Conflicts of Interest

As Christian physicians and dentists, we seek to glorify God in our profession by serving our patients. The practice of medicine and dentistry necessarily poses situations in which clinicians' personal interests, financial and otherwise, may conflict with those of their patients. The existence of these conflicts of interest is not inherently wrong.

We believe that when interests conflict, clinicians should resolve the conflicts by voluntarily subordinating their personal interests to the best interests of their patients. On occasion, a clinician may need to arrange alternative means of providing patient care in order to respond to family or personal needs.

We recognize that some clinicians, Christians and non-Christians alike, may at times fail to make the virtuous choice of placing their patient's' interests before their own. We therefore support professional efforts to prohibit health care practitioners from engaging in activities which place their personal interests above those of their patient's, when such activities can be clearly defined.

Approved by House of Delegates
Passed with more than a two-thirds majority
April 29, 1994. Dallas, Texas.

Explanation

A conflict of interest exists in medicine or dentistry when the clinical judgment of the physician or dentist concerning a primary interest may be unduly influenced by a secondary interest. Legitimate primary interests include the health and best interests of our patients, the education of students, and the integrity of research. We most often think of money as the secondary interest which may cloud our thinking, but other secondary interests include fame, fun, free time, even family priorities.

Financial conflicts of interest are inherent in clinical practice; they cannot be eliminated. In fee for service practice, the incentive is to increase utilization. In prepaid practice, the incentive is most often to decrease utilization. There are potential conflicts of interest with hospitals, laboratories, industry, publishers. Numerous empiric studies have confirmed that financial incentives (both positive and negative) do influence clinical decisions.

Financial conflicts of interest must first be recognized, and they must be managed. Ideally, they should be managed by the individual practitioner using personal integrity. He or she should commit to making clinical decisions based on what is best for the patient, not influenced by his or her own income. We must recall Jesus teaching to His disciples that No one can serve two masters...You cannot serve both God and Money. (Matt. 6:24 NIV) In addition to personal integrity, checks can be built into the system by professional guidelines or governmental regulations. Some financial conflicts of interest can be handled adequately by full disclosure (e.g. minor lab testing in the office), others should probably be prohibited (e.g. fee splitting; ownership of imaging centers to which the clinician refers patients).

There are inherent conflicts of interest in some types of medical and dental practice, e.g. industrial medicine, prison medicine, military medicine, sports medicine, legal medicine, and others. It is necessary for practitioners in these and all fields of practice to clearly focus on who they are working for (i.e. the patient), and what is their primary goal (i.e. the patient s best interests).

Conflicts of interest in medical and dental research are another matter. The individual doing research must wear two hats: that of the clinician who is committed to doing what is best for the patient, and that of

the investigator who is seeking an answer to a scientific question by using a human subject. The clinician/patient relationship and the investigator/subject relationship have different goals which must be clearly identified. Institutional Review Boards have been mandated by the federal government to oversee all research involving human subjects in order to assure informed consent and protection from undue risk.

It is possible to carry to extremes the concept of focusing on patient needs such that the clinician ignores personal needs and family obligations. This statement is not meant to encourage workaholism. The clinician must control his or her practice and arrange for protected time for rest, exercise, worship, and family activities.

Abstracts

Greene RF. Kingdom quality stuff. CMDS Journal Summer 1990; XXI (2):12-14 with a response by Mellerstig KE.

Starting with a portion of Bunyan's Pilgrim's Progress, the surgeon/author examines his own priorities and challenges us not to look one way and row another by which he means the natural tendency of Christians to be concerned about advancing God s Kingdom while at the same time spending our time, money, and effort at securing our own lives and estates.

In response, another surgeon contrasts praise for the gift of a second-hand sofa to guilt over the cost of a Christian conference at a Kingdom Quality resort.

Schiedermayer DL. The free lunch syndrome: Physicians and the pharmaceutical industry. CMDS Journal Summer 1993; XXIV(2):30-33

The physician/ethicist author defines this syndrome as mild to moderate greed, mild and early compromise of ethical standards, all found in the clinical setting of pharmaceutical promotional activities and he observes that it seems to afflict many otherwise ethical physicians. After relating the gift-giving practices of pharmaceutical representatives, he examines pertinent biblical and ethical principles. A side-bar offers specific guidelines and examples of those promotional activities which are clearly acceptable, probably acceptable, probably not acceptable, and clearly unacceptable.

Rodwin MA. Medicine, Money and Morals. New York: Oxford University Press, 1993; 411 pp

This book, by an attorney who specializes in health policy, offers an in-depth look at the problems of financial conflicts of interest in the practice of medicine and the profession s response over the last 100 years. He explains why the profession has failed to cope successfully with them, and shows how the problems have become worse over time. He shows what can be learned from the way society has coped with conflicts of interest involving other professions (lawyers, government officials, and financial professionals), all of whom are held to higher standards of accountability than medical professionals. He looks carefully at the current problems of financial incentives and offers some suggested remedies.

Bloche MG. Clinical loyalties and the social purposes of medicine. JAMA 1999;281(3):268-74

Physicians increasingly face conflicts between the ethic of undivided loyalty to patients and pressure to use clinical methods and judgment for social purposes and on behalf of third parties. The principle legal and ethical paradigms by which these conflicts are managed are inadequate, because they either deny or unsuccessfully finesse the reality of contradiction between fidelity to patients and society's other expectations of medicine. This reality needs to be more squarely acknowledged. The challenge for ethics and law is not to resolve this tension -- an impossible task -- but to mediate it in myriad clinical circumstances in a way that preserves the primacy of keeping faith with patients while conceding the legitimacy of society's other expectations of medicine.

Bibliography

Relman AS. The new medical-industrial complex. N Eng J Med 1980; 303(17):963-970

This now-classic article by the then-editor of the NEJM was the first to identify the danger of the overuse of technology encouraged by the rise of the for-profit medical industry.

Relman AS. Dealing with conflict of interest. N Engl J Med 1985; 313(12):749-751

In this editorial, Relman warns of the dangers of joint ventures and other forms of entrepreneurialism. He criticizes the AMA s limited response as inadequate because it does not address the matter of damage to public trust by even the appearance of conflicts of interest.

Rodwin MA. Physicians' conflicts of interest: the limitations of disclosure. N Engl J Med 1989;321(20):1405-1407

This opinion piece examines disclosure policies in medical informed consent, consumer protection laws, disclosure by lawyers to clients, and disclosure by government officials, and compares the new emphasis on disclosure as the prominent way to deal with financial conflicts of interest in the practice of medicine. The attorney/author concludes that disclosure is helpful, but insufficient to adequately protect patients.

Three articles on the issue of conflicts of interest resulting from physician self-referral, i.e. physician ownership of ancillary facilities to which he or she might refer patients for income producing procedures: JAMA 1989; 262(3):390-397

- Morreim EH. Conflicts of interest: profits and problems in physician referrals. 390-394
- Todd JS, Horan JK. Physician referral - the AMA view. 395-396
- Rep FH Stark. Physicians' conflicts in patient referrals. 397

Three articles which look at specific conflicts of interest:

- Relman AS. Doctors and the dispensing of drugs. N Engl J Med 1987; 317(5):311-312
- Relman AS. Economic incentives in clinical investigations. N Engl J Med 1989; 320(14):933-934
- Rennie D, Flanagin A, Glass RM. Conflicts of interest in the publication of science. JAMA 1991; 266(2):266-267

Five articles which document with empiric data that physicians clinical judgment may be influenced by financial incentives:

- Hemenway D, Killen A, Cashman SB, et al. Physicians' responses to financial incentives. N Engl J Med 1990; 322(15):1059-1063
- Hillman BJ, Joseph CA, Mabry MR, et al. Frequency and costs of diagnostic imaging in office practice - a comparison of self-referring and radiologist-referring physicians. N Engl J Med 1990; 323(23):1604-1608
- Krasnik A, Groenewegan PP, Pedersen PA, et al. Changing remuneration systems: effects on activity in general practice. BMJ 1990;300:1698-1701
- Hillman AL, Pauly MV, Kerstein JJ. How do financial incentives affect physicians clinical decisions and the financial performance of health maintenance organizations? N Eng J Med 1989;321(2):86-92
- Langa KM, Sussman EJ. The effect of cost-containment policies on rates of coronary revascularization in California. N Eng J Med 1993;329(24):1784-1789

Thompson DF. Understanding financial conflicts of interest. N Eng J Med 1993; 329:573-576

The author maintains that conflicts of interest in medicine are more complex than is often appreciated. He then offers the clearest description of conflicts of interest available in recent medical literature. He goes on to posit that a better understanding of the nature of conflicts of interest and a clearer formulation of standards could increase confidence in the medical profession.

Council on Ehtical and Judicial Affairs, AMA. Sale of non-health-related goods from physicians' offices. JAMA 1998;280(6):563

This is new addition to the AMA's position statements on potential conflicts of interest and concludes "With one very narrowly delineated exception, the sale of non-health-related goods from physicians' offices is an activity that should be avoided."

Lyckholm LJ. Should physician accept gifts from patients? JAMA 1998;280(22):1944-6

The author encourages physicians to be sensitive to the patient's motivation in offering a gift. In addition he or she must not let the acceptance of a gift interfere with patient care. She offers some guidelines on this issue.