CHEST Medical Ethics

Conflict of Interest in Clinical Practice*

Mark R. Tonelli, MD, MA, FCCP

Conflicts of interest, ubiquitous in medicine, occur when the interests of clinicians do not align with the interests of their patients. When systemic and institutionalized, such conflicts become particularly problematic, not only creating risks for individual patients but also undermining the integrity of the medical profession. Financial conflicts of interest arise when the reimbursement of clinicians appears to encourage decisions and actions that are unlikely to be in the best interest of individual patients. More insidiously, the influence of the pharmaceutical and medical device industry on clinicians, whether through gift giving, support of continuing medical education, or guideline development, creates conflicts of interest that may go unrecognized. Recognition and acknowledgment are the first steps in ameliorating conflicts of interest, which can then be disclosed and potentially eliminated. ***(CHEST 2007; 132:664–670)***

Key words: conflict of interest; disclosure; ethics

Abbreviations: ACCME = Accreditation Council for Continuing Medical Education; CME = continuing medical education

Editor's Note: *The review by Tonelli addresses the fourth topic in the core curriculum of the ongoing Medical Ethics series—Constantine A. Manthous, MD, FCCP, Section Editor, Medical Ethics*

That a physician should attempt to arrive at "a right and good healing action for a particular patient" is a primary expectation of patients, clinicians, and society-at-large.[1] In health care, conflicts of interest occur anytime circumstances exist that might be expected, through either coercion or inducement, to predispose a physician from reasoning, recommending, or acting in a manner that would be construed to be in a patient's best interest. Neither wrong action on the part of the clinician nor actual harm to patients needs to occur for a conflict of interest to exist: an appearance of conflict is sufficient. Although the term *conflict of interest* is usually reserved for circumstances in which personal interests appear to be in opposition to professional duties, conflicts can arise between duties that are both, in themselves, noble and good. For instance, a clinician's duty to a patient may come into conflict with duty to family. Professional obligations may also come into conflict. For example, the recognition that clinicians have an obligation to society to be good stewards of limited medical resources may come into direct conflict with the interest of an individual patient desiring an expensive but marginally beneficial intervention. While one may still argue that the primary obligation must be to the patient-at-hand,[2] the duty of thoughtful stewardship must be acknowledged as a right and good one.

For editorial comment see page 370

Defined broadly, conflicts of interest are ubiquitous and unavoidable in clinical practice.[3] As individuals, physicians can be expected to have a variety of desires and commitments, whether hunger and the need of lunch, plans to attend a child's soccer game, or other waiting patients, that conspire to thwart the exercise of their duty to the patient-at-hand. In general, society trusts individual physicians to negotiate these daily conflicts, subjugating other interests as the clinical situation demands. These pedestrian conflicts tend to be

*From the University of Washington, Seattle, WA.
The author has no conflicts of interest to disclose.
Manuscript received February 2, 2007; revision accepted May 30, 2007.

Correspondence to: Mark R. Tonelli, MD, MA, FCCP, Box 356522, 1959 NE Pacific St, Seattle, WA 98195-6522; e-mail: tonelli@u.washington.edu
DOI: 10.1378/chest.07-0315

less ethically concerning as well, because they can usually be negotiated without unduly compromising patient care. As conflicting interests become more permanent and more systemic, the ethical stakes become higher. Systemic conflicts of interest, those that are institutionalized, are longstanding, and affect multiple clinicians, raise legitimate ethical concerns for patients and the public, and challenge the integrity of the profession as a whole.[4]

Systemic conflicts of interest may be designed or unintentional, financial or nonmonetary, and bias the clinician toward overtreatment or to limit potentially beneficial interventions. While conflicts may be made explicit in employment contracts and reimbursement programs, many will be insidious, potentially going unrecognized and undetected by clinicians, who are not trained to recognize such conflicts. Such covert conflicts are the most ethically troublesome, for the primary remedies, avoidance and disclosure, are impotent if the conflict goes unrecognized. Here, we will examine common systemic conflicts of interest arising in the practice of clinical medicine, particularly financial conflicts and those that stem from clinician's relationships with the pharmaceutical industry, including subsidized continuing medical education (CME). While by no means exhaustive, this survey of common conflicts of interest in clinical practice is intended to elucidate their ethical dimensions and highlight potential remedies.

Financial Conflicts of Interest

The inherent tension built into remuneration for the healing arts has been recognized as far back as Plato, who devoted a small part of *The Republic* to the issue.[3] In a classic fee-for-service arrangement, physicians benefit financially from the provision of more interventions, with patients and the market poorly positioned to make judgments regarding the necessity of these services.[5] Historically, a physician's service largely equated with the physician's presence, but systemic conflicts of interest could still arise, such as agreements for fee splitting from referrals or commissions from pharmacies. As the number and kinds of medical services have exploded over the last half-century, so has the potential for clinicians to profit from the profligate use of these services. The practice of medicine now provides the entrepreneurial physician with ample opportunities to develop ancillary business interests, such as owning radiology and other diagnostic or therapeutic centers or equipment, even entire hospitals.[6] Clearly, the attendant financial gain in "self-referring" a patient for testing or intervention under such circumstances creates a conflict of interest as, logically, only a subset of patients will be likely to benefit from the additional procedures, whereas all patients (at least all those with the ability to pay) sent for testing or intervention would financially benefit the physician-owner. Empiric evidence amply demonstrates that such circumstances lead not simply to a perceived conflict of interest, but to a marked increase in utilization of services when compared to financially disinterested clinicians.[7–9]

The combination of rising health-care costs and the appearance of impropriety on the part of entrepreneurial clinicians has led to multiple attempts to remedy such conflicts of interest, from guidelines developed by professional organizations[10] to federal statutory interventions, primarily the "Stark" laws.[11] Regulatory intervention, which initially was a blunt instrument, has continued to evolve over the last decade, recognizing that not all instances of physician ownership raise the same ethical concerns and that the absolute prohibition of physician ownership may actually disadvantage patients under some circumstances.[12] Currently, the Stark laws explicitly prohibit some forms of physician ownership while allowing exemptions for others. While the law remains subject to interpretation, and some physician-entrepreneurs will continue to take advantage of loopholes and uncertainties, clinicians should recognize that specific structures and systems providing financial benefit to them remain ethically problematic if such structures appear to promote decisions that are not clearly in the best interest of individual patients. Certainly, arrangements that both increase physician remuneration and improve the care of patients are theoretically possible and, if patient care can be demonstrated to improve, would be ethically preferred.[13] But such arrangements demand a high burden of proof demonstrating that patients, and not simply clinicians, are benefited.

As expenditures on health care have grown and new managed care systems have been developed with an explicit goal of limiting costs, clinician behavior has become the primary target for those desiring to limit services to patients. Structured reimbursement plans have been designed to control physician-directed spending, creating a relatively new kind of conflict of interest for physicians, one that biases them toward withholding potentially beneficial care.[14] However formally structured, these systems share the feature that clinician remuneration is inversely related to expenditures per patient. (More restrictive structures that prohibit physicians from recommending or prescribing specific treatments or interventions go beyond creating a conflict of interest to directly controlling physician behavior