

Virtual Mentor

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Clinical Case

Is the Surgery Necessary Now? The Surgeon's Conflict of Interest

Commentaries by Howard Brody, MD, PhD, and David Zientek, MD

Dr. Hendry, a neurosurgeon in his first year of private practice, entered the exam room to see Ms. Davis. She explained that she had been experiencing back pain and paresthesia in her right leg. Her symptoms had begun one month before, after she had bent down to pick up her grandson. While examining her, Dr. Hendry noticed that Ms. Davis's right leg was slightly weaker than her left and that she had a right foot drop. After reviewing the MRI, Dr. Hendry saw that Ms. Davis had a ruptured L5-S1 disk and mild degenerative changes. He explained the MRI results to her, and said that she could either have surgery now or wait longer to see if her symptoms would resolve on their own. "I thought I might need surgery," she said. "Is that what you recommend?" she asked.

As the newest member of a three-surgeon practice, Dr. Hendry had the fewest patients and had performed the fewest surgeries. At the group's monthly meeting the week before, one of the partners assured him that it was normal for young surgeons to take a few months to build their practices. But Dr. Hendry also noticed subtle suggestions that his was moving slower than most. There was a joking reminder that, as surgeons, they were paid for doing surgery and that office visits alone would not "pay the rent." Ms. Davis was the first patient on his schedule for the following week.

Dr. Hendry felt confident that he could remove the extruded disk material and that Ms. Davis, who was 58 years old and in good health, would have a favorable outcome. She seemed to have come to his office expecting that she would need—and he would recommend—surgery, and she had medical insurance that would pay a substantial part of the bill.

Dr. Hendry also knew that, as he explained to Ms. Davis, some patients recover without surgery. The disk fragment can be resorbed by the body, relieving the pressure on the nerve. He also knew that it was impossible to predict if or when the symptoms might resolve, and, as he told Ms. Davis, the longer they were allowed to persist, the greater the chance of doing lasting damage to the nerve. As Dr. Hendry considered the case, he remembered his partner's joking that office visits would not cover the group's expenses. Dr. Hendry knew that—from a clinical point of view—it was one of those 50/50 calls in which the patient, having been given the necessary information, should make the decision, based on her own pain and reduced function.

He was still conflicted about how to answer Ms. Davis's question of, "Do you think we should schedule the surgery?"

Commentary 1

by Howard Brody, MD, PhD

In 1983, philosopher-ethicist Albert Jonsen contributed a brief article to the *New England Journal of Medicine* entitled "Watching the Doctor." Hidden beneath this rather uninformative title was an analysis that cut to the heart of medical ethics in a way that few others have, before or since. Jonsen said very simply that the central moral tension in medicine was that between the physician's altruism and self-interest [1].

Most of the literature in medical ethics, especially in recent times when we claim that we have rediscovered "professionalism," is a one-sided appeal to altruism, suggesting implicitly that self-interest is unworthy of the ethical practitioner. Jonsen was more modest and realistic. He suggested that the tension between altruism and self-interest would never disappear; it was a fact of life. It's the elephant in the room, and all the rest of medical ethics must proceed with full acknowledgement of its presence.

In our case, Dr. Hendry experiences the altruism-self-interest tension in an old form—the conflict of interest inherent in fee-for-service medicine. George Bernard Shaw famously observed nearly a century ago, "That any sane society, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity" [2]. (Since Shaw lived well before the days of managed care, we don't know what he would have thought of the "political humanity" of a system that gives doctors greater pecuniary interest in doing less for the patient rather than in doing more. Given Shaw's bias that nature and healthy living usually did more for illness than did drugs and medical technology, he probably would have approved.)

Physician Interest versus Physician Duties

"Conflicts of interest" in medicine are often misnamed. Most of these situations are actually conflicts between an interest and a duty [3]. Dr. Hendry's *duty* to Ms. Davis is to explain carefully to her the pros and cons of the surgical and watchful-waiting options and not to rush to schedule an operation until he is reasonably sure that she has appreciated the existence of a nonsurgical option. Dr. Hendry also has an *interest* in increasing his income and in getting his partners off his back.

Dr. Hendry is tempted to elevate the interest to the level of duty, arguing that he owes it to his practice to pull his share of the weight. That would be a mistake, an obfuscation of his true professional priorities as a physician. Jonsen helpfully urged us to keep in mind the tension between altruism (or professional duty in this case) and self-interest. He was therefore opposed to talking about medical ethics as if self-

interest did not exist. But he would equally oppose talking about medical ethics as if professional duty and self-interest were of *equal* moral weight in cases such as Ms. Davis's.

Suppose that Dr. Hendry explains adequately the risks of surgery as well as the benefits of waiting, and Ms. Davis promptly says that she prefers the surgery (as this case description suggests that she might). Dr. Hendry is then in the happy position of seeing the tension between professional duty and self-interest dissolve. He is not obligated to try to talk a patient out of surgery once she has been informed and made up her mind, unless he has a well-supported clinical opinion that surgery would be contrary to her interests.

But even if Ms. Davis trots off happily to the operating room, Dr. Hendry's work of moral reflection is not yet done. Sometimes a moral tension is unavoidable due to the brute facts of the case. But other times, a moral tension is unnecessarily exacerbated due to the way that the systems within which we work are set up. If cases like Ms. Davis's—in which Dr. Hendry feels torn between doing what is best for the practice and what is best for the patient—occur frequently, then he must begin to question whether he has chosen the best work environment for himself. Perhaps his partners have different practice values from his and either expect a higher level of income as the norm or are willing to do surgery in cases that he would find questionable. Rather than try to resolve these persistent moral tensions one case at a time, Dr. Hendry might, in the end, be better advised to consider finding new partners or a different practice location, as difficult and as disruptive as that option would be.

Getting the balance between altruism (or professional duty) and self-interest just right is extremely difficult. In years past, American physicians may have steered too close to the altruism end of the spectrum, being available to their patients 24/7, commonly neglecting their families, and not infrequently dying prematurely of heart attacks. Today, American physicians (perhaps influenced by the enshrinement of greed as a desirable trait in American society generally) are arguably tilting too far in the self-interest direction.

To take just one example, it is very hard to find a U.S. physician who does not accept any gifts from the pharmaceutical industry, and a substantial number accept levels of payment that would appear to exceed the limits proposed even by weak codes of ethics [4]. What seems most worrisome about these benefits is less that physicians routinely accept them and more that an overwhelming majority of medical students, relatively early in their training, come to believe that they are *entitled* to such gifts [5]. The result is serious conflicts of interest that legitimately lead the public to wonder whether they can still trust physicians to advocate for them.

As a family physician, I will add a final bit of advice to Dr. Hendry. When I engaged in practice for many years, I gradually came to know many of the consultants in town. I knew the surgeons who would cut on anyone who walked in, and I also knew the surgeons who would talk with my patients and recommend against surgery if that

was the best option. Guess to whom I referred the most patients? If Dr. Hendry sticks to his scruples, he might in the short run upset his partners and the practice bottom line, while in the long run becoming a preferred consultant for the best primary physicians in his community. It is pleasant to think that sometimes virtue is more than merely its own reward.

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Commentary 2

by David Zientek, MD

When a physician encounters a new patient, he or she “professes” to have special knowledge and skills that will be used to benefit the patient [1]. Implicit in this claim is the understanding that the physician will act in the patient’s best interest even at the expense of his or her own. But as soon as such a promise is made, the physician is at risk for conflicts of interest. Indeed it has been argued that such conflicts are the defining ethical dilemma in any profession, including medicine [2, 3]. Procedures performed by physicians have the potential to enhance not only their financial well-being but also their stature within the medical community. The conflicts of interest that receive public notoriety often involve physicians owning stock in, or receiving large payments from, companies for whom they do research or about whose products they speak in public. But the dilemma faced by the physician in the case presented here is far more common for those practicing clinical medicine. Dr. Hendry must make a decision which has the potential to enhance his financial productivity and his stature within his group but which may subject his patient to the pain, trauma, and cost of unnecessary surgery.

Even though some medical professionals have conflicts with society’s goals or those of the institutions in which they practice, the most frequent involve their obligations to patients. A conflict of interest occurs when the physician’s action is likely to

compromise the patient's trust by serving his or her own interests before those of the patient [3, 4]. It is notable that this definition implies that a conflict is present not only when a breach of obligations to the patient has occurred but also when there is *potential* for compromising the patient's interests.

How can conflicts such as those faced by Dr. Hendry be managed? First, it is important to realize that the majority of dilemmas in clinical practice are unlikely to ever come to the public's attention. As a result, the medical profession is dependent on its members having a well-formed conscience and being continually aware of the pervasive nature of conflicts of interest in practice. The four techniques most commonly used to regulate conflicts are: prohibition of certain activities that are particularly prone to exploitation of the patient with little likelihood of benefit, use of informed consent with disclosure of the conflict, adherence to professional standards of practice, and soliciting review of the activity by other members of the profession (e.g., second opinions) [2]. We can now apply these guidelines to Dr. Hendry's quandary.

Managing Conflicts of Interest

The first technique for regulating conflicts of interest is to prohibit an activity or divest one's involvement in an entity if the nature of the activity or involvement is extremely likely to compromise one's obligations to the patient. It is difficult to expect Dr. Hendry to give up performing lumbar surgery to avoid any possibility of recommending a surgery which might not be strictly necessary. In fact, patients would suffer from limited access to such surgery, when indicated, if large numbers of physicians removed themselves from these types of interventions over concerns about conflicts of interest. If, however, he believes that his partners are taking advantage of vulnerable patients, it may be wise for him to find another practice to avoid being placed in situations where he is likely to act against his patients' interests.

This form of regulation might also come into play for the physician who has a major interest in a company or device used for a particular type of surgery—if, for example, the physician invents a type of implant that compromises his or her ability to objectively choose between different options for a patient. If this surgeon found it difficult to recommend a competing device, even one that was more appropriate for treatment of a particular patient, he or she might find it necessary to divest interest in the device or give up clinical practice to work for industry.

A robust use of informed consent is more applicable in the case presented. In instances such as this, where both conservative and surgical approaches are reasonable, providing the patient with a careful discussion of the various options with the risks and benefits of each is crucial to avoiding recommendations that are based on the physician's interests. If there is truly no clearly preferred approach in the medical literature, the physician must be careful to avoid subtly introducing a bias in this conversation that is not grounded in purely clinical facts. Given appropriate information, many patients will be able to decide on a course of action

based on their particular philosophy and tolerance for risk. Still, many other patients will want or need a recommendation from the physician. It appears that Dr. Hendry has appropriately informed Ms. Davis of the options available, so how should he advise her? It is here that professional guidelines may be helpful.

Many specialty societies publish clinical guidelines for the diagnosis and treatment of various conditions based either on review of the literature or on professional consensus of opinion, when the literature does not provide clear guidance. When there is a clear consensus among published studies, following these guidelines can help the physician ensure that he or she is not acting primarily from self-interest in recommending a particular therapeutic option. As in the case presented, however, there may be no definitive guidance, and the recommendations will have to allow for clinical judgment in the choice of treatment. If guidelines suggest that an initial trial of conservative therapy is an acceptable option without major risk of progressive neurological dysfunction, Dr. Hendry might be wise to recommend such a trial for four to six weeks, especially if he is concerned about his motivation for recommending surgery. If no professional guidelines have been issued, he should make an effort to follow the best available data from the literature.

The final option to minimize the danger of conflicting interests in the case presented is to obtain consultation from other medical professionals. Dr. Hendry could consider discussing the case with colleagues in his practice. Indeed, one of the advantages of a group practice is the availability of partners with varied experience and interests to provide a sounding board about the appropriateness of a recommendation. Some have even argued in a situation analogous to this case—that of angioplasty or stenting versus medical therapy for stable angina—that the cardiologist who places a stent or performs angioplasty on a patient should not be the same one who performs a diagnostic arteriogram and makes the decision to pursue medical therapy versus an intervention [5].

Given the subtle pressure placed on Dr. Hendry by his partners, he may be uncomfortable with the advice he would receive in this case. Because he has recently completed training, a call to a respected mentor from his training program or a senior member of his local medical community may make him more comfortable with his recommendation to his patient.

In summary, the best defense against compromising obligations to patients is constant awareness of the pervasiveness of conflicts of interest in medical practice. When a conflict is identified, consideration should be given to prohibiting the activity if the likelihood of compromising the patient's interests is sufficiently high. If not, the clinician should depend on meticulous informed consent, use of professional guidelines if available, and consultation with partners or trusted senior physicians.

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