Does Fortune Foul Fidelity?

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Kenneth Kipnis hypothesizes that a company paying a physician for services related to one of its products merits a share of responsibility for harmful outcomes (Kipnis 2011). His arguments fail because they are based on a widely held but false assumption and on misleading analogies. The false assumption is that industry payments to physicians result in harm to patients. Misleading analogies appear throughout his paper.

**PHYSICIAN–INDUSTRY CONFLICTS OF INTEREST**

Codes of ethics for physicians in general (Council on Ethical and Judicial Affairs [CEJA] 2011, xvii) and for gynecologic specialists (ACOG, I.1)2 exhort physicians to hold their patients’ welfare above their own. In doing so, physicians uphold their professional ethical obligation to individual patients. In his current work, Kipnis argues that payments from sources other than services to the patient comprise a conflict of interest (COI) that must be disclosed to the patient because it constitutes a potential harm to patients (Kipnis 2011).

Our current health care system recognizes that physician compensation legitimately may come from many sources: government programs, private insurance, self-payment, entrepreneurship, business consulting, legal consulting, grants, and pharmaceutical or device companies’ payments. In this laundry list, the only item that has been singled out as morally suspect in recent years is compensation provided by industry sources. We question whether this suspicion is justified.

Physicians’ interactions with industry have come under scrutiny by professional societies, accreditation agencies, government agencies, and investigative reporters, who seem convinced that all financial interactions represent a COI. Disclosures of COIs have become de rigueur as an introductory slide for oral presentations, a signed form for journal publications, and a filing with the medical school dean’s office. Such disclosures were previously thought to be sufficient to sanitize the conflict; however, recent work has suggested that they might not only fail to solve the problems associated with COIs, but may actually make matters substantially worse (Cain, Loewenstein, and Moore 2005).3

COI disclosure requirements have been imposed under the premise that financial relations of a physician with a company could compromise the physician’s integrity and result in harm to patients, even though evidence supporting the premise is extremely weak. The available evidence consists of published reports of Congressional hearings, investigative reports of large payments to individual physicians, and online blogs (Nguyen, Ornstein, and Weber 2010). Scientific studies of the issue are drawn from social science and psychology, in which assumptions of the behavior of medical personnel are extrapolated from analysis of nonclinical encounters. Surveys have explored the opinions of trainees, patients, and practicing physicians. These categories of evidence lie at the lowest end of value and quality of evidence. Little or no medium- or high-quality evidence exists to show that patients are harmed by payments from industry to physicians (Sade 2011).

Unfortunately, in the current paper, Kipnis perpetuates the COI mythology linking industry-to-physician payments with patient harm. Kipnis’s central argument—“In that Dr. Baker’s misadventure was a foreseeable consequence of Anodyne’s marketing efforts, the company merits a share of responsibility for the death of Elaine Robbins”—fails because it is based on the assumption that companies’ payments to physicians harm patients by shifting physicians’ loyalty away from patients toward companies, despite the lack of relevant and reliable published evidence that this actually occurs. For this reason, we should take with a grain of salt unfounded assertions that appear throughout the paper, such as, “The company’s contract compromised Dr. Baker’s loyalty to his patient and, much as a bribe would, increased the risk of a consequential departure from the standard of practice.”

One focus of the argument is on Anodyne’s $50,000 payment, taken as evidence of undue influence on Dr. Baker. The payment is assumed to have swayed Dr. Baker’s ethics to risk harm to a patient for money. On the contrary, however, Dr. Baker’s televised breakfast seminar can be understood as an instantiation of Principle V of the AMA’s Principles of Medical Ethics—“A physician shall continue to

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1. The American Medical Association Code of Medical Ethics states: “A physician shall, while caring for a patient, regard responsibility to the patient as paramount.”
2. The first item in the Code of Conduct of the American College of Obstetricians and Gynecologists is this: “The patient–physician relationship is the central focus of all ethical concerns, and the welfare of the patient must form the basis of all medical judgments” (ACOG, I.1).
3. Cain and colleagues have shown perverse effects of disclosure: Advice from biased advisors is not sufficiently discounted by advisees, and disclosure can lead advisors to exaggerate their opinions and advice, thus increasing rather than decreasing bias (Cain et al. 2005).
study, apply and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues and the public” (CEJA 2010, xviii)—and of a similar guideline in the ACOG Code (ACOG n.d., II.2). By participating in the televised surgical procedure, Dr. Baker’s compensation for his educational efforts, above his operative fees, was both legal and ethically sound.

Kipnis also argues that the magnitude of the Anodyne payment was so out of proportion to the routine fee collected by Dr. Baker that the payment was an inducement to violate ethical standards and that, to the patient, “financially, Anodyne is more important to her doctor than she is.” This assumption, actually an accusation, cannot be supported. Dr. Baker’s routine charge for the procedure he did would be approximately $5,000, based on currently charged fees. Anodyne’s $50,000 annual payment should be spread over all the procedures the surgeon did annually (Kipnis’s assumption of one telesurgery per year seems unreasonably low). At, say, one telesurgery a month, Anodyne’s payment, now less than $4200 per operation, is not only reasonable for the physician’s time and expertise, it is also lower—not outrageously higher, as Kipnis suggests—than his fee for the operation.

While Dr. Baker might have chosen a different surgical procedure had he known the patient’s genetic risk factors, in the absence of such knowledge, the procedure he chose was not inappropriate. The important issue here is not whether a COI exists, for it clearly does; rather, it is how the COI is resolved, and Kipnis has provided no good reason for us to believe that Dr. Baker resolved it in favor of the company instead of his patient.

MISLEADING ANALOGIES

Kipnis supports his argument with misleading analogies. He equates Dr. Baker’s performance of educational telesurgery to a reality TV show. He implies that televised surgery must be commercially motivated, and cites AMA Opinion 5.045, “Filming Patients in Health Care Settings” (CEJA 2010, 157), to highlight the disclosure requirement for physicians when they are compensated for the filming. Because the operation was to a professional audience, the appropriate reference would be to AMA Opinion 5.046, “Filming Patients for the Education of Health Professionals” (CEJA 2010, 159), which contains no stipulation on disclosure of the physician’s compensation.

Kipnis condemns Dr. Baker’s behavior by likening him to murderous resurrectionists and Anodyne to Dr. Knox. The anatomist studied cadavers, and solicited a supply of them, for which he compensated local providers. His offer was an appeal to unscrupulous base elements of society, who robbed graves and circumvented naturally occurring death by murdering innocent victims in order to profit from a steady stream of cadavers to Dr. Knox. The analogy fails, however, because Dr. Baker has an ethical obligation to the patient, whereas the criminal resurrectionists had no professional obligations to their victims. Dr. Knox’s offer of money was an inducement to murder because murder was the most certain way his providers could supply his needs, while Anodyne’s offer to Dr. Baker does not require any violation of other obligations. Regrettably, this analogy also demonizes physicians by implying that they honor the fidelity they owe patients at the same level as grave robbers and murderers honor the obedience they owe the law.

Other analogies are so flawed as to be misleading. For example, the comparison of Anodyne to Henry II and Dr. Baker to the Plantagenet king’s knights who brutally murdered Thomas à Becket suffers from the same flaw as the Knox–resurrectionist analogy. Consider also that a professor who is paid $500 for every D grade on a transcript differs substantially from Dr. Baker because Anodyne’s reasonable (as we have argued) payment is for the time and expertise he provided legally and (probably) ethically, whereas the professor unequivocally has acted unethically.

CONCLUSION

Kipnis wrongly concludes that Anodyne was partially culpable for the death of Mrs. Robbins by contributing to the corruption of Dr. Baker. His arguments in support of his position depend upon assumptions that have no basis in fact, as well as denigration of physicians’ fidelity to patients and poorly grounded criticism of nonclinical compensation for physicians’ knowledge and skills. Not only does he unjustifiably assume that physicians’ interactions with industry compromise patient care, he fails to balance putative harms with consideration of the benefits—innovations and vast improvements in patient care—that have come from decades of collaboration between physicians and industry. While Kipnis’s arguments may be of benefit to plaintiffs who have been harmed during medical procedures, they do not prove his hypothesis and should be rejected.

REFERENCES


