Reframing the conflicts of interest debacle: academic medicine, the healing alliance and the physician's moral imperative

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The recent committee report from the Institute of Medicine in Washington, DC, containing proposals for controlling conflicts of interest[1] reflects the medical profession's limited understanding of the actual scope of the issues and demonstrates how reactive academic physicians have become to media and congressional priorities instead of those of the medical field. The near-exclusive focus on the compromising of medical decision-making by the receipt of fungible support from the commercial sector fails to identify critical interdependencies of the relationship between academic physicians and capitalist industry, the historical and economic context in which it takes place and the other stakeholders in the process who are trying to, or should be trying to, manage similar issues of ethical prioritisation of manpower and resources, allegiances and alliances.

In the process of protecting ourselves, our patients and our institutions from the scourge of the market and its undue influence, we are participating in a much larger discussion, which we are so far neglecting. In redefining academia–industry relations, we are also negotiating over the means of support for translational clinical research, our educational mission as experts and our capacity to serve at centres of excellence in healthcare. Even more fundamentally, the process of examining ourselves and our institutions for conflicts of interest that negatively impact on our ability to protect and to treat our patients, as well as on how we educate the next generations of healthcare workers, goes to the moral core of what it means to be healing arts professionals.

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The Institute of Medicine report has chosen to overlook the existing complex web of interrelations of physician faculty members and their academic medical centres with not just drug and device manufacturers and research sponsors, but also with the grantors of government and nonprofit healthcare research funding. These latter sources of salary support are, in a miraculous feat of purification, transformed from dollars spent by someone with the usual mix of selfish and altruistic motives into the manna of "internal" institutional support. In the process, this "filthy lucre" *in potentia* is magically protected from conversations about conflict of interest, not to mention review of how those dollars impact on how resources are allocated to meet the needs of patients and research participants, as well as in support of salaries and institutional overheads.

Overlooked by expert panels, and by the institutions who wait quaking for the next Damocles' sword of righteous indignation to fall, is the reckoning with the fact that every dollar paid, every priority exercised, every assignment of time and effort, carries a value to the giver and to the receiver and thus has the capacity to suborn and bias. Academic physicians and their institutions depend on a broad variety of financial resources to create salary and infrastructure. That income is cobbled together, faculty member by faculty member, year to year, from sources public and private, explicit in the contract or implicit in the recognition of a faculty member's capacity to attract both intra- and extra-curricular support. Every one of those dollars comes with certain strings attached, certain expectations of return on investment; with critical decisions made by the institution, the department, and that individual faculty member on where and to whom those dollars are ultimately delivered, and which services, programmes and departments will benefit.

By only reacting defensively to the juggernaut of righteous indignation over how this lunch, that pad, that pen, that conference invitation has resulted in the loss of purity in a faculty physician's approach to medical problem-solving, we are allowing the process to blind us to the difficulties in establishing fair and equitable management of *all* the potential conflicts of commitment and conflicts of interest we incur, both as faculty members and as departments and academic medical centres. Critically, this involves all sources of revenue—private, commercial, and public—that support our missions.

But the problem is more pervasive than this, and deeper. The Institute of Medicine report has seemingly devalued the physician into a technocrat, a commodity-purveyor and resource-utiliser. There is more to being a physician than as the delivery end of the government–industrial medical complex. To effectively counter the present crackdown on inappropriate financial relationships, we will need to reframe the questions and convince all stakeholders in the process that public confessions of physicians' personal finances aren't solutions. Our sin is deeper.

The ostensibly altruistic forces we invoke on behalf of our work as physicians have betrayed us. We've made some decisions as a profession over the past century that have returned to haunt us, and they have allowed us to neglect too much of what we promised ourselves and each other, as well as those awaiting us in the exam room or hospital bed. We are called to account in this process of suasion for perfidy because the role of physician as healer has been lost in a welter of other roles that we have taken on in good faith, but without adequate protection of the still, small voice at the centre of our desire to serve. Conflicts of commitment and interest arise in all of our multifarious roles as educators, faculty members, researchers and physicians, and as institutions that accept financial support for our work.

A more balanced and inclusive approach to what constitute vitiating influences on medical decision-making would, on the one hand, cast a wider net than has been advocated but, on the other hand, misses the deeper implication of the controversy: the loss of the moral standing of the practitioner of the healing arts. This has been discussed as an

example of a "death of the guild" by Elliott Krause,[2] but in the Institute of Medicine committee's condemnation of our inability to truly "keep the faith" we might hear, over and above that socio-economic thesis, a call for a reframing of the process of recognising and managing conflicts of interest and commitment in the light of the primary goal of our profession—establishing the healing alliance and treating people.

In some way that doesn't force us into algorithms of care, or enactment of legislation that enforces morality, we need to re-examine ourselves in the best Socratic tradition and present this whole issue anew to our fellow citizens. We need to make it clear how what we do can be explicated in ways that are data-driven and evidence-based, but also experienced as mysteriously imbedded in the soul-to-soul dyadic encounter of the patient and ourselves as we face morbidity and mortality. The physician's progress is not simply about technical competency; it is about managing and reconciling the annihilating collision of the profane of healthcare with the sacred trust of the healing encounter, where the arising phoenix is the patient, hopefully recovered and ready for life's continuing challenges. Poetic and unscientific as this metaphor is, search the heart of the physician–scientist and discover how such archetypal images drive us to achieve and succeed.

As physicians, we need to re-establish that in all of our actions—in the clinic and hospital ward and operating room, the teaching and conference halls, the committee rooms and remote video meetings, the investigator meetings and research review panels—we try to achieve the morally defensible management of our conflicts of interest and commitments. Then we can demonstrate the virtue of our labours and re-establish the uniqueness of the practice of medicine.

If we fail to identify, and exalt, what it is in ourselves that we bring to the process of being half of the healing alliance, the present piecemeal deconstruction of the physician's progress by the Institute of Medicine's well-meaning committees, by our courts of law or acts of Congress, by demagogic publications or inflammatory media or public opinion, will fail to recognise our attempts at attaining and maintaining the moral authority requisite to our task. Physician, heal thyself.

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