CONFLICTS *of* INTEREST *and the* FUTURE *of* MEDICINE

THE UNITED STATES, FRANCE, AND JAPAN

MARC A. RODWIN

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For
Wendy,
Nina,
and
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Contents

Foreword

Concern over conflicts of interest first caught my attention in the early 1990s, when I was editor-in-chief of the *New England Journal of Medicine*. During the White House deliberations on the design of the Clinton health care plan, doctors were more or less excluded from the discussions based on the presumption that they were just another interest group. How could a profession on which health care so critically depends be so undervalued, I wondered?

I soon found the answer when the *Journal* published Douglas Waud's "Pharmaceutical promotions—a free lunch?" and Dennis Thompson's "Understanding financial conflicts of interest," and I read Marc Rodwin's path-breaking book, *Medicine, Money, and Morals: Physicians' Conflicts of Interest*.[1] These analyses explained that professionalism had been steadily eroded by complex financial ties between practicing physicians and academic physicians on the one hand and the pharmaceutical, medical device, and biotechnology industries on the other. These financial ties were deep and wide: they threatened to bias the clinical research on which physicians relied to care for the sick, and they permeated nearly every aspect of medical care. Physicians were accepting gifts, taking free trips, serving on companies' speakers' bureaus, signing their names to articles written for them by industry-paid ghostwriters, and engaging in research that endangered patient care.

What had been a covert issue, occasionally brought to the surface by reporters who stumbled on a story, soon morphed into a national concern. Revelations soon surfaced that some Food and Drug Administration and clinical practice guideline panels were tainted by the participation of physicians with financial ties to companies that marketed the drugs and devices under scrutiny, that leaders of some professional physician organizations had inappropriate financial ties to industry, and that some editors were using their own journals to call attention to products in which they had a financial stake.

Slowly the public became more and more aware. People who had sat in their doctors' offices surrounded by drug company materials and forced to

wait while drug reps brought lunch for the doctor's staff began to complain. Although when polled, patients claimed that they trusted their own doctor, they expressed skepticism about the motives of the profession and began to ask what the profession was doing about these financial conflicts. The answers they received were not reassuring. Most major medical institutions and professional organizations had no policies against financial arrangements with industry, or they set limits on gifts that were exceptionally lenient. When organizations did develop guidelines, they had no enforcement mechanisms.

How much clinical research is tainted by financial conflicts of interest is difficult to assess. More money is now spent on clinical research by industry than by the National Institutes of Health, and many researchers depend on industry support to keep their laboratories operating. Although many of these researchers do not personally receive funds from industry, they nonetheless are under pressure to find outcomes favorable to their study's sponsor, and some are intimidated in describing the class of drugs they study as anything but the top choice in fear of losing research funding. The pressure to get positive results is strong. Researchers are well advised to insist that they retain control of the data, are able to publish their results no matter what the outcome, and have full authority over the manuscripts submitted for publication. Unfortunately, some are willing to compromise if their research program is in jeopardy.

Eventually, position papers by the Association of American Medical Colleges and the Institute of Medicine of the National Academy of Sciences, two influential organizations, set new standards, at least for academic institutions and physicians. One by one, universities and medical schools developed or revised their conflict of interest policies. True, many of the policies were not overly restrictive and "picked off the low-hanging fruit," such as eliminating "free" lunches sponsored by drug companies. Yet they failed to eliminate more egregious practices, such as paid participation in speakers' bureaus and industry-sponsored continuing medical education.

Many of the solutions to financial conflicts of interest rely on disclosing the nature and amount of the conflict. Disclosure, as Rodwin pointed out twenty years ago in a "Sounding Board" piece in the *New England Journal of Medicine*, is a weak solution or a nonsolution.[2] The patient who receives a statement of the physician's conflict of interest is in a quandary. Knowing that an individual has such a conflict does not enable the patient to interpret his or her remarks or written material about a product from a company with which the physician has financial ties. Some physicians believe that disclosing a conflict allows them to say whatever they wish: the disclosure makes them feel absolved of any bias. Needless to say, the ideal solution to financial conflicts of interest is not disclosure but to have no conflict at all. Financial arrangements are, after all, optional. A physician who is recruited by a company can accept or reject the arrangements the company offers.

Critics of physicians' financial ties to industry generally do not seek to eliminate collaborations between academic physicians and industry scientists: such collaborations can result in new drugs, new uses for old drugs, refinements in medical devices, and other breakthroughs. But the discussion about what constitutes appropriate and inappropriate collaborations has become polarized. In general, the greater the social value of a physician's relation with industry, the greater should be our willingness to bear the risk of financial conflicts of interest. Yet identifying these boundaries is difficult and as yet there is no universally accepted guideline.

The lack of a nuanced approach has been problematic. Some highly placed scientists have interpreted criticism of their collaborations with industry as personal attacks. Others have launched a backlash, using irrational arguments to try to avoid rules that might inhibit their relations with industry and personal gains from these arrangements.

Given the lack of an accepted approach by the profession, legislators have launched their own creative attempts to address the issue. A few states have required companies to report their payments to physicians, and the revelations from these requirements have been interesting and useful. By far the most potent legislative action, however, has been taken by the staff of Senator Chuck Grassley (R-IA), which has the power to subpoena records from industry, universities, and individuals. These initiatives have shone the light on physicians' financial conflicts, and in some instances have uncovered vast sums of money that academic physicians have received from industry but failed to report even to their own universities. In addition, a "Sunshine Act" Grassley and Herb Kohl (D-WI) introduced in the U.S. Senate and attached to health reform legislation sets up a searchable Web site of physicians who have received even minimal payments from industry.

Finding effective approaches to deal with financial conflicts of interest in medicine is a continuing challenge. Until now, little has been known about how other countries approach this problem. Marc Rodwin has added immeasurably to this fund of knowledge. As he points out, France and Japan use very different strategies to handle the issue, and their efforts should certainly inform the debate in the United States. Rodwin's book also analyzes how the American medical economy and physician' conflicts of interest evolved and gave rise to policies to cope with conflicts of interest. He turns a critical eye to the current proposals to address conflicts of interest and suggests new directions for reform. His book offers important advice that policy makers must heed if we are to restore trust in our profession.

Jerome P. Kassirer, M.D.
Distinguished Professor, Tufts University School of Medicine
Visiting Professor, Stanford University
Editor-in-Chief Emeritus, *New England Journal of Medicine*

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Part I

FRAMING THE ISSUES

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Introduction: Patient Stories

In the introduction to his 1906 play, *The Doctor's Dilemma*, George Bernard Shaw wrote:

> And what other men dare pretend to be impartial where they have a strong pecuniary interest on one side? Nobody supposes that doctors are less virtuous than judges; but a judge whose salary and reputation depended on whether the verdict was for plaintiff or defendant, prosecutor or prisoner, would be as little trusted as a general in the pay of the enemy.
>
> That any sane nation, 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 for political humanity.[1]

Shaw suggests that patients and the public should worry about physician payment. More generally, they should consider what sort of financial incentives compromise good medical care. Three stories of contemporary patients illustrate his point.

When Tom Jones felt his chest tightening again, he decided to play it safe. He consulted a cardiologist in a private group practice in Boston. Dr. Nilufar Sharif asked Tom some questions about his symptoms, reviewed his medical history, listened to his heart, checked his blood pressure, and had her assistant draw blood for testing and take an electrocardiogram. After reviewing the results, she recommended further tests. First, Tom had a stress test to check his cardiac output. While he walked on an exercise treadmill set on an uphill slope, a physician monitored his heart with an electrocardiogram. Then Tom had an angiogram. Dr. Sharif inserted a catheter into an artery near his groin, extended it to his heart, and checked Tom's arteries. Informing Tom that plaque had reduced the blood flow to his heart, she recommended that he have coronary artery bypass graft surgery performed by the surgeon in her group practice and scheduled the surgery for the next week. The surgeon removed a piece of blood vessel from Tom's leg and grafted it into the heart muscle so that blood would flow through it and around the blocked artery. He also implanted a pacemaker to regulate Tom's cardiac rhythms.

In the weeks after his surgery, Tom kept meeting people who also had been treated for arteriosclerosis. To his surprise, their treatment was different. Esperance Garcia's physician, Dr. Sean Carroll, performed a stress test and electrocardiogram but did not recommend an angiogram. Dr. Carroll prescribed calcium channel blockers to increase blood flow to her heart and control her blood pressure, beta blockers to slow her heart rate and lower her blood pressure, and ACE (angiotensin converting enzyme) inhibitors to increase blood flow. Dr. Carroll also prescribed statins to help lower her cholesterol and slow the progression of her coronary artery disease. In addition, Dr. Carroll told Esperance to change her diet, exercise, and lose weight. Esperance also received training in managing her medications and in biofeedback to reduce her stress.

After an initial exam, Kang Li's physician, Dr. Rachel Feldman, told him that she found no signs of a heart attack and that several ailments could cause his symptoms. Most likely, she thought, the culprit might be his long-standing hiatal hernia. But it might be angina, caused by coronary artery disease restricting blood flow to his heart. Dr. Feldman referred Kang to a colleague for the same stress test that Tom received and then for an angiogram. After reviewing the results, Dr. Feldman informed Kang that plaque was reducing blood flow to his heart and recommended angioplasty. Dr. Feldman explained that she would insert a catheter into his artery and a balloon at the end would inflate to push away the plaque and widen the artery. Dr. Feldman performed the procedure two weeks later at a separate cardiac facility. Afterwards, she told Kang that one artery was narrow even after she removed the plaque, so she had inserted a wire stent to hold the artery walls apart and reduce future plaque buildup.

Tom, Esperance, and Kang initially thought that differences in the extent of plaque in their coronary arteries accounted for their differing treatment. As they compared notes, however, they found that factors other than their clinical condition might have caused their different treatment. Tom speculated that having different insurers affected their treatment. His interest was also piqued when he read the front-page *New York Times* article on financial ties between cardiologists and drug companies and stent and pacemaker manufacturers.[2] The article suggested that these ties affected physician prescribing and clinical choices and could cause inappropriate medical care and higher costs. When Tom shared the article with Esperance and Kang, they discussed whether their doctors' practice settings and payment arrangements affected their treatment.

These factors might well have influenced their medical care. Tom's physician was in private group practice and earned income from the tests and from the surgery. Esperance's physician, on the other hand, worked in a group practice that had a contract with the insurer, and their compensation

varied with the cost of their treating all their patients. If the cost of hospital care and tests exceed a target, physician income declined. Esperance's physician needed to get her insurer's approval for any invasive medical procedures. Moreover, if Esperance's insurer became dissatisfied with the group practice's performance, it could remove the group from the network. Kang's physician was employed by a Health Maintenance Organization and received a set salary. Other ties might also affect their physicians' choices. Dr. Carroll had his expenses for attending the American Cardiology Association annual meeting paid by a drug company that made the drug he prescribed for Esperance. Dr. Feldman inserted a stent from a company that paid her to serve on its advisory board and to lecture other physicians about its stents as part of their promotion.

In Paris, François Fort experienced symptoms similar to Tom. François consulted a general practitioner in private practice, Dr. Claude Pascal, who examined him and prescribed blood tests and an electrocardiogram. But French private practitioners are not allowed to be paid for these tests, so Dr. Pascal referred François to an independent testing center. After seeing the results, Dr. Pascal referred François to a cardiologist who worked at a private hospital. The cardiologist performed the angiogram and then discussed with François whether he should be treated by angioplasty or coronary artery bypass graft surgery. François was treated with angioplasty and a stent implant. However, his cardiologist used a stent without drug coating of the kind Tom had received. Dr. Pascal said he thought the drug-coated stents presented greater risk. Dr. Pascal also prescribed medication for François to reduce the risk of future cardiac problems, including Enalapril (Vasotec) manufactured by Merck, Sharpe and Dome.

François was pleased with his care but found that some of his colleagues had received different treatment for similar cardiac problems. He was disturbed when a colleague told him that to promote their new cardiology drugs, Merck, Sharpe and Dome invited nearly all French cardiologists and their spouses to attend a meeting on their new drug in Beijing, China, with all expenses paid.[3] François wondered if Dr. Pascal had accepted the invitation to Beijing and if so, whether it influenced his choice of medication. Later, François was reading *Le Canard Enchaîné*, a newspaper known for its exposés and satirical commentary, when he spied an article exposing hip prosthesis manufacturers paying kickbacks to physicians to choose their product.[4]

In Tokyo, Hideo Tanaka also felt chest pain. He consulted Dr. Tatsuo Watanabe, who owned a small, well-equipped clinic near his home. Dr. Watanabe drew Hideo's blood for tests and arranged for one of his colleagues to perform an electrocardiogram and stress test. Then Dr. Watanabe prescribed eight medications, which he dispensed to Hideo immediately,

and scheduled a follow-up visit to perform an angiogram. Before the follow-up visit, however, Hideo spoke to a neighbor about his cardiac treatment. The neighbor suggested that he would be better off seeking care at the prestigious Tokyo University Hospital. He pointed out that the university hospital employed elite physicians and that, as public servants, they did not need to prescribe medication to ensure their livelihood. So Hideo consulted Dr. Naoko Sakae at the Tokyo University Hospital. Dr. Sakae performed new tests, told Hideo that he needed a pacemaker to control his cardiac arrhythmias, and implanted one. Hideo learned that some fellow workers also had coronary artery disease and were treated with different regimes. A month later, when reading the *Mainichi Daily News*, Hideo learned that the head of the Tokyo University Metropolitan Hospital was prosecuted for taking kickbacks from an American pacemaker manufacturer in return for using their model rather than a competitor's.[5]

The hypothetical patients in these stories all fared well, but their treatment might have resulted in injury or death, and the main effects of their treatment are in the future. Because their treatment varied, these patients have different risks of complications and of future cardiac problems. Variations in these patients' medical condition or their physicians' training might explain their differing treatment. But financial incentives also affect clinical care.

Conflicts of interest are endemic in private practice in countries with very different medical, legal, and political systems. Yet there are also big differences among countries in the extent and kind of conflicts of interest that exist in private practice, the measures used to cope with them, and the alternatives to private practice that are available. Each country's laws, insurance, and medical institutions shape medical practice; and within each country, different forms of practice affect clinical choices. Consider just a few differences relevant to these patients.

Francois Fort's physician referred him to an independent testing facility because France prohibits nearly all physicians from earning income by prescribing ancillary services they supply. Private practitioners cannot be paid to dispense drugs or medical products, perform clinical or diagnostic tests, or supply ancillary services, although they can own or invest in private hospitals that do. Physicians cannot even dispense vaccines; patients obtain a prescription for a vaccine, purchase it from a pharmacy, and then bring it to their physician to perform the inoculation.

Tom's, Esperance's, and Kang's American physicians could legally provide stress tests, electrocardiograms, and blood tests. They could also have dispensed medication because they did not reside in the only five states that prohibit physician drug dispensing. But Esperance's insurer requires physicians to obtain their approval before performing an angiogram, while Tom's

and Kang's insurers do not. Moreover, when ordering more tests, Tom's physician earns more money, while Esperance's physician's income declines and Kang's physician's income is unaffected.

Dr. Watanabe provided all tests for Hideo Tanaka. In Japan, there are no prohibitions on private practitioners dispensing drugs, performing clinical and diagnostic tests, or supplying ancillary services. Physician drug dispensing in Japan began with ancient Chinese medicine, when physicians were compensated not for their services but only for supplying drugs. Until very recently, drug dispensing and laboratory testing were a major source of physician income. However, in public hospitals in Japan, as in France and the United States, physicians are paid a fixed salary and have no incentive to make particular clinical choices.

In Japan, as in the United States and France, medical suppliers sometimes pay physicians kickbacks to induce sales. The temptation is not greater for publicly employed physicians than for those in private practice, but often laws are stricter for public employees. Hideo Tanaka read a story about the prosecution of the Tokyo University Hospital physician for switching pacemakers in return for kickbacks. Publicly employed Japanese physicians can be criminally prosecuted for accepting kickbacks, but their colleagues in private practice cannot. In France private practitioners can be prosecuted for accepting kickbacks; in the United States federal law prohibits kickbacks for private practitioners only for patients insured by Medicare or Medicaid.

In all three countries, drug firms and other medical suppliers use gifts and grants to influence physician choices and boost sales. A drug firm paid for Esperance's physician to attend a professional meeting. Merck, Sharpe and Dome invited French cardiologists to Beijing. A stent manufacturer cultivated Tom's physician by hiring her as a consultant and speaker. Each of these countries regulates gifts to doctors differently, with varying results.

Patients are not usually familiar with the details of medical organization and finance. As a result, they typically believe that practice arrangements do not affect what is most important in medicine—the patient-doctor relationship. As we shall see, nothing could be further from the truth.

1

The Heart of the Matter

The patient-doctor relationship lies at the heart of medicine. Patients rely on physicians to advise them about their medical needs, to supply medical treatment and services, and to act in their interest. Society expects that medical norms will induce physicians to act on behalf of patients. Yet, physicians earn their living through their medical work and so may practice in ways that enhance their income rather than the interests of patients. Moreover, when physicians prescribe drugs, devices, and treatments and choose who supplies these or refer patients to other providers, they affect the fortunes of third parties. As a result, providers, suppliers, and insurers try to influence physicians' clinical decisions for their own benefit. Thus, at the core of doctoring lies tension between self-interest and faithful service to patients and the public. The prevailing powerful medical ethos does influence physicians. Still, there is conflict between professional ethics and financial incentives. Consequently, patients have reason to ask: "Is my physician's judgment biased by her economic interests? Will she serve me loyally?"

In part to address this tension, society often arranges medical care differently from the way it does many other services. The institutions that supply medical services and the manner in which medical practice is organized shape how these conflicts unfold and sometimes contain them. The state grants the medical profession a monopoly over medical practice and allows physicians to set standards for entry into medical practice, to judge their work performance, and to a high degree, to regulate themselves.[1] Physicians and others justify this arrangement on the grounds that physicians have expert knowledge and that medicine is a profession, not merely an occupation. Professional values embody important ideals, they say, and medical practice should be governed by them, rather than by business and bureaucratic values, which are very different. In sum, they claim that *medical professionalism* has a moral core that both justifies physician authority over medical practice and regulates these conflicts.

In the last four decades of the twentieth century, however, new thinking challenged the authority of physicians and the value of professionalism.[2]

Market proponents argued that organized medicine created an oligopoly that advanced physicians' interests over those of patients. Professionals masked their self-interest, they maintained, and markets would better serve the public. Other critics championed patients' rights and individual autonomy. They claimed that physicians used their authority to usurp value-laden choices that patients ought to make. Still others believed that medical organizations should be subject to democratic processes and have to listen to the voices of patients and consumers to be held accountable.[3] A common theme unites these and other critiques: that physicians' conflicts of interest compromise medical practice. This concern spurs efforts to reform the organization and financing of medicine and to increase legal oversight. Failure to cope effectively with conflicts of interest undermines the credibility of physicians and professionalism.

THE MEDICAL PROFESSION AND THE MEDICAL ECONOMY

The future of the medical profession will be shaped largely by how society answers these key questions: In what context can physicians be trusted to act in their patients' interests? How can medical practice be organized to minimize physicians' conflicts of interest? How can society promote what is best in medical professionalism? What roles should physicians and organized medicine play in the medical economy? What roles should insurers, the state, and markets play in medical care?

This book explores these questions by examining the political economy of medicine in the United States, France, and Japan—all postindustrial democratic societies. They illustrate how differences in the roles of organized medicine, markets, and the state affect the existence and resolution of physicians' conflicts of interest.

In each country the state assumes major responsibility for financing medicine, allows private practice and physician ownership of medical facilities, and operates public hospitals. In each, most citizens receive medical insurance through their employer. In the United States and Japan, private insurers cover much of the public. France and Japan have universal coverage and national health insurance (NHI), but the United States does not.

These countries initially supplied medical care through unregulated markets. However, charities, the state, and mutual aid societies created alternatives. Their efforts were driven by religious missions, political revolutions, efforts to Westernize society, wartime necessity, and in peacetime by movements to enhance social solidarity and economic security. The alternatives were at first designed for the poor but later were extended to the general

public. Over time, several arrangements were used to supply medical care. They were sometimes symbiotic, but at other times they clashed, and their boundaries overlapped, blurred, and shifted. Practice now occurs in four main forms:

- under physician ownership and direction
- through lay-directed charities and not-for-profit organizations
- under state sponsorship, usually through public institutions
- through investor-owned firms

How do these alternative ways of supplying medical care affect the tension at the core of doctoring? An unregulated medical market—one that does not even require training or certification—exhibits the greatest tension between provider self-interest and patients' interest. Yet, even with state licensing, private practitioners confront this tension because they are entrepreneurs who accrue profit or loss from their practice. In contrast, medical care supplied as a public service using publicly employed physicians typically precludes physician entrepreneurship. These physicians do not earn profits or risk loss and have employment security, so profit seeking does not affect their advice or clinical choices.

Supplying medical services through lay-directed charities and not-for-profit organizations presents an ambiguous alternative between private practice and public employment. When not-for-profit organizations employ physicians, they can preclude physician entrepreneurship. However, they sometime choose to compensate physicians in ways that reward practicing medicine in an entrepreneurial manner, particularly when they seek to generate income to expand, or when they need to be frugal to stay solvent. Investor-owned firms that employ physicians are likely to compensate them in ways that call forth entrepreneurial behavior that influences clinical choices. These four forms of practice are not mutually exclusive. For-profit firms sometimes form joint ventures with physicians or not-for-profit organizations, and both not-for-profit and for-profit entities can intermingle with private practitioners.

In addition, several factors affect medical practice. Organized medicine can influence practice standards, professional norms, professional discipline, and medical institutions. Physician compensation, ties to third parties, and other aspects of the economy also affect physicians and medical institutions. The state and insurers may regulate all four forms of medical practice. This book examines the interaction of the four basic forms of practice with

- organized medicine's influence over private practice;
- professional self-regulation;

- market competition;
- the role of the state and insurers.

These shape the presence of conflicts of interest and how nations address them. Each country's experience offers evidence about what helps cope with these conflicts and what does not work well.

NATIONAL PROFILES

This book takes the reader on a journey across three continents spanning several centuries, so bear in mind some key points of each nation's experience.

France

France illustrates the effects of professional control and self-regulation on physicians' conflicts of interest. Organized medicine has had long-standing, strong influence over France's medical economy. The medical profession regulates itself and the state grants it an official legal role. Since World War II, organized medicine has exercised authority through the Order of Physicians and physician trade unions. The Order of Physicians oversees the organization of private practice. It drafts a legal code and uses it to supervise the finances of private practice, physician contracts, and professional licensing and discipline. The code also affects the behavior of private firms and insurers. Physician unions negotiate accords on fees and other matters with national health insurance funds (NHI funds) and influence the policies of state and NHI funds through strikes, lobbying, and other political activities.

Organized medicine has restricted physicians from engaging in certain entrepreneurial activities, but it has tolerated many more. In the nineteenth and early twentieth centuries it opposed public hospitals and the public employment of physicians except to serve the poor. In the early twentieth century, France developed not-for-profit medical practice overseen by lay-directed insurers that own medical facilities and employ physicians, but this model did not thrive because of organized medicine's opposition. Since 1930, organized medicine blocked state and NHI efforts to monitor private practitioners, oversee their practice, set practice guidelines, or use alternatives to fee-for-service to pay physicians. Starting in 2004, however, the state began reforms that may give it the tools necessary to manage private practice.

To control compromising ties between physicians and firms that sell drugs, medical devices, and other medical products, in 1993 the state

assigned to the Order of Physicians responsibility to oversee financial ties between commercial firms and physicians. It only prohibited grants unrelated to professional activities and kickbacks. Rather than stop commercial interests from developing financial ties that compromise physicians, the Order of Physicians joined with industry trade associations to ensure continued funding. Pharmaceutical and other medical supply firms still pick up the tab for physician registration fees, travel and related expenses to attend conferences, continuing medical education (CME), and other professional activities. Commercial interests also supply most of the funds to develop CME, conduct clinical research, and publish medical journals, all of which are powerful means to influence practice norms and individual clinical choices.

State direction is a distinctive feature of France's medical economy. The state operates a prestigious public hospital system that employs about 28 percent of physicians and owns 75 percent of hospital beds. The state restricts the scope of entrepreneurship within private practice. It prohibits most private practitioners from being paid to dispense drugs or provide tests or ancillary services, and from having financial ties with facilities that do. State regulation restricts the growth of physician-owned hospitals and medical facilities. Yet, the state neglects many physicians' conflicts of interest. It allows public hospital physicians to spend 20 percent of their time in private practice, to accept funds from commercial interests to cover their professional expenses, and to consult for commercial firms.

The United States

The American medical economy is distinguished by the dominance of markets and the private sector. Its experience reveals that promoting markets for medical services and insurance increases the variety and scope of physicians' conflicts of interest. However, markets also supply some means to help cope with them. In overseeing contemporary markets, public authorities have not imposed broad, clear limits on the scope of physician entrepreneurship as France has. Market freedom has created conditions that led the government to regulate particular practices. Detailed rules have had only minimal effect, however, because the remarkable adaptability of entrepreneurs and markets quickly makes regulations obsolete.

American medicine arose without the restrictions of medieval guilds, monopolies, or strict state licensing. Only in the early twentieth century did organized medicine become a significant political force and secure state licensing laws that allowed it to create a protected medical market.

As a protected medical market replaced an unregulated one in the United States, professional control yielded consequences somewhat

different from those in France. During this phase, organized medicine assumed many responsibilities that were exercised by the state in other developed countries, including oversight of hospitals, medical education, and drug marketing. Professional control allowed the American Medical Association (AMA) to secure for physicians roles as intermediaries between their patients and hospitals, insurers, and drug companies. As gatekeepers, physicians influenced these third parties and were influenced by them.

Meanwhile, the AMA blocked alternatives to private practice with fewer conflicts of interest and resisted oversight by insurers and the state. Then, in the 1950s, the AMA relaxed its ethical restrictions to allow greater physician entrepreneurship. It also deepened its financial ties with the drug industry, which created conflicts of interest for the AMA and its journals and for private practitioners. Professional self-regulation addressed certain conflicts of interest but neglected many others. The inadequacy of self-regulation set the stage, in the 1970s, for the state to chip away at organized medicine's control. It increased its oversight role and promoted market competition. Nevertheless, the state sets comparatively few restrictions on the medical economy's development and operates relatively few public hospitals.

The promotion of markets allowed private insurers to become countervailing powers to organized medicine. Some insurers ended fee-for-service payment and certain entrepreneurial aspects of private practice. Staff-model health maintenance organizations (HMOs) employed physicians. Other HMOs oversaw self-employed physicians and countered entrepreneurial incentives. To manage private practitioners, HMOs changed physician payment, monitored their practice, and oversaw, or even restricted, their clinical options. In this way insurers helped cope with many physicians' conflicts of interest. However, they often rewarded physicians when they reduced services, creating new conflicts of interest.

Not-for-profit organizations, which are more prominent in the United States than in France of Japan, played an ambiguous role. Charities became the dominant owners of hospitals and, along with public hospitals, supplied some medical care to the poor through the mid-twentieth century. Subsidized by the state, not-for-profit hospitals performed a public service, but they also supported the entrepreneurial practice of self-employed physicians. Not-for-profit insurers also performed dual roles. Prepaid group practice and staff-model HMOs created alternatives to entrepreneurial practice. However, Blue Cross and Blue Shield insurance and independent practice association HMOs promoted private practice rather than alternatives to it.

Investor-owned insurers and medical facilities control a much larger market share in the United States than in France or Japan. They promoted

the logic of markets, which affected the behavior of physicians and not-for-profit entities. They sometimes formed joint ventures with physicians and not-for-profit organizations, which also reduced the differences among these sectors.

Japan

Japan's medical economy is characterized by physicians who dispense drugs, supply ancillary services, and own most hospitals and clinics. The law virtually precludes investor-owned hospitals and clinics. Japan enables us to explore whether physicians' conflicts of interest exist in the absence of for-profit firms when physicians own medical facilities. In fact, they thrive—even though Japan traditionally considered medicine a humane art in which physicians did not charge fees for specific services but accepted voluntary contributions to defray their expenses.

Japan has relatively few lay-directed not-for-profit hospitals and insurers compared to France and the United States. This difference is due, in large part, to the fact that Japan had no equivalents to the religious medical charities that in Europe have operated hospitals since the medieval era. Although Japan developed medical co-ops in the late nineteenth and early twentieth centuries, they never dominated the medical economy in the way that France's mutual insurers or the U.S.'s Blue Cross insurers once did. The comparatively weak role of independent not-for-profit hospitals and insurers reduces the alternatives to physician entrepreneurship.

Organized medicine in Japan concentrates on the protection of private practice. After World War II, the Japan Medical Association neglected to develop standards for ethical conduct; relations between physicians and drug firms; clinical practice, competency, and education; quality assurance; hospital accreditation; physician certification; and continuing medical education. It focused on raising fees and blocking government and insurer oversight of physicians.

The state plays a prominent role in Japanese medicine. It introduced Western-style practice, hospitals, and medical schools. Today, state-operated medical schools and public hospitals employ 30 percent of physicians and own about one-third of hospital beds. The state also leads in promoting hospital accreditation and physician certification, and raising standards for practice and CME.

Until recently the state regulated private practice mainly by capping physician fees and drug prices. That controlled spending but did not mitigate physicians' conflicts of interest. In the early twenty-first century, the state began to curb physician entrepreneurship. It modified or replaced fee-for-service payment; it disallowed new physician-owned medical corporations

through which physician groups own hospitals; it promoted a new kind of not-for-profit hospital by reorganizing state-funded university hospitals into independent not-for-profit organizations; and it offered physician-owned medical facilities tax incentives to reorganize into entities that resemble American-style not-for-profit hospitals.

Japan oversees relations between drug firms and private practitioners using laws that promote fair trade practices. Since 1993, Japan has restricted *individual* drug firms from granting funds to physicians or medical societies. Pharmaceutical firms now pool money and collectively grant funds for medical activities through two drug industry foundations. This approach precludes direct links between individual drug firms and individual recipients, which still exist in the United States and France.

Collective industry funding makes it more difficult for individual firms to influence physicians. But it still allows the industry to decide what to fund and to promote activities that highlight drug therapy rather than other important medical practice issues. Japan's reform points toward the ultimate solution to this problem: severing the link between drug firms and physicians entirely and replacing it with alternative funding through a tax on medical suppliers and insurers.

SOURCES OF CONFLICTS OF INTEREST

Before assessing the relative effectiveness of alternative strategies that address physicians' conflicts of interest and proposed reforms, it is helpful to lay some groundwork.

Medical ethics, law, and social norms require that physicians act in their patients' interests. Many writers describe this as a fiduciary obligation.[4] Physicians have conflicts of interest when they have incentives to act in ways that breach their obligations to their patients or when their loyalties are divided between their patients and other parties.[5] Conflicts of interest compromise physicians' loyalty to their patients and their independent judgment. They increase the risk that physicians will not fulfill their obligations, but they are not themselves a breach of duty. The law can regulate conflicts of interest or supply remedies when there is misconduct or harm to patients.

Two main kinds of conflicts of interest exist. Financial conflicts of interest arise from incentives that bias physicians. Incentives that reward physicians for increasing or decreasing services, or providing one kind of service rather than others, encourage treatment that is not based on the patient's circumstances or criteria of good medical practice. Instead, they

encourage physicians to make medical choices for their own financial benefit. Incentives to refer to particular providers or to prescribe particular tests and therapies also bias their choices. The risk of misconduct increases as the incentive grows larger and the link grows closer between the physicians' actions and their reward. But not all financial incentives create conflicts of interest. Incentives that reward excellent medical outcomes, quality, or patient satisfaction are unequivocally in patients' interests. Bonuses for working longer than average hours or night shifts do not bias clinical choices or advice.

Divided loyalty conflicts of interest occur when physicians perform roles that interfere with their acting in their patients' interest or when their loyalty is split between patients and a third party. Physicians often engage in activities that are fine in themselves, yet compromise their ability to act in their patients' interest, for example, by conducting experiments to assess a new drug while simultaneously treating patients. Patients and doctors can easily confuse these two roles despite efforts to ensure the patient's informed consent. For example, patient care and research are at odds when a physician enrolls one of his patients in a drug trial because the aim of research is not to benefit the research subject but to advance science. True, the experimental drug may help the patient who volunteers as a research subject; but whether it is safe or effective is unknown, and the patient might fare much worse than otherwise.

Conflicts of interest arising from financial incentives and those that arise from divided loyalty or dual roles often overlap. Physicians who prescribe and supply services perform two roles: (1) they diagnose medical problems and prescribe treatment; and (2) they supply therapies. Performing the second role can interfere with the first because it creates an incentive for the physician to prescribe therapies she can supply. That perverse incentive disappears when an independent provider supplies these services.

Certain aspects of medical practice affect key sources of conflicts of interest, including these five salient features:

- which services physicians perform
- whether physicians or other parties own medical facilities
- whether physicians are self-employed or employed by others
- how physicians are paid
- what financial ties exist between physicians and third parties

Providing Services

Self-employed physicians are entrepreneurs in the sense that they earn profits by selling services and bear the risk of any financial loss or debt. The

entrepreneurial aspect of private practice calls forth self-interested behavior, which compromises the ability of physicians to give patients disinterested advice regarding what services they need. However, private practice can be more or less entrepreneurial depending on the type of services that physicians supply. First, they can perform basic services: examine patients, diagnose problems, prescribe therapies, advise patients, and refer them to others. Second, physicians can perform medical procedures or treatments. Third, they can supply ancillary services, such as laboratory or diagnostic tests. Finally, physicians can sell medications, medical devices, and other products.

Consider a continuum of practice arrangements from the least to most entrepreneurial. Start with traditional solo practitioners who are paid on a fee-for-service basis. The main way they can boost their income is to raise fees or supply more services. If they have time available, they might persuade their patients to obtain more services than they sought, or than are desirable. In addition, they can market their services, solicit business, and seek referrals, or negotiate reciprocal referral arrangements with other practitioners.

Physicians increase their entrepreneurial opportunities when they offer more than basic services or develop their practice so that it can produce a higher volume of services. They can broaden the kind of services they offer by learning new skills and procedures or developing practice specialties. They can increase their volume of services by employing assistants, allied health professionals, or other physicians.

In addition, physicians can add ancillary services such as laboratory and diagnostic tests, or sell medication and medical products. When they provide more than basic services, physicians can leverage their diagnoses, prescriptions, and advice to generate income. They have an incentive to prescribe tests, therapies, procedures, and medicines that they supply. By forming group practices, physicians facilitate supplying ancillary services because they share the cost of the necessary equipment and personnel. Physicians in groups can refer patients within the group and share practice income.

Owning Medical Facilities

Physician ownership or investment in medical facilities extends the range of entrepreneurial opportunities. It expands the variety of services physicians sell and their opportunity to generate income through their prescriptions and referrals. Groups of physicians, or physicians jointly with not-for-profit organizations or for-profit firms, can own clinical laboratories, centers for diagnostic imaging and other testing, clinics, ambulatory care

surgical centers, hospitals, and nursing homes. Legal rules and the economics of practice, not medical requirements, limit what services physicians can supply in their practice and whether they can invest in medical facilities.

Employment

When not self-employed, physicians can be employed by public authorities, not-for-profit organizations, for-profit firms, or physician-owned practices. Employers can influence physicians' clinical choices through compensation or supervision so physicians might promote their employers' rather than their patients' interests. Whether employers do compromise medical choices depends on their authority and practice arrangements.

Consider physicians employed as public servants in public hospitals. Typically, they receive a fixed salary set by rank, enjoy tenure, and have clinical discretion. As a result, they lack financial incentives that bias their choices and have clinical freedom. Such arrangements preclude employment conflicts of interest. But relax some of these conditions and employers can compromise medical practice. Physicians who lack job security are more likely to take account of their employer's interests. When employers can vary physician compensation they acquire another tool to sway medical decisions.

Furthermore, employers can manage physicians to promote the organization's goals. As a result, employed physicians might practice in ways that promote their employer's over their patients' interests. If employed physicians practice with the aim of increasing their employer's profits, typically, they will increase services or choose expensive services over inexpensive ones. However, if the employer is compensated with a fixed payment or with some form of financial risk sharing, then employed physicians may reduce the volume of services or reduce other practice expenses.

The conventional wisdom holds that physicians have greater conflicts of interest when employed by a for-profit firm than a not-for-profit organization. This conclusion presupposes that physicians will help their for-profit employer generate profit, even when compensated by salary, and that not-for-profit employers lack a profit motive and so will not offer physicians compromising incentives. However, not-for-profit employers face pressures to remain solvent and can offer financial incentives for physicians to reduce costs or generate revenue in ways that are detrimental to patients' welfare. Similarly, many physicians suppose that employment by lay-owned firms creates conflicts of interest while employment by physician-owned firms does not. However, both might offer physician employees compromising financial incentives.

Physician Payment that Biases Clinical Choices

Payment can encourage physicians to supply more, less, or different kinds of services, or to refer to particular providers. Each form of payment has some bias, but some compromise clinical decisions more than others do.

Fee-for-service rewards increasing services regardless of whether they are beneficial. Depending on how fees are set, it may also encourage physicians to choose some services over others and skew their choices. As George Bernard Shaw remarked in the quotation that begins the Introduction, it can perversely encourage physicians to perform procedures that harm their patients rather than heal them.

In contrast, salary is relatively neutral because it does not typically link physician income to particular clinical choices or reward them for increasing, decreasing, or providing particular services. But it has other drawbacks; it does not reward physicians for extra work, productivity, or efficiency. It may engender what its critics pejoratively call a *civil-service mentality*. Moreover, employers can adjust salary yearly to reward performance. In theory, they can increase or decrease salary to reward physicians who generate revenue, reduce costs, or both, encouraging financially driven medical choices. Employers can also set salary to reflect the organization's financial performance, another incentive to practice in ways that promote the employer's interest. Still, annual salary adjustments are less sensitive to individual clinical choices than physician income that is fee-for-service.

Some insurers employ *capitation* payment and *risk sharing* to create incentives for physicians to control spending. Capitation is a fixed payment per patient for a set period. Typically, physicians receive capitation payment in return for their labor, not other medical services that patients may need. Frequently, payers adjust capitation rates for the age and gender of the patient to account for differences in expected medical needs. Often used to pay primary care physicians, capitation provides physicians a fixed monthly income that varies with the number of patients under their care, but not with the volume of patient visits, services supplied, time spent, or referrals. When a primary care physician has a full practice, capitation payment resembles a salary.

Sometimes insurers modify capitation to make physicians responsible for part of the resources used to care for their patients. They increase the capitation rate but make the primary care physician responsible for the cost of certain services, such as laboratory or diagnostic tests, medication, or treatment by specialists. This arrangement encourages physicians to change their clinical choices to reduce expenditures. They can order fewer or different tests, prescribe fewer or different drugs and services, and make fewer or different referrals.

Modified capitation payment and other arrangements that make physicians bear certain medical costs are called *risk sharing*, because physician compensation is at risk based on how they manage their patients' medical care. Payers can also modify fee-for-service and salary so that physicians bear a portion of the financial risk, making part of the physician's fee or salary contingent on the cost of their patients' treatment. For example, the payer can set aside 20 percent of physician fees or salary and pay the amount withheld only if medical spending for their patients does not exceed a threshold. Risk sharing creates conflicts of interest. It rewards physicians for reducing services, regardless of whether it is in their patients' interest. Still, risk sharing is not the exact opposite of fee-for-service. Rather, physicians' income increases or decreases based on the total volume of services that they provide for a group of patients over time.

Typically, insurers have a group practice share financial risk for its physicians' patients. Spreading the risk over the physician group reduces the effects of any individual physician's decisions or a particular patient's medical condition. Yet payers can make individual physicians bear financial risk. Payers who do that often limit physician risk with so-called stop-loss protection, which ends physician responsibility for any individual patient's expenses after they exceed a set amount.

Payers sometimes combine different compensation methods. They may pay physicians by salary or capitation but add fees for specified services. Alternatively, they can pay physicians fee-for-service or salary while placing part of this compensation at risk. In short, they blend different types of payment to create more nuanced incentives. In recent years, some payers have introduced *pay for performance*, which supplements compensation based on several measures of performance. It usually includes incentives that reward quality or patient satisfaction and do not create conflicts of interest.

Financial Ties to Third Parties

Insurers may not only share financial risk with physicians but also monitor physicians' practice and restrict the services that physicians provide by limiting what they reimburse. They may require that patients and physicians receive their authorization before paying for certain services, referrals, and elective hospitalizations. In this way, they can influence physicians' clinical choices and oversee their practice.

Physicians affect other providers' income through their prescriptions and referrals. These providers sometimes offer physicians financial incentives for referrals. For example, hospitals sometimes subsidize the practices of affiliated self-employed physicians. Some guarantee practice income to recruit physicians to relocate near their hospital and be affiliated with it;

others provide free or subsidized office space, or assistance with office management. Hospitals, clinical laboratories, diagnostic testing centers, and other providers sometimes pay physicians kickbacks to refer patients or medical work. They may pay cash, or in-kind benefits, such as medical equipment, or personal goods and services or gifts, such as wine, art work, or trips to vacation resorts. Today, many physicians' activities rely on discretionary funding from pharma and other commercial interests that also creates conflicts of interest. These activities include CME, medical research, and testing drugs and medical devices to ensure they are effective and safe.

Even physicians employed in public or not-for-profit organizations can have ties with third parties. They may receive funding, gifts, or kickbacks from drug and medical device firms and other medical suppliers. They may consult for private firms on a part-time basis. The risk is clearer when the quid pro quo for the payment is explicit and direct, as occurs when firms pay physicians kickbacks. However, more subtle arrangements also place patients at risk. Gifts beget indebtedness and generate reciprocity. Even though most physicians do not believe gifts influence their conduct, studies show they do.

REFORMS

The experiences of the United States, France, and Japan highlight the inadequacy of six common remedies for physicians' conflicts of interest. One proposal attributes the problem to investor-owned firms and would replace them with physician-owned or physician-directed organizations, or with not-for-profit organizations. Yet physicians' conflicts of interest exist even with physician ownership and not-for profit organizations. A second attributes the problem to external influences on physicians and would grant the organized medical profession greater authority to oversee medical practice. Yet, when organized medicine controlled or significantly shaped the medical economy in all three countries, it often tolerated or even spawned serious conflicts of interest. A third approach attributes the problem to professional monopoly and promotes markets instead. Yet, far from eliminating conflicts of interest, market competition increases their variety.

The problems with markets prompt proposals to eliminate any profit motive by employing all physicians as public servants. That would eliminate a great many conflicts of interest, but not necessarily those arising from ties to third parties. It also makes physicians dependent on the state, which can be a source of other conflicts of interest. A fifth idea is to make physicians legally accountable as fiduciaries through court oversight. Yet judicial oversight has enormous practical limitations. A sixth approach sees disclosure of

conflicts of interest as a panacea. But, disclosure neither eliminates conflicts of interest nor provides adequate safeguards or remedies.

No magic bullet can eliminate or cure physicians' conflicts of interest. Yet the collective experience of these countries yields evidence that several strategies help to cope with them. It suggests that regulation of the market is necessary, but a market under professional control is not the answer. Increasing the supply of medical care outside of physician-owned private practice, either through public hospitals or carefully structured and regulated not-for-profit organizations, creates a setting that avoids entrepreneurial conflicts of interest. Similarly, restricting entrepreneurial opportunities in private practice—for example, by not allowing physicians to supply ancillary services or dispense medication, or to invest in facilities that do—reduces the presence of conflicts of interest.

When private practitioners have incentives to increase services, then insurers, the state, or others can oversee medical practice to make it more difficult for physicians to supply unneeded services or the wrong kind of therapy. Furthermore, regulation of physician payment can minimize incentives to increase or decrease services for self-employed physicians and physician employees. Finally, rules can protect physicians who exercise professional judgment from interference by third parties that attempt to override physicians without adequate evidence or grounds to do so.

State control and employment can also create physicians' conflicts of interests, so it is wise to preserve options to receive medical care outside of public medical facilities. Physician employment in carefully structured not-for-profit entities can offer an alternative to entrepreneurial practice. The state and private sector can each supply checks and balances to conflict-of-interest problems caused by the other, yet independently neither is sufficient to cope with them all effectively.

Physicians often have financial ties to drug firms and other commercial interests through grants, gifts, and consulting. The varied approaches of France, the United States, and Japan demonstrate why most current regulation fails and suggest that the solution is to eliminate these financial ties. I offer examples of alternative ways to finance activities now funded by the pharmaceutical and medical device industries.

Changing the organization of practice and financial incentives can reduce the scope of conflicts of interest and mitigate the harm caused by those that remain. But we need to allow physicians a measure of clinical discretion and to rely on their medical judgment. That makes it important to foster medical professionalism.

The conventional wisdom holds that in order for professionalism to thrive, physicians must be insulated from the state and the market, both of which promote antithetical values. But this study reveals that this thesis

oversimplifies the relation of professionalism to the market and the state. Both the state and the market have in different ways promoted key professional values, such as public service over profit, fidelity to patients, and the development of knowledge and expertise. Although both the state and the market sometimes undermine professionalism and professional values, both have also fostered what is most valuable about professionalism. Robust professionalism requires the countervailing power of the state and markets, but limits on both as well.

In the future, public policy must also address the conflicts of interest of investor-owned firms, not-for-profit organizations, third-party payers, and government organizations. If there are controls on physicians' conflicts of interest the medical profession can help oversee the conflicts of interests of these actors and hold them accountable.[6]

As the twenty-first century began, the United States, France, and Japan all sought to control spending and promote efficiency; to improve quality of care, service, and public health; and to rationalize the organization of medicine. Policy makers, however, neglected to consider how alternative measures to promote these objectives affect physicians' conflicts of interest. That was a major oversight, because reforms that set up conflicts of interests or fail to resolve those that exist often undermine those policy goals.

Following President Barak Obama's lead, the U.S. Congress debated several health reform proposals in 2009 and in 2010 passed Patient Protection and Affordable Care Act.[7] The law (1) extends Medicaid coverage to all individuals earning less than 133 percent of the federal poverty level; (2) provides subsidies to help individuals with low income purchase private insurance; (3) lowers the price of insurance purchased individually or through small groups by creating a federally regulated health insurance exchange where firms sell policies; (4) encourages employers to offer health benefits to employees and individuals to purchase insurance by levying modest penalties on employers and individuals if they do not; and (5) prohibits private insurers from denying coverage to individuals based on their individual medical risk or to limit coverage based on an individual's preexisting medical conditions.

Some critics argued that a public program modeled on Medicare would be less expensive than subsidies for private insurance, because it would eliminate the 15–20 percent of premiums that private insurers typically spend on marketing, underwriting, administration, and profit. Moreover, a public program could also lower spending by controlling provider reimbursement. However, many insurers and private firms opposed the creation of a public insurance program, believing that it was detrimental to their interests.

The law enacted will not resolve the conflicts of interests that plague U.S. medical practice and it will have only a minor impact on medical quality and

spending.[8] Nor would the alternative proposals debated cope with physicians' conflicts of interest much better. Even a Medicare-style program would leave intact entrepreneurial private practice and the other key sources of physicians' conflicts of interest. The United States needs more fundamental reform. Self-styled realists may claim that the political obstacles are so large that we should abandon efforts to reduce physicians' conflicts of interest. But this book shows that each of these three countries have made reforms that reduced the severity and effects of conflicts of interest. The future of medicine is at stake; we should not remain prisoners of the past.

THE PLAN OF THE BOOK

The core of this book is the case studies of France, the United States, and Japan. Each one includes two parts. The first part traces the history of the nation's medical political economy through the interaction between organized medicine, the market, and the state. It chronicles the rise of organized medicine, changes in medical markets, the growth of national legal and organizational frameworks, the origins of private and social medical insurance, and changes in the relations between physicians and the pharmaceutical industry. Struggles between organized physicians, the state, and various groups shaped the political economy that gave rise to physicians' conflicts of interest and sometimes helped tame them. The second part of each case study focuses on strategies used to respond to physicians' conflicts of interest.

Following the case studies three chapters reflect on the experience of these countries. One chapter draws lessons from common reform efforts that are inadequate and reveals several measures that have proved effective. A second chapter draws inferences for medical professionalism. A conclusion sets forth the direction in which I propose we move. An appendix traces the origin and spread of law related to conflicts of interest.

Part II

FRANCE

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The Evolution of French Medicine

France has national health insurance (NHI) funded by contributions from employers, employees, and the self-employed and general tax revenue for the unemployed. The state finances insurance for individuals with low income, including their private supplemental insurance for items not included in NHI. The state operates public hospitals that own over three-quarters of hospital beds and employ 28 percent of physicians. Public hospitals supply an alternative to private practice with its conflicts of interest. The private sector includes physician-owned and lay-owned for-profit hospitals, with about 19 percent of beds, and independent not-for-profit hospitals with 5 percent of beds. The state controls the growth and operation of private hospitals through licensing, planning, and regulation.[1]

Private practitioners have conflicts of interests that arise from entrepreneurship, fee-for-service payment, and financial ties to commercial interests, particularly drug and medical device firms. However, the state restricts entrepreneurial opportunities within private practice. Self-employed practitioners cannot generally earn income from dispensing drugs or performing laboratory and diagnostic tests, nor have a financial interest in facilities that supply those services.

Organized medicine has greater authority over the medical economy in France than it does in most countries. The physician-elected Order of Physicians sets rules for the private sector with a Code of Medical Deontology (Medical Deontology) and reviews physician contracts to ensure that they comply. Publicly employed physicians are also bound by Medical Deontology and the state and NHI insurers respect Medical Deontology. Multiple physician trade unions represent self-employed physicians and negotiate accords over fees and terms of practice with NHI insurers. They also influence policy through lobbying, electoral politics, lawsuits, and strikes. Organized medicine has exercised its authority to thwart competition and oversight of private practice. It blocked effective use of practice guidelines and utilization review, thereby hampering state and insurer controls on physicians' conflicts of interest. It restricted the growth of