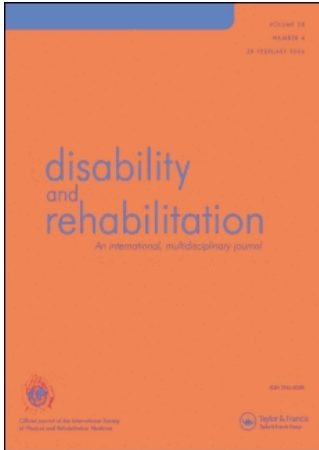


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Service, advocacy and adjudication: Balancing the ethical challenges of multiple stakeholder agendas in the rehabilitation of chronic pain

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Abstract

Purpose. To highlight potentially conflicting roles of the rehabilitation professional in the treatment of clients with persistent pain conditions. In assisting clients requiring rehabilitation, the role of the rehabilitation professional is usually fairly clear and unambiguous. If however questions about the authenticity of the client's presenting disability have been raised, then a major role conflict can arise. Many clients present with symptoms of pain and disability yet there is no objectively discernible disease, and in these cases, the authenticity of the condition may be questioned. As rehabilitation professionals we may thus find ourselves acting in different roles: (i) We might be a clinical service provider working to reduce the client's suffering, (ii) We might become the client's advocate working to protect the client in conflicts with an insurer, (iii) We might become an adjudicator working to help the insurer detect evidence of our client's fraudulent behaviour. The principal objective of this paper is to distinguish these roles, and highlight their incompatibility. It is stressed that accreditation for and competence in clinical intervention does not guarantee or legitimize competence in advocacy or adjudication.

Conclusions and recommendations. The paper concludes by suggesting that the primary role of the rehabilitation professional should be the provision of clinical service and that the adoption of the role of advocate or adjudicator may cross unacceptable ethical boundaries resulting in bringing harm, intentionally, or unintentionally, to the client.

Keywords: *Rehabilitation, role conflict, ethics of clinical practice*

Introduction

Rehabilitation professionals are sometimes invited to participate in discussions about clients' lack of motivation in treatment, secondary gain issues, or even malingering. At times, the focus of these discussions may be on possible explanations for a client's lack of progress; at other times, on whether there is evidence of malingering or secondary gain. Such discussions may raise fundamental ethical dilemmas for the rehabilitation professional in his or her role as clinical service provider to the injured client.

As rehabilitation professionals, we must reflect on the defining boundaries of our involvement with a client. Four fundamental questions require consideration: Will we act as clinicians, providing our clients with services that will promote recovery and

facilitate progress in rehabilitation? Is part of our role to assist our client in navigating the rough legal and policy waters of insured services? Ought we to assist the insurer in determining whether certain features of a client's presentation suggest that the client's problems lie outside the insurer's service and compensation mandate? Finally, will we assist the insurer in determining whether a client's claim of disability is authentic, exaggerated or fabricated?

The present paper will discuss the varied nature of involvement that might be requested of a rehabilitation professional in the course of treating a client. The first objective of the paper is to highlight how a rehabilitation professional might become embroiled in a range of activities, not all of which would be considered as lying within the domain of expertise of the rehabilitation professional. A second objective is to explore how multiple role involvement might

compromise the potential effectiveness of rehabilitation interventions. A third objective is to identify potential ethical issues raised by multiple role involvement.

These objectives will be pursued in the context of rehabilitation services provided to insured clients. The rehabilitation population of interest includes individuals who have sustained injuries in the workplace, or individuals who have been injured in motor vehicle accidents. For the purposes of this paper, 'insurer' will be defined broadly as any organization, private or public, financially responsible for the provision of health care services and/or wage indemnity following injury.

In some geographical regions such as North America, New Zealand and Australia, injury insurers exist as organizations independent of the broader health or social security system. Private injury insurers often, but not always, operate within an adversarial 'tort' system (e.g., United Kingdom, United States). In tort systems, legal action is taken against the insurer in order to obtain financial compensation for losses incurred. As a defense, the insurer will frequently challenge the credibility of the plaintiff (i.e., injured person). In many European countries, services and provisions for individuals who have sustained injuries are handled within the health or social security system where challenges to the credibility or 'authenticity' of injury claims might be less frequent or less aggressive.

Injury insurers, whether public or private, typically operate under a mandate to provide the injured individual with services that will maximize the probability of successful rehabilitation and recovery. These might include health services, wage indemnity and a host of other assistive services. In order to contain costs, insurers must maintain a watchful eye on the legitimacy of an individual's claim. Although the question of the legitimacy of a claim originates within the legal domain (e.g., fraud), the insurer must often appeal to the rehabilitation clinician for assistance in determining the degree to which presenting symptoms are 'legitimate'. The relative emphasis on the detection of non-legitimate claims likely varies a great deal across geographical regions (and type of insurer), and the focus on the detection of non-legitimate claims might be most striking in completely privatized insurance systems. Nevertheless, similar issues are likely to be represented to some degree for all insured services.

Although the balancing of multiple stakeholder agendas is relevant to a variety of rehabilitation contexts, this balancing act may be most challenging in the context of clients for whom disability has arisen subsequent to injury. Much of the discussion that follows will draw on issues that arise from the treatment of individuals with pain-related disability.

To varying degrees, the issues addressed in this paper will be applicable to other client populations receiving rehabilitation services.

Client-centred or person-centred rehabilitation is typically construed as a rehabilitation approach where rehabilitation goals or programs are developed in collaboration with the client, or in relation to the client's definition of quality of life. As will be highlighted in this paper, when the rehabilitation professional strays from the service provider role, client-centredness will necessarily be compromised.

Symptoms and complaints: The grist of clinical inferences

With very few exceptions, humans are motivated to minimize their suffering and their pain. Following injury, attentional engagement to pain symptoms, and the initiation of behaviour aimed at reducing or managing pain often take precedence over competing goals [1]. Individuals with persistent pain show a propensity to attend to their pain, to reduce their involvement in activities that further exacerbate pain, and to communicate their pain experiences to others [2]. It is assumed that individuals communicate their pain in order to enlist the care of others in order to reduce their suffering and maximize their potential for recovery [3,4].

In modern society, a number of intervention disciplines have evolved with the specific goal of reducing suffering and increasing functional abilities in individuals who might be limited by their pain symptoms. Following injury, interventionists such as physicians, nurses, physical therapists, occupational therapists, psychologists and social workers might be called upon to offer their assistance in the treatment of the injured client [5]. Usually, the clinician's initial objective will be to conduct an assessment as a basis for choosing among different treatment options. If it were possible to assume that every behavioral indicator of pain and suffering was a veridical representation of a presenting health condition, the task of the clinical service provider would be greatly simplified.

However, the task of the clinical service provider is not simple. Anecdotal and empirical research suggests that not all presentations of pain, suffering, and disability can be considered authentic or veridical indicators of an underlying health condition that requires treatment [6,7]. Experience tells us that there may be important differences between what the client 'appears to have' and what the client 'actually has' [8–10].

The clinician must often rely on the client's expressive abilities in order to make diagnostic inferences [10]. It is clear that clinicians cannot 'see' others' pain [11]. It is also clear that the

underlying pathology of many clients' presenting symptoms will not always be discernible [12]. Diagnostic and imaging tools for soft tissue pathology have not evolved sufficiently to provide the precision required to make confident statements about the source of a client's pain. To complicate the matter further, research suggests that for some clients, the source of pain (e.g., pathology) may have moved from the original lesion site to central regions, at which point discerning the organic pathology of a particular pain condition becomes impossible [13].

In the absence of discernible organic pathology, the clinician must proceed on the basis of clinical signs and symptoms [10]. Clinical signs and symptoms will include clients' self-reported difficulties, their apparent movement limitations, and a variety of behaviours that might communicate to the clinician something about the source or cause of symptoms. All forms of communication, whether verbal, para-verbal or movement-related as behaviours [14], need to be understood in their social context. Behaviours associated with pain might be automatic or intentional; they might be initiated following conscious deliberation and planning, or they might be invoked through unconscious processes [2]. Pain behaviours should be understood both in their social context, as susceptible to influence from environmental contingencies, and also as potentially susceptible to modulation and possible distortion from a variety of psychological factors [5,15].

Identifying all possible sources of influence on presenting symptoms and complaints would appear to be a challenge of enormous proportion [16]. Indeed, the task of the rehabilitation professional is not a simple one [17].

It is precisely because the presenting symptoms of pain and disability might not always represent 'authentic' injury that the rehabilitation professional finds himself or herself forced or compelled to move beyond the boundaries of clinical practice [7,18]. Suspiciousness on the part of the insurer might lead to the development of adversarial relations with the client, and rehabilitation professionals may find themselves having to adopt the role of advocate for the client. Alternately, rehabilitation professionals may choose explicitly to assist the insurer in the policing of potentially fraudulent behaviour [8]. However, we contend that these roles can and should be clearly distinguished, not only clinically but also in terms of their ethical implications.

The rehabilitation professional as clinical service provider

Although modern rehabilitation may involve both clinical and non-clinical personnel, at its core,

rehabilitation typically is construed as a sub-category of medicine (see Gzil et al. [19] in this issue of the journal). The rehabilitation professional will possess a 'tool kit' that can serve to alleviate the suffering and improve the function of the client. The core curriculum for training the rehabilitation professional will likely have involved basic knowledge of the function and dysfunction of the human body, the development of skills in assessment and diagnosis, and the use of various tools that can be used to intervene with the client's condition.

The medical heritage of rehabilitation continues to influence both the philosophical orientation and activities of many rehabilitation disciplines. The objectives of traditional medical practice are often stated in terms of the provision of a 'cure' for the client's presenting health care condition. However, in the case of chronic conditions, it is not clear that 'cure' is an attainable goal. Nevertheless, our medical heritage may cause us to persist, sometimes indefinitely, in the application of ineffective treatment, because the thought of leaving the client 'uncured' will leave the rehabilitation service provider feeling like he or she has failed.

In many domains of intervention, there is an increasing call for the application of evidence-based principles in clinical practice [20]. It has been argued that the clinician has an ethical responsibility to provide treatments that have been shown to be effective and not to provide treatments that have been shown to be ineffective. However, a quick glance at the tools used in typical rehabilitation interventions reveals all too clearly that many of the tools used are not evidence-based, and many have been shown to be ineffective [21–23]. So why do we persist in using ineffective tools?

Turk [24] noted that many clinicians fail to distinguish between evidence-based medicine (e.g., research supports this treatment) and eminence-based medicine (e.g., someone important said this was good). It has also been suggested that in rehabilitation, many of the interventions used might be more aptly described as compassion-driven as opposed to evidence-driven. We intervene because we do not want to watch our clients suffer. However, the manner in which we intervene, more often than not, has little basis in clinical science.

Even within the minority of rehabilitation professionals who speak the language of evidence-based practice, there is often a misunderstanding of precise meaning of evidence-based practice. What is frequently neglected is the link between the objective of treatment, and the evidence-based approach used. For example, biofeedback could be discussed as an evidence-based approach, but it will not help the client return to work. If the objective is to reduce muscle tension, biofeedback might be justified as an

intervention; if the objective is return to work, then biofeedback would not be considered an evidence-based approach.

A mentor of one of the authors once commented, 'your client doesn't care what you know, your client wants to know you care'. As discussed by McLeod and McPherson (in this issue [25]), caring is central and critical element of rehabilitation treatment. For many rehabilitation professionals, an empathic orientation and an interest in the relief of suffering likely played a significant role in the decision to pursue a career as a 'care' professional.

At the very foundation of the 'caring' or 'therapeutic' relationship is the issue of trust. The rehabilitation professional presents himself or herself as someone who can be trusted, and the client's ability and willingness to invest his or her trust in the rehabilitation professional will determine, at least in part, the probability of successful outcome [26].

There is an ethical responsibility that emerges from the trust relationship established between a clinician and a client [10]. As a function of the establishment of a trust relationship, the client will be sharing personal, and sometimes intimate, information with clinician; some of this information might be injury-related, some of this information may pertain to life areas not directly related to injury. The client shares this information under the implicit assumption that the clinician will not use this information in ways that could be harmful to the client. If the rehabilitation professional presents in a manner that suggests to the client that he or she is not trustworthy, the potential impact of treatment will be markedly reduced.

Thus, if we consider some of defining features of the role of rehabilitation service provider, we might suggest that the ideal clinician is:

- (1) One who is professionally competent in the relevant matters of assessment and intervention
- (2) One who is able to establish treatment goals appropriate to the nature of the health condition and the intervention tools available, and
- (3) One who is able to engage in a relationship with the client characterized by caring, honesty and trust.

The rehabilitation professional as an advocate

The context of disability can be adversarial. Health insurers, occupational injury or accident insurers remain viable to the degree to which they accumulate more financial resources than they expend. In relation to the injured client, the insurers' viability can be achieved through the provision of services that

will assist the client in regaining the independence and function required to return to work, or by restricting access to compensation. Even in jurisdictions where health services for disabling health conditions are funded by governmental agencies, promoting return to function and resumption of occupational activities is a key objective of interventions.

The world of insured services and benefits can be complex, and unforgiving. Anecdotal accounts abound of severely disabled individuals who signed away their rights to treatment or compensation in exchange for a \$500 cheque, simply because they did not understand the implications of their decision. The adversarial tone that can characterize relations with insurers has led many rehabilitation professionals to refuse to take on clients who are still involved in litigation or appeal. As unpleasant as it might be, the stress of adversarial relations with insurers impacts on clients to a far greater degree than it impacts on the rehabilitation professional.

The perceived unfairness of difficult situations in which their clients find themselves has led many clinicians to play an advocacy role for the client. The rehabilitation professional might behave in a manner that he or she perceives as best protecting the client's rights. Some clinicians might take on this advocacy role as an extension of their 'caring' for their client. Others might take on an advocacy role as a reflection of their personal attitudes toward insurers.

In this context, the advocacy role differs from the helping or service provider role. Advocacy takes a step beyond the provision of information or offering suggestions about possible courses of action that a client might consider. Advocacy moves into activity domains that include siding with client in relation to a dispute or disagreement with an insurer, or even another service provider. Advocacy also entails speaking or acting on behalf of a client.

Although likely to be driven by altruistic motives, choosing to act as an advocate for the client can sometimes contribute to escalation, rather than resolution, of the conflict situation that prompted the clinician's advocacy behaviour. In the role of advocate, the rehabilitation professional might find himself or herself engaged in activities for which he or she has little or no formal training. More importantly, many of these activities were likely not part of the initial treatment agreement between the clinician and the client.

The character of the relationship between the client and the clinician changes dramatically when the clinician adopts the role of advocate. The role change might not necessarily be conducive to better outcomes; in fact there is reason to believe that, although altruistically driven, advocacy might contribute to poorer rehabilitation outcomes.

The implicit message that underlies the service provider role could be stated as 'I will use all the tools at my disposal to help you get better'. The implicit message that underlies the advocacy role could be stated as 'I will do everything I can to protect you' or 'I will take your side in this battle'. Although both can be marshaled as client-centred messages, the former will likely yield better outcomes than the latter.

In the treatment of most chronic conditions, a cure will be an unlikely outcome of even our best efforts in intervention. The essence of sound rehabilitation practice is the ability to equip clients with the skills and tools they will require to effectively, and independently, meet the challenges associated with their disability (see Patston in this issue [27]). There is an element of empowerment that evolves in the course of (successful) rehabilitation, an element of autonomy and an element of responsibility [28]. Will these same elements emerge out of a relationship characterized by protection?

Implicit in any action designed to protect is the view that the object of protection is unable to act on his or her own behalf. The psychology of protection is one that subsumes elements of helplessness, passivity, lowered self-confidence and lowered self-esteem [29,30]. These do not resemble a recipe for successful rehabilitation outcome.

These observations are not meant to imply that the client does not require advocacy. Nor is it suggested that all advocacy takes the form of protection. Rather, it is to suggest that the rehabilitation professional might not be the ideal candidate to provide this service. In most regions where individuals might have access to insured health services or compensation for injury, advocacy services are also available. The client might be better served by seeking out professional advocacy services, if needed, rather than have these services provided by someone with limited knowledge and training in the area of advocacy.

The issue of competency for advocacy likely varies according to context and intervention discipline. It could be argued that some rehabilitation disciplines, such as social work, might possess the skill set necessary to effectively function as a client advocate. Nevertheless, the questions can still be raised whether the social worker who plays the role of the service provider should also be the social worker who plays the role of advocate.

The rehabilitation professional as adjudicator

It appears that rehabilitation professionals have been willing collaborators in the insurer's quest to seek out and expose patients are 'taking advantage of the system'. The frequency with which references to

'poor motivation', 'secondary gain', or 'functional overlay' appear in rehabilitation reports is alarming [7]. It is alarming because there are no objective measures of poor motivation, secondary gain or functional overlay [31]. These are all 'inferences' based on very ambiguous behavioural signs. It is unlikely that these areas were the targets of the treatment provided by the rehabilitation professional and as such, even more surprising that they should appear in a treatment termination report.

If factors like poor motivation, secondary gain or functional overlay are so critical in explaining the outcome of (failed) treatment, why were these factors not the focus of assessment or the target of intervention? One reason might be that we have difficulty blaming ourselves for failed treatment, so we look for ways to blame the patient for not having improved.

Another reason why words such as secondary gain or functional overlay might appear in the treatment termination reports of rehabilitation professionals is that there might have been a request from the insurer that these issues be addressed. By complying with such requests, whether implicit or explicit, the rehabilitation professional adopts the role of adjudicator [10].

As noted earlier, the insurer can contain costs by providing services to restore lost function, or can restrict access to service or compensation. The latter is often the preferred option as it is less costly. To the degree that the insurer can enlist the collaboration of the rehabilitation professional, the financial savings for the insurer can be quite attractive.

This discussion of the adjudicator role does not question the task of the clinician of discerning relative physical and psychological influences on presenting symptoms. For example, clients whose physical symptoms might arise from a somatoform condition must still be considered 'authentic' in their presentation. Discerning relative physical and psychological influences on presenting symptoms is part of good clinical practice and does not constitute adjudication [32]. The role of adjudication enters the picture when the clinician makes inferences about the client's intentional exaggeration or fabrication of presenting symptoms.

The 'double agent' behaviour of the rehabilitation professional, the one who presents himself or herself as invested in the treatment of the client, while at the same time seeking evidence of client's fraudulent behaviour will almost inevitably result in negative outcomes for the client. At a basic level, this dual role will impede the development of a trust relationship between the client and clinician. If the client perceives that the clinician might be acting as an extension of the insurer, a more guarded stance will characterize the relationship and the necessary

elements of a relationship conducive to rehabilitation success will be missing. In this manner, it could be argued that when the rehabilitation professional chooses to collaborate with the insurer's investigation of possible deception, the rehabilitation professional immediately compromises his or her potential effectiveness as a clinician.

An ethical issue arises from this situation, one related to deception on the part of the clinician. If the rehabilitation professional chooses to act as both a clinical service provider and as a 'detective' for the insurer, this information should be brought to the client's attention prior to participating in treatment. To knowingly withhold this information prevents the client from making an informed decision about participation in treatment. Such a situation would probably be considered in violation of ethical guidelines for most clinical practice professions.

When rehabilitation professionals suggest that factors such as secondary gain or functional overlay might be contributing to disability, these suggestions are rarely based on the outcome of systematic evaluation, they are rarely accompanied by objective assessment results, and more often than not, they are not evidence-based [7]. In many medical fields, when conditions do not recover 'as expected', there is a tendency to make the 'leap to the head'. The logic of clinician's conclusion is that 'if this was a medical/physical problem it would have improved, and since it has not improved, it must be a psychological problem'. However, diagnosis or diagnostic impression must be supported by clinical signs and symptoms consistent with the diagnosis, not be the absence of clinical signs and symptoms of an alternate diagnosis [10]. Still, we continue to make the leap to the head when our interventions do not yield positive outcomes.

'Secondary gain' is a term used to describe potential disincentives for recovery. It is a term sometimes used to account for a client's lack of progress. Although, a full discussion of the concept of secondary gain is beyond the scope of this paper, it refers generally to a variety of internal, external, conscious and unconscious factors that might have a negative impact on motivation for change [33,34]. It is an overly inclusive concept; indeed it is difficult to think of what would not constitute a possible secondary gain.

There is no objective assessment of secondary gain and to invoke the potential contribution of secondary gains, the clinician must make inferences about how the relative rewards and stresses of working balance against those of not working, and then make a decision about the factors underlying the client's presenting disability. Financial compensation for injury could be considered secondary gain: the opportunity to avoid the stress of the workplace or

the reduction in parenting guilt now afforded by the opportunity to stay at home might all be taken as examples of secondary gain. In practice, the process of attribution of secondary gain often seems to be accompanied by flawed logic in which evidence of potential disincentives to change is taken as evidence for the absence of physical/medical pathology.

A further concern is the competency of the rehabilitation professional in making such a judgment. What skill set does the rehabilitation professional possess that will permit him or her to draw conclusions about the factors that might be impacting on the client's motivation for change? The client might not be consciously aware of the secondary gain issues at play, and clients rarely admit that these factors are the primary determinants of their disability. As such, the rehabilitation professional must invoke his or her 'special powers' to examine the contents of the client's unconscious mind.

It has in fact been suggested that the 'detection' of non-clinical influences on a client's presenting symptoms of disability is not a clinical question. One possible scenario is that the client does not suffer from a medical/physical problem yet presents himself or herself in a manner that suggests that a medical/physical problem exists. In this scenario, the client is intentionally falsifying information for financial gain. The client's behaviour in this scenario would be considered fraud. Fraud is not a clinical condition. Fraudulent behaviour is a criminal offence. Is the rehabilitation professional the best candidate for conducting an investigation of potential fraudulent behaviour [10].

Here too emerges an ethical challenge. It is not necessary to belabour the point that the rehabilitation professional (even the psychologist) does not possess the tools required to draw conclusions about the forces impacting on the client's motivation for change. To offer opinion on factors that lie outside of one's domain of expertise begins to strain the principles of responsible and ethical practice. To offer opinion on issues outside of one domain of expertise, knowing that such opinion will have negative repercussions on the client, unambiguously violates principles of responsible and ethical practice.

It could be argued that in spite of the ethical dilemmas surrounding the service provider-adjudicator conflict, the rehabilitation professional might still be the individual best suited for the task of adjudication. After all, the rehabilitation professional possesses the tools necessary to assess and diagnose conditions associated with disability. If the rehabilitation professional does not perform this task, who will? There is perhaps a solution to the problem. In some jurisdictions, insurers have established adjudication divisions staffed by clinicians and claims

administrators. The primary mandate of these adjudication divisions is to determine the extent of disability associated with a presenting health condition, and to determine its compensability. Under these conditions, the rehabilitation professional can be spared some ethical tension because the nature of the mandate of the rehabilitation professional is made clear to the client from the onset.

Conclusions

In this paper, we have tried to elaborate on the multiple roles that a rehabilitation professional might be invited to play, implicitly or explicitly, in the treatment of a client with a debilitating pain condition. We have tried to draw the conceptual lines that demarcate the boundaries of the role of service provider, advocate and adjudicator. The boundaries of these different roles might not be as distinct in reality as we have sketched them in this paper. Indeed, the boundaries may be sufficiently blurred, and porous, that we might be less-than-aware that we have crossed them.

Clearly, rehabilitation professionals do not play multiple roles with the intention of compromising treatment efficacy or straining professional ethics. The movement from one role to another, can be subtle, and can evolve as a function of multiple forces. It is difficult for a clinician to witness injustice towards one's client; advocacy might be seen as a logical and legitimate extension of the service provider role. It can be difficult to expend one's time and energy on the treatment of a client whom one suspects of willful symptom exaggeration. Bringing this information (opinion) to the attention of the insurer might appear to be the 'right' thing to do.

It is precisely because of the subtle nature of these forces that it can be a useful exercise to reflect on the different roles that rehabilitation professionals play during their involvement with a client. Such reflection might reveal that the rehabilitation professional has a skill set better suited for some roles rather than others. Such reflection might also reveal that some roles might require the breaching of ethical guidelines.

The position that emerges from the issues discussed in this paper is that the rehabilitation professional should restrict his or her role involvement to that of the service provider. This is the role where the rehabilitation professional has received formal training and will best be able to act in a manner that meets the rehabilitation needs of the client.

In the role of advocate, the rehabilitation professional must bear in mind the negative psychological impact of any form of protective behaviour.

Similarly, assistance or help outside the clinical practice arena does not always yield positive outcomes for the client. As the rehabilitation professional begins to step outside of the domain that he or she has received formal training, the likelihood of disservice to the client increases.

The role of adjudicator is one that violates ethical principles, and impacts negatively on public perception of the integrity of the rehabilitation professional. Any clinician who has used to the language of 'poor motivation', 'secondary gain' or 'functional overlay' in reporting on a client that he or she has treated, could be considered to be have moved into the domain of adjudication. Such language reflects a judgment about the 'authenticity' of presenting symptoms and has a high probability of damaging the client whether in terms of access to care or wage indemnity. If such language is used in the context of a treatment mandate, then it represents a clear and unambiguous breach to trust and presumed confidentiality that likely characterized the development of the treatment relationship.

It is unfortunate that rehabilitation professionals are called upon to render judgments about the authenticity of presenting clinical symptoms. As highlighted earlier, such judgments call upon a skill set that the rehabilitation professional simply does not possess. If rehabilitation professionals choose to continue to act as the policing arm of the insurer, it will be paramount that such a role be clearly distinct from the service provider role, and that the client be made aware from the outset that the goal of the assessment is to detect their fraudulent behaviour. Any other approach would constitute deception with intention to harm.

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