get anywhere near enough sort of background in communication I think and in motivational interviewing or those kinds of things"*

These counseling interventions were nonetheless seen as an essential component of treatment. Several participants also said that they felt it was hard to remain professional and impartial when discussing WCB procedures with their patients, sometimes feeling like a negotiator or a mediator. They tried to help patients understand their injuries and to support them. Yet they also felt that they had to explain why some decisions were made by the WCB, but were unsure how best to do so. Some solutions proposed by the participants were to clarify for their patients at the start of the therapeutic relationship the particular context of WCB-sponsored care. They also expressed that discussing more thoroughly the patient's and therapist's expectations with regards to treatment and return to work could ease the provision of care. To do so, participants wished they had more time to talk and care for their patients during each treatment session.

The other competence area in which most participants felt ill equipped was in *navigating workers' compensation* systems (i.e. acquiring useful knowledge about the system, assessing readiness to work). All participants said that the knowledge they had was acquired through the experience of working with this clientele, and some spoke about how this initially required a steep learning curve. Several participants stated that it would have been easier if they had a better understanding of the overall workers' compensation system prior to starting to work with this clientele. Some suggested that WCBs could present to PT clinics about how they functioned either via interactive presentations or using online tutorials. Participants also reported challenges assessing patient readiness (both physically and mentally) to RTW, as well as the work setting's readiness to safely reintegrate the injured worker. A participant discussed these challenges:

"So, if it's modified duties what can they do, what can they not do? Modified hours, how many hours should they start and how to progress them. […] they don't really teach us that in school […] and that's something you have to learn on the job."

3. Professional autonomy

The third ethical value participants had difficulty to uphold was professional autonomy. Participants experienced three different challenges associated with this important value in the care of injured workers. First, participants expressed concerns regarding the *sharing of duties and responsibilities* with other personnel, including PT assistants (Ontario), kinesiologists (Ontario and BC) and PT technicians (Quebec). Many participants described these rehabilitation providers as making positive contributions to patient care, but sharing some of their professional duties with these groups was also seen as potentially hindering their capacity to progress treatment adequately. Some participants worried that injured workers who were primarily treated by assistants could not be monitored and taken care of as thoroughly. Trust and hierarchical concerns were also discussed. Several participants viewed the capacity for assistants and technicians to recognize and discuss the limits of their competency as a crucial element to attenuate the struggle in sharing duties.

[…] um, if you ask me, I prefer to just… cause not that I don't trust the assistants with exercises but I feel like I'd rather be the one who is doing it to so I know how patients respond to it and how I can progress them, basically.

For participants working in a team-based rehabilitation program with other professionals (e.g. occupational therapists or psychologists) the distribution of professional tasks was mostly seen as

beneficial and described as easier than when professional duties were shared with technicians or assistants.

Second, participants also described how the workers' compensation system impacts their professional and decisional autonomy and how they were *looking for greater autonomy in decision-making*. For example, many Quebec participants stated that even if they judged that PT was not required anymore and wished to terminate treatment, the ultimate decision to end PT rests with the treating physician. More globally, the lack of professional autonomy was also perceived as creating a systemic issue with regards to overuse of healthcare resources in a time of budget cuts and constraints. Indeed, in order to seek official opinions and make decisions, patients from BC and Quebec have to make repeated visits to their physicians during their rehabilitation process. Even though all the participants saw the involvement of the physician as an asset, they believed that repeated visits contributed to increasing the burden on the healthcare system. In that regard, some participants expressed that physical therapists' roles should be expanded (e.g., decisional power on RTW process, prescription of imaging tests, etc.).

> *"[…] if I want a decision made, or if the employer wants a note saying that they need to be off work for another two weeks […] now they have to go waste healthcare time and money to go see the doctor. I think it would be so much more…expedient and efficient and money efficient is if that was something that was possible for the physiotherapist to write."*

Third, almost all participants also expressed frustration regarding the lack of recognition of the PT profession's contributions by the stakeholders involved in the care of injured workers. Many said that they were *seeking recognition of the value of PT* and stated that their professional opinions

were insufficiently valued by WCB case managers who held decisional power for their patients' case in BC and Ontario:

> *"So I think if WCB had faith in the providers to say "okay, we sent the client to you and you get them back to work and do it whatever way you want to do it" then I think that would make a big difference."*

The participants wished to be part of the discussions and decisions concerning the patient's overall progression, as well as receiving more respect for their particular knowledge and skills in the musculoskeletal field.

DISCUSSION:

In this study, we provide new insights on ethical tensions that PTs encounter in the field of work disability, and the institutional and structural features that give rise to them. Participants from all three provinces expressed concerns regarding the difficulty to treat patients equitably, as injured workers are treated for a shorter duration of time compared to other patients or are treated by personnel other than PTs, which concurs with our previous study (Hudon et al. 2015). However, this study also shows that for a few participants, disparities in PT services between injured workers and other clienteles were justified by the lower treatment reimbursement fees for injured workers. This finding suggests that some physical therapists have internalized economic efficiency as part of their professional reasoning. To our knowledge, the pervasive effects of the rise of the neoliberal framework on the practice of physical therapists and the management of PT clinics by their owners have not been investigated in Canada. In this study, economic incentives seemed to drive behaviors and affect the care provided to injured workers. New studies should investigate more closely the

effects of these incentives on the practice of PT since they can drive and sustain important inequalities in patient care. Our findings regarding equity between clienteles should also draw the attention of professional PT associations because current care practices for injured workers could potentially lead to inadequate care. Stigma was also a concern for participants since it could potentially influence their treatment decisions and create biases towards some patients. Issues of trust in patients' reports of pain and difficulty treating according to a broader psychosocial model have also been reported in healthcare professionals' experiences of working with chronic pain patients (Toye et al. 2018) and with injured workers (Tarasuk and Eakin 1995). Although stigmatization with regards to injured workers has been discussed in the literature (Beardwood et al. 2005; Eakin and Mykhalovskiy 2003; Lippel 2007; Roberts-Yates 2003), the need for physical therapists to reflect on their practice and to evaluate their own prejudices towards their patients has not been extensively studied (Setchell et al. 2017; Slade et al. 2009).

This study also highlights some gaps in PT undergraduate or continuous development training with regards to injured workers' care and work disability. Many participants felt they lacked knowledge and skills necessary to provide competent care to all their patients. Several participants emphasized the role of physical therapists in reducing injured workers' fears and anxieties. This is also in line with findings from a recent meta-ethnography exploring healthcare professionals' experience of treating adults with chronic non-malignant pain (Toye et al. 2018). Although physical therapists are trained to assess musculoskeletal injuries, our study demonstrates that they do not feel that their professional training adequately prepares them for undertaking the particular tasks associated with returning injured patients to work. These findings echo those of a recent study in Australia showing that physical therapists believe they have an important role to play in returning patients to work, but lack knowledge about the best strategies to assess readiness and capacity to work and lack

clarity about this role (Johnston et al. 2012). Participants also felt ill equipped in navigating some aspects of the workers' compensation system although healthcare professionals have a crucial role in helping their patients work with the system (Lippel 2007). As primary care professionals, physical therapists should be more prepared to undertake this role. Continuous professional development training that specifically targets physical therapists' struggles with psychosocial issues, patients' anxieties, evaluation of functional activities and functioning of workers' compensation systems could be highly beneficial and ultimately help in increasing these therapists' feelings of competence, and potentially improve the quality of care for patients.

More globally, the organization of care also had a significant influence on the ethical tensions and challenges experienced by the participants in this study. For example, the administrative burden felt by participants is consistent with the experiences of other health professions (Cote et al. 2001; Kosny et al. 2011; MacEachen et al. 2010). Indeed, the solutions put forward by participants to attenuate tensions frequently entailed modifications to the clinic or department in which they worked. Participants working in contexts that were more flexible experienced less tension related to their professional values. This is an interesting finding since the broader 'workers' compensation policies' are often deemed responsible for most of the difficulties encountered by healthcare professionals (MacEachen et al. 2010). Even though WCB policies impact the organization of care in PT clinics and departments, this study shows that clinical settings themselves play an important role in creating or decreasing the challenges lived by PT professionals on a regular basis. This is in line with research on challenges stemming from institutional constraints in the fields of nursing (Beagan and Ells 2009; Varcoe et al. 2004), medicine (Førde and Aasland 2008) occupational therapy (Bushby et al. 2015; Foye et al. 2002; Penny et al. 2014) and PT (Carpenter 2010; Santos et al. 2010). These institutional constraints and system-level challenges create dissonance between

values held by professionals and what is possible for them to achieve in their clinical context (Beagan and Ells 2009). Indeed, "role stress, particularly the frustrations and strains created by conflicting demands, appears to contribute to diminutions in the emotional and physical well-being of physical therapists" (Deckard and Present 1989, p. 716). Professionals may encounter ethical distress and disillusionment if their work environments prevent them from living up to their values (Beagan and Ells 2009). Moreover, having a work environment in line with personal values was found to be one of the most significant factors for career satisfaction (Randolph and Johnson 2005). Findings from our study are thus particularly important given that ethical tensions have been linked to negative consequences such as decreased quality of patient care (Aiken et al. 2001), and difficulties in relationships with colleagues (Radzvin 2011) burnout (Sundin ‐ Huard and Fahy 1999), as well as having implications for satisfaction, recruitment, and retention of health care providers (Pauly et al. 2012).

Finally, this study also clearly highlights that some of the key drivers for many of the tensions experienced by physical therapists concern remuneration rates for professionals and the neoliberal context in which most of the care for injured workers is currently provided. As a first step, the remuneration rates for physical therapists treating injured workers should be reviewed and increased to better match current PT fees for other patients. At the same time, PT models of care for injured workers should be revised and improved to better address the complexity of care for this clientele. These model changes should be planned and developed by all the major stakeholders involved (i.e., injured workers, physical therapists, PT associations, PT colleges and WCB authorities) so that physical therapists experience fewer struggles living out their professional values and, ultimately, provide better quality care. Findings from this study also support the

literature that invites healthcare organizations and workers' compensation boards to move away from a microsystemic vision of the process of care (i.e., focused on the individual) towards a meso and macrosystemic perspective, to find solutions tailored to the current complexity of care (Costa-Black et al. 2013; Durand and Loisel 2001). Strong partnerships between compensation boards, professional associations, private PT clinics and patient groups should be developed. Organizations providing or supporting the care for injured workers should also formally commit, through their mission statements and by developing concrete practical mechanisms, to treat patients equitably and with dignity.

Limitations

We recruited participants working in a diversity of settings and providing treatments for patients at different stages of recovery, from primary acute and sub-acute care, to capacity development programs involving patients with more chronic conditions. This approach allowed us to develop a broad understanding of the ethical tensions experienced by physical therapists treating injured workers. It did not allow us to develop in-depth comparisons of tensions arising at different stages of the patient's recovery. Although we sought to identify similarities and differences across the three provinces, common patterns related to struggles in living out professional values emerged more strongly than contrasts between policy contexts. The median number of years of experience of the participants is lower in BC and Ontario compared to Quebec, which may account for some differences among the views of participants from the three provinces. Furthermore, at the time of data collection, some modifications to the provision of PT care in the BC workers' compensation system had just been made, which may have had an effect on the types of challenges discussed by the participants.

CONCLUSION

Health professionals must live up to their values to provide quality care to their patients in an equitable and respectful manner. The results from this study offer insights regarding ethical tensions experienced by physical therapists providing care to injured workers supported by WCBs in three provinces in Canada. These tensions relate to physical therapists' commitments to the values of equity, competence and professional autonomy. We have demonstrated that there are inequalities in the provision of PT care, roles of physical therapists working with this clientele, and the influences of organization of care on physical therapists' experiences. Until now, difficulties for physical therapists to work in accordance with their values have not been thoroughly reported in the literature. Further, these tacit difficulties can have major implications on the care provided to patients and on physical therapists' own well-being. Although complexity of care seems inevitable in a context where workers' compensation systems are involved, our results can be used to initiate dialogue among physical therapists, clinic owners/managers and WCBs to target specific aspects of the current models of practice where improvements could be instituted. By providing a better understanding of the struggles faced by physical therapists in their day-to-day work with injured workers, physical therapists can improve their practices in work disability and implement proposed solutions.

REFERENCES

Aguilar, A., Stupans, I., Scutter, S. and King, S. 2012. "Exploring the Professional Values of Australian Physiotherapists." *Physiotherapy Research International*. doi: https://doi.org/10.1002/pri.1525

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. A., Busse, R., Clarke, H., . . . Shamian, J. 2001. "Nurses' Reports on Hospital Care in Five Countries." *Health Affairs*, 20(3): 43-53. doi: https://doi.org/10.1377/hlthaff.20.3.43

Association des commissions des accidents du travail du Canada. (2015). Annual Key Statistical Measures (2013). from http://www.awcbc.org.

Baril, R., Clarke, J., Friesen, M., Stock, S. and Cole, D. 2003. "Management of Return-to-Work Programs for Workers with Musculoskeletal Disorders: A Qualitative Study in Three Canadian Provinces." *Social science & medicine*, 57(11): 2101-2114. doi: https://doi.org/10.1016/s0277-9536(03)00131-x

Beagan, B. and Ells, C. 2009. "Values That Matter, Barriers That Interfere: The Struggle of Canadian Nurses to Enact Their Values." *CJNR (Canadian Journal of Nursing Research)*, 41(1): 86-107.

Beardwood, B. A., Kirsh, B. and Clark, N. J. 2005. "Victims Twice Over: Perceptions and Experiences of Injured Workers." *Qualitative health research*, 15(1): 30-48. doi: https://doi.org/10.1177/1049732304268716

Bruhn, J. G. 2008. "Value Dissonance and Ethics Failure in Academia: A Causal Connection?". *Journal of Academic Ethics*, 6(1): 17-32. doi: https://doi.org/10.1007/s10805-008-9054-z

Bushby, K., Chan, J., Druif, S., Ho, K. and Kinsella, E. A. 2015. "Ethical Tensions in Occupational Therapy Practice: A Scoping Review." *British Journal of Occupational Therapy*, 78(4): 212-221. doi: https://doi.org/10.1177/0308022614564770

Canadian Institute for Health Information. (2015, February 27, 2017). Physiotherapists 2015. from http://www.cihi.ca.

Carpenter, C. 2010. "Moral Distress in Physical Therapy Practice." *Physiotherapy theory and practice*, 26(2): 69-78. doi: https://doi.org/10.3109/09593980903387878

Carpenter, C. and Suto, M. 2008. "Qualitative Research for Occupational and Physical Therapists: A Practical Guide." Oxford, UK: Blackwell Publishing Ltd.

Charmaz, K. 2006. "Constructing Grounded Theory: A Practical Guide through Qualitative Research." London: Sage Publications Ltd.

Cohen, J. S. and Erickson, J. M. 2006. "Ethical Dilemmas and Moral Distress in Oncology Nursing Practice." *Clinical journal of oncology nursing*, 10(6): 775. doi: https://doi.org/10.1188/06.cjon.775-780

Costa-Black, K. M., Feuerstein, M. and Loisel, P. 2013. Work Disability Models: Past and Present *Handbook of Work Disability* (pp. 71-93). New York: Springer.

Cote, P., Clarke, J., Deguire, S., Frank, J. W. and Yassi, A. 2001. "Chiropractors and Return-to-Work: The Experiences of Three Canadian Focus Groups." *Journal of Manipulative and Physiological Therapeutics*, 24(5): 309-316. doi: http://dx.doi.org/10.1067/mmt.2001.115267

Deckard, G. J. and Present, R. M. 1989. "Impact of Role Stress on Physical Therapists' Emotional and Physical Well-Being." *Physical Therapy*, 69(9): 713-718. doi: https://doi.org/10.1093/ptj/69.9.713

Dionne, C. E., Bourbonnais, R., Frémont, P., Rossignol, M., Stock, S. R. and Laperrière, È. 2013. "Obstacles to and Facilitators of Return to Work after Work-Disabling Back Pain: The Workers' Perspective." *Journal of occupational rehabilitation,* 23(2): 280-289. doi: https://doi.org/10.1007/s10926-012-9399-4

Durand, M. J. and Loisel, P. 2001. "La Transformation De La Réadaptation Au Travail D'une Perspective Parcellaire À Une Perspective Systémique." *Perspectives interdisciplinaires sur le travail et la santé,* 3(2): 1-14. doi: https://doi.org/10.4000/pistes.3799

Eakin, J. M. and Mykhalovskiy, E. 2003. "Reframing the Evaluation of Qualitative Health Research: Reflections on a Review of Appraisal Guidelines in the Health Sciences." *Journal of evaluation in clinical practice,* 9(2): 187-194. doi: https://doi.org/10.1046/j.1365-2753.2003.00392.x

Førde, R. and Aasland, O. 2008. "Moral Distress among Norwegian Doctors." *Journal of medical ethics,* 34(7): 521-525. doi: https://doi.org/10.1136/jme.2007.021246

Foye, S. J., Kirschner, K. L., Wagner, L. C. B., Stocking, C. and Siegler, M. 2002. "Ethical Issues in Rehabilitation: A Qualitative Analysis of Dilemmas Identified by Occupational Therapists." *Topics in stroke rehabilitation*. doi: https://doi.org/10.1310/7824-1ae0-gff0-kt55

Friesen, M. N., Yassi, A. and Cooper, J. 2001. "Return-to-Work: The Importance of Human Interactions and Organizational Structures." *Work: A Journal of Prevention, Assessment and Rehabilitation,* 17(1): 11-22.

Guzman, J., Yassi, A., Cooper, J. E. and Khokhar, J. 2002. "Return to Work after Occupational Injury. Family Physicians' Perspectives on Soft-Tissue Injuries." *Canadian Family Physician,* 48(12): 1912-1919. doi: https://doi.org/10.1007/s10926-018-9754-1

Hellman, T., Jensen, I., Bergström, G. and Busch, H. 2015. "Returning to Work–a Long-Term Process Reaching Beyond the Time Frames of Multimodal Non-Specific Back Pain Rehabilitation." *Disability and Rehabilitation,* 37(6): 499-505. doi: https://doi.org/10.3109/09638288.2014.923531

Hudon, A., Laliberte, M., Hunt, M. and Feldman, D. E. 2015. "Quality of Physiotherapy Services for Injured Workers Compensated by Workers' Compensation in Quebec: A Focus Group Study of Physiotherapy Professionals." *Healthcare Policy,* 10(3): 32-47. doi: http://www.longwoods.com/product/download/code/24171

Hunt, M. R. 2009. "Strengths and Challenges in the Use of Interpretive Description: Reflections Arising from a Study of the Moral Experience of Health Professionals in Humanitarian Work." *Qualitative health research,* 19(9): 1284-1292. doi: https://doi.org/10.1177/1049732309344612

Jensen, G. M. and Greenfield, B. 2012. "Ethics Education: Developing Habits of Mind through the Use of Pedagogical Content Knowledge." *Physical Therapy Reviews,* 17(3): 149-156. doi: https://doi.org/10.1179/1743288x11y.0000000056

Johnston, V., Nielsen, M., Corbière, M. and Franche, R.-L. 2012. "Experiences and Perspectives of Physical Therapists Managing Patients Covered by Workers' Compensation in Queensland, Australia." *Physical Therapy,* 92(10): 1306-1315. doi: https://doi.org/10.2522/ptj.20110194

Kilgour, E., Kosny, A., McKenzie, D. and Collie, A. 2014a. "Healing or Harming? Healthcare Provider Interactions with Injured Workers and Insurers in Workers' Compensation

Systems." *Journal of occupational rehabilitation*: 1-20. doi: https://doi.org/10.1007/s10926-014-9521-x
Kilgour, E., Kosny, A., McKenzie, D. and Collie, A. 2014b. "Interactions between Injured Workers and Insurers in Workers' Compensation Systems: A Systematic Review of Qualitative Research Literature." *Journal of occupational rehabilitation*: 1-22. doi: https://doi.org/10.1007/s10926-014-9513-x
Kinsella, E. A., Park, A. J.-S., Appiagyei, J., Chang, E. and Chow, D. 2008. "Through the Eyes of Students: Ethical Tensions in Occupational Therapy Practice." *Canadian Journal of Occupational Therapy*, 75(3): 176-183. doi: https://doi.org/10.1177/000841740807500309
Kosny, A., MacEachen, E., Ferrier, S. and Chambers, L. 2011. "The Role of Health Care Providers in Long Term and Complicated Workers' Compensation Claims." *Journal of occupational rehabilitation*, 21(4): 582-590. doi: https://doi.org/10.1007/s10926-011-9307-3
Lippel, K. 2007. "Workers Describe the Effect of the Workers' Compensation Process on Their Health: A Quebec Study." *International Journal of Law and Psychiatry*, 30(4-5): 427-443. doi: http://dx.doi.org/10.1016/j.ijlp.2007.06.013
Lippel, K., Eakin, J. M., Holness, D. L. and Howse, D. 2016. "The Structure and Process of Workers' Compensation Systems and the Role of Doctors: A Comparison of Ontario and Québec." *American journal of industrial medicine*. doi: https://doi.org/10.1002/ajim.22651
Lippel, K. and Lötters, F. J. 2013. Public Insurance System: A Comparison of Caused-Based and Disability-Based Income Support Systems. In P. Loisel andJ. R. Anema (Eds.), *Handbook of Work Disability*. New York: Springer.
Loisel, P. and Anema, J. R. (Eds.). (2013). *Handbook of Work Disability*. New York: Springer.
Loisel, P., Durand, M. J., Baril, R., Gervais, J. and Falardeau, M. 2005. "Interorganizational Collaboration in Occupational Rehabilitation: Perceptions of an Interdisciplinary Rehabilitation Team." *Journal of occupational rehabilitation*, 15(4): 581-590. doi: https://doi.org/10.1007/s10926-005-8036-x
MacEachen, E., Kosny, A., Ferrier, S. and Chambers, L. 2010. "The "Toxic Dose" of System Problems: Why Some Injured Workers Don't Return to Work as Expected." *Journal of occupational rehabilitation*, 20(3): 349-366. doi: https://doi.org/10.1007/s10926-010-9229-5
Morse, J. M. 2010. "How Different Is Qualitative Health Research from Qualitative Research? Do We Have a Subdiscipline?". *Qualitative health research*, 20(11): 1459-1464. doi: 10.1177/1049732310379116
Newnam, S., Petersen, A., Keleher, H., Collie, A., Vogel, A. and McClure, R. 2016. "Stuck in the Middle: The Emotional Labours of Case Managers in the Personal Injury Compensation System." *Work*(Preprint): 1-11. doi: https://doi.org/10.3233/wor-162406
Parrish, M. and Schofield, T. 2005. "Injured Workers' Experiences of the Workers' Compensation Claims Process: Institutional Disrespect and the Neoliberal State." *Health Sociology Review*, 14(1): 33-46. doi: https://doi.org/10.5172/hesr.14.1.33
Pauly, B. M., Varcoe, C. and Storch, J. 2012. "Framing the Issues: Moral Distress in Health Care." *HEC Forum*, 24(1): 1-11. doi: https://doi.org/10.1007/s10730-012-9176-y

Penny, N. H., Ewing, T. L., Hamid, R. C., Shutt, K. A. and Walter, A. S. 2014. "An Investigation of Moral Distress Experienced by Occupational Therapists." *Occupational therapy in health care,* 28(4): 382-393. doi: https://doi.org/10.3109/07380577.2014.933380
Pergola, T., Salazar, M., Graham, K. and Brines, J. 1999. "Case Management Services for Injured Workers. Providers' Perspectives." *AAOHN journal: official journal of the American Association of Occupational Health Nurses,* 47(9): 397.
Pincus, T., Woodcock, A. and Vogel, S. 2010. "Returning Back Pain Patients to Work: How Private Musculoskeletal Practitioners Outside the National Health Service Perceive Their Role (an Interview Study)." *Journal of occupational rehabilitation,* 20(3): 322-330. doi: https://doi.org/10.1007/s10926-009-9217-9
Praestegaard, J., Gard, G. and Glasdam, S. 2015. "Physiotherapy as a Disciplinary Institution in Modern Society–a Foucauldian Perspective on Physiotherapy in Danish Private Practice." *Physiotherapy theory and practice,* 31(1): 17-28. doi: https://doi.org/10.3109/09593985.2014.933917
Radzvin, L. C. 2011. "Moral Distress in Certified Registered Nurse Anesthetists: Implications for Nursing Practice." *AANA journal,* 79(1).
Randolph, D. S. and Johnson, S. P. 2005. "Predicting the Effect of Extrinsic and Intrinsic Job Satisfaction Factors on Recruitment and Retention of Rehabilitation Professionals." *Journal of Healthcare management,* 50(1): 49. doi: https://doi.org/10.1097/00115514-200501000-00011
Roberts-Yates, C. 2003. "The Concerns and Issues of Injured Workers in Relation to Claims/Injury Management and Rehabilitation: The Need for New Operational Frameworks." *Disability and Rehabilitation,* 25(16): 898-907. doi: http://dx.doi.org/10.1080/0963828031000122203
Robichaud, M.-M. 2016. Retour Au Travail À La Suite D'une Lésion Professionnelle: Perspective Des Intervenants En Réadaptation Du Système. (Mémoire de maîtrise), Université Laval, Québec.
Russell, G., Brown, J. B. and Stewart, M. 2005. "Managing Injured Workers: Family Physicians' Experiences." *Canadian family physician Medecin de famille canadien,* 51: 78-79.
Santos, M. C., Barros, L. and Carolino, E. 2010. "Occupational Stress and Coping Resources in Physiotherapists: A Survey of Physiotherapists in Three General Hospitals." *Physiotherapy,* 96(4): 303-310. doi: https://doi.org/10.1016/j.physio.2010.03.001
Setchell, J., Gard, M., Jones, L. and Watson, B. 2017. "Addressing Weight Stigma in Physiotherapy: Development of a Theory-Driven Approach to (Re) Thinking Weight-Related Interactions." *Physiotherapy theory and practice*: 1-14. doi: https://doi.org/10.1080/09593985.2017.1328718
Slade, S. C., Molloy, E. and Keating, J. L. 2009. "Listen to Me, Tell Me': A Qualitative Study of Partnership in Care for People with Non-Specific Chronic Low Back Pain." *Clinical Rehabilitation,* 23(3): 270-280. doi: https://doi.org/10.1177/0269215508100468
Smith, N. 2018. Neoliberalism *Encyclopaedia Britannica*: Encyclopaedia Britcannica, inc.
Soklaridis, S., Ammendolia, C. and Cassidy, D. 2010. "Looking Upstream to Understand Low Back Pain and Return to Work: Psychosocial Factors as the Product of System Issues." *Social science & medicine,* 71(9): 1557-1566. doi: https://doi.org/10.1016/j.socscimed.2010.08.017

Soklaridis, S., Tang, G., Cartmill, C., Cassidy, J. D. and Andersen, J. 2011. "“Can You Go Back to Work?” Family Physicians’ Experiences with Assessing Patients’ Functional Ability to Return to Work." *Canadian Family Physician,* 57(2): 202-209.

Sundin‐Huard, D. and Fahy, K. 1999. "Moral Distress, Advocacy and Burnout: Theorising the Relationships." *International Journal of Nursing Practice,* 5(1): 8-13. doi: https://doi.org/10.1046/j.1440-172x.1999.00143.x

Tarasuk, V. and Eakin, J. M. 1995. "The Problem of Legitimacy in the Experience of Work-Related Back Injury." *Qualitative health research,* 5(2): 204-221.

Thorne, S. 2016. "Interpretive Description: Qualitative Research for Applied Practice. (Vol. 2)." Walnut Creek, California: Left Coast Press.

Thorne, S., Kirkham, S. R. and MacDonald-Emes, J. 1997. "Focus on Qualitative Methods. Interpretive Description: A Noncategorical Qualitative Alternative for Developing Nursing Knowledge." *Research in nursing & health,* 20(2): 169-177. doi: https://doi.org/10.1002/(sici)1098-240x(199704)20:2%3C169::aid-nur9%3E3.3.co;2-b

Thorne, S., Kirkham, S. R. and O’Flynn-Magee, K. 2004. "The Analytic Challenge in Interpretive Description." *International Journal of Qualitative Methods,* 3(1): 1-11. doi: https://doi.org/10.1177/160940690400300101

Toye, F., Seers, K. and Barker, K. 2018. Health Services and Delivery Research *A Meta-Ethnography of Health-Care Professionals' Experience of Treating Adults with Chronic Non-Malignant Pain to Improve the Experience and Quality of Health Care*. Southampton (UK): NIHR Journals Library.

Varcoe, C., Doane, G., Pauly, B., Rodney, P., Storch, J. L., Mahoney, K., . . . Starzomski, R. 2004. "Ethical Practice in Nursing: Working the in‐Betweens." *Journal of Advanced Nursing,* 45(3): 316-325.

Whiteside, H. 2009. "Canada’s Health Care “Crisis”: Accumulation by Dispossession and the Neoliberal Fix." *Studies in Political Economy,* 84(1): 79-100. doi: https://doi.org/10.1080/19187033.2009.11675047

Wynne-Jones, G., van der Windt, D., Ong, B. N., Bishop, A., Cowen, J., Artus, M. and Sanders, T. 2014. "Perceptions of Health Professionals Towards the Management of Back Pain in the Context of Work: A Qualitative Study." *BMC musculoskeletal disorders,* 15(1): 210. doi: https://doi.org/10.1186/1471-2474-15-210

Acknowledgements

We wish to thank the all the participants who took time to participate with such great enthusiasm in this project. We also wish to thank the physiotherapy associations and colleges who helped in the recruitment of the participants and Julie Des Lauriers, Erin Douglas and Tatiana Orozco for their help with some of the project aspects. We also thank members from the McGill journal club, Marie Laberge and Marie-Hélène Raymond for their input on earlier version of this manuscript. Finally, we want to express our deepest gratitude to the other members of the research team who contributed in time and advices on this project: Maude Laliberté, Barbara Mazer and Bryn Williams-Jones.

We also thank all the organizations that made this research project possible. At the time of this study, Anne was supported by a doctoral fellowship from the Fonds de recherche du Québec-Santé (FRQ-S) and was also supported by a scholarship from the MENTOR program in collaboration with Canadian Institutes of Health Research (CIHR) and the Quebec Research Rehabilitation Network (REPAR). She is currently supported by a postdoctoral fellowship from the Fonds de recherche du Québec-Santé (FRQ-S). This project was funded by the Canadian Institutes of Health Research (CIHR-EOG-120255) and by the Physiotherapy Foundation of Canada through the Dominion of Canada Scholarship.

Declaration of interests

The authors of this manuscript declare no financial or non-financial competing interests.

Endnotes

[i] In Quebec, in 2008, less than 5% of all workers' compensation payments for physical therapy and occupational therapy treatments came from the public sector. [Camiré, V. (2010) Groupe de travail chargé de faire des recommandations concernant le régime québécois de santé et de sécurité du travail p. 154.]

[ii] The term "physical therapist" is used throughout the text, but it also includes PT technicians when discussing Quebec PT professionals.