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SOLUTIONS TO CONFLICTS OF INTEREST AND CONFLICTS OF CONSCIENCE

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Abstract:-

In recent decades, significant changes within medical field have not only facilitated healthcare professionals to conduct their duties but also have created conflicts among healthcare professionals when they make decision to provide medical services to their patients. The major conflicts which physicians commonly confront are the financial conflicts of interest and the conflicts of conscience. The two types of conflicts are unavoidable and impossible to be eliminated, yet it is possible to remedy the conflicts; thereby, both physicians and patients have benefit in the medical settings. The ultimate consequence will be an effective operation within healthcare organizations since the foundation of the success for organizations is a healthy doctor-patient relationship. Several approaches and models have been suggested in attempt to relieve such conflicts within the organizations. However, only some of them are helpful and they are supported by the principle of cooperation. To find the balance amongst all these parties, some models have to be enforced in the health care organization. Principle of cooperation is one of the most effective means to outstand the successful model. The principle of cooperation assists cooperators in making moral decisions when encountering accomplice. The object or the meanings of moral actions play essential role in the principle.

Keywords:- *Conflict of interest, Conflict of conscience, Patient best interest, the principle of cooperation*

1. The current organizational complicity

1.1. Conflicts of interest

The conflicts of interest have caused by the new complex financial ties between the practicing physicians and the facilities which are controlled by their healthcare organizations. Even though, according to medical ethics, law, and social norms, physicians have to act in their patients' best interests, their obligations to their patients have recently divided between their patients and other involved parties. [i]

There are two major kinds of conflicts of interest, they are the financial conflicts of interest arise from incentives and the financial conflicts of interest arise from divided loyalty or dual roles often overlap. On one hand, the conflicts of interest are derived from incentives when physicians must make medical choices based not upon their patient's condition but upon the financial benefit. Physicians provide alternative medical services which benefit the patient less than another type of service for the financial ties. The decisions are significantly dependent on the organizations they work for or the parties who pay for the medical services but do not have the service.[2] For instance, for different patients diagnosed with the same disease, each may have different treatments, various among tests, surgery, and device. In addition to the variations in the patients' medical condition or the physicians' capabilities, other factors that influence on the treatment schemes are also the factors induce financial conflicts of interest for the physicians. Such factors are the contract with the insurer, the quota for hospital care set by the healthcare organization, or the drug or medical device companies that the physicians somehow relate or have financial ties.[3]

The financial conflicts of interest have effects on the most essential relationship in health care- the patient- doctor relationship. On one side, patients and society expect doctors to act on behalf of the patients and act in the patient's best interest. On the other side, physicians perform their work to earn their living expense, and how they provide treatments financially affects the third parties, who decide the physicians' income. Accordingly, conflicts between professional ethics and financial incentives have induced. When the organization fails to establish policies about medical practice and financing of medicine that cope effectively with the conflicts, the conflicts not only remain among the physicians but also undermine the credibility of physicians and professionalism. [4]

On another hand, the conflicts of interest originated from the divided loyalty occur when their loyalty is divided between the patients and the third party. These two types of conflicts often overlap since the physicians diagnose medical problems and prescribe the treatment, and the organization for which they work for provides the therapies. In this case, physicians play dual roles.[5] Briefly, the decisive factors for the existence of such conflicts involve the types of services that the physician practice, the attribute of the ownership of medical facilities, the types of employments of the physician, payment for the physician, and the financial ties between physicians and the third parties.[6]

Some people argue that the financial conflicts of interest may be resolved if the nature and the amount of the conflicts are disclosed; thereby, the physician may feel free from bias. However, the idea of disclosure seems not to be feasible because even the information of the conflicts is insufficient for the patient to assess the services or products which the physician has financial ties.[7] financial conflicts of interests are inevitable, yet there still have solutions to remedy the conflicts.

1. 2. Conflicts of conscience

Earlier, the common relationship between doctors and patients was known as paternalism. Patients followed any instructions of their physicians without asking about the alternatives or risks and benefits; also patients did not have convenient access to any type of medical information. Physicians acted on behalf of their patients under any circumstances and patients put absolute trust in their physicians. Thus, conflicts occurred infrequently. Since the 1960s, the idea of patient autonomy has widely spread out throughout the healthcare field, the medical decision making has significantly changed that patients' decisions usually override the physicians' decisions. Physicians have become patients' agents and are expected to comply with patients' requests, disregarding their own moral agency. This current trend has created a challenge to the autonomy of physicians. What physicians believe to be right is intruded.[8] the new trend in doctor-patient relationship has created another sort of conflicts that occur to practicing physicians- the conflicts of conscience. In many circumstances, doctors have to refuse to comply with a patient's request for the request that is against their moral beliefs. Different from the financial conflicts of interest, conflicts of conscience is derived from within the physicians themselves, not from the third parties. The conflicts are between the professional's personal moral belief and the responsibilities for the patient. [9] Justification of the doctors' refusal or the doctor's violation of his conscience is dependent on several factors, such as the inexpedience of the patient's request, the extent of the possible violation of the physician's conscience, and, also the most important, the foundation of the physician's conscientious refusal. The conscience of the physicians may be based upon the religious beliefs, secular moral beliefs, and medical expertise which are useful in justification for the decision. On a contrary, when the physician refuses to provide particular healthcare services for his or her discriminatory attitudes or for the financial reasons, the refusal is unjustified.[10]

To contend for the conscious refusal by the physician, some people adopt the principle of autonomy in the situation. They argue that both physicians and patients should equally have their moral autonomy and both should respect for one another's autonomy in the doctor-patient relationship. However, others argue that since doctors join the health care field as healthcare workers, they should adopt their obligations assigned in the field and should not impose their moral views on patients. These two arguments originate from the two views: physician-centric system and patient-centric system. These two extreme systems tend to increase the conflicts of conscience rather than resolve the problems associated with the conflicts as either of the ideas will damage the doctor-patient relationship- the essence of the effectiveness of healthcare service.[11]

The ideal solution is to maintain the physician's integrity as well as create doctor-patient relationship based upon share moral values though it is a challenging approach.[12]

The conflicts of conscience are more complicated in a society whose characteristics are pluralism and cultural diversity, such as the United States. Although such society indicates a genuinely free society in which individual beliefs and values are absolutely respected, the coexistence of various cultures and beliefs have particularly brought rising conflicts of conscience in the medical field. In order to justify for their conscientious refusal, many physicians argue that they do not impose their beliefs or values on anyone, they merely protect their own beliefs and values by refusing the requests that are objectionable to their beliefs and values. The requests may be proceeded by someone else who do not hold the same opinions. Yet, this argument places the professionalism- the essential component of the conscience below the personal conscience.[13] appropriate adjustment of personal and professional conscience would be a sufficient solution to the conflicts of conscience.

In medical history, professionalism defined physicians as ones who held extraordinary duty, had enormous social privileges, were compensated by admiration, and had absolute control over their patients. Nevertheless, the power of physicians has been shifted to the patients in medical decisions. Besides, advance medical technology which facilitates doctors in healthcare services has created more controversies about the physician's duties. As professional conscience, the physician should take advantage of the technology at best to preserve the patient's life, but such conscience often encounters many obstacles since his or her decision is no longer made solely by him or her; patients and their family or relatives as well as healthcare organizations and insurers take part in the decision making process, too. Another factor that changes the definition of professionalism in modern society is the various roles that a physician may hold in life; therefore, the physician does not neglect or sacrifice his or her person life or interests, or accept personal risks anymore. The physician may have other important duties that compete with the duties to patients.[14] To relieve the conflicts originated from the above factors, it is important to determine which personal interests are considered as illegitimate, so that physicians have to decide to avoid those and preserve their commitment to the services of patients.

2. Solutions to the organizational complicity in the perspective of the ethical principle of cooperation

2. 1. The ethical principle of cooperation

In medical setting, it is complicated to determine the responsibilities of involved parties in a wrongdoing. In Catholic moral tradition, the principle of cooperation is applied when deciding the involvement of the cooperator is whether morally culpable or not. The principle also guides people to make good moral decisions even there is complicity with wrongdoing.[15]

The essence of the principle is the object or the meanings of moral actions. Understanding the meanings of the moral actions helps us to put the moral actions in two types of cooperation, illicit formal and licit material cooperation, by which we can judge whether the actions are moral culpability or not.[16] Illicit formal cooperation means that the cooperator intends, explicitly or implicitly, to commit the wrongdoing with the main agent. This type of cooperation is always morally culpable.[17] On the other hand, licit material cooperation means that an individual unavoidably cooperates, only physically, with the wrongdoing without intention to commit under any circumstances. The cooperation is justified and the cooperator does not involve moral culpability.[18] In the latter case, justification is at various levels depending on particular cases.

In sum, illicit formal cooperation is always morally wrong as the cooperator intends the object of the wrongdoing while licit material cooperation may be justified as long as the cooperator does not intend the wrongdoing's object even being forced to physically cooperate.[19]

2. 2. The current solutions to the conflicts of interest

Financial conflicts of interests are unavoidable; therefore, policy makers have made a lot of effort to establish policies that cope with such conflicts. Recently, in France, Japan, and the United States, which distinctively operate their health care systems, the six proposals of remedies for the financial conflicts have been introduced in attempt to eliminate the conflicts, still they fail to attain the goals. The first approach suggests a necessary shift from investorowned forms to physician-owned or physician-directed or non-for-profit organizations. The result is that the conflicts still exist.[20] The second approach states that medical professions hold more authority in medical practice in order to avoid the external influences on physicians.[21]

The result is that the conflicts even escalate. The third approach encourages the market competition by decreasing or even discharging professional monopoly. .[22] The competition complicates the financial conflicts of interest. The fourth approach turns all physicians into public servants in order to get rid of the conflicts, yet the conflicts arising from ties to the party, which is the state in this case, appear. The sphere of conflicts is expanded.[23] The fifth approach bridges the physicians' financial accountability and judicial oversight. However, it appears to be impractical.[24] The last approach is to disclose the conflicts of interests since the undisclosed information was assumed to be the sole source of the conflicts. Again, this approach fails.[25]

It is possible to reason for the failure of the coping strategies that the strategies are offered by the states while the essence of health care services which is the physicians and the patients is not placed in the center. In the conflicts, physicians are the direct moral agent. Therefore, professionalism, along with other factors, plays a crucial role in confronting the conflicts of interest in particular, and with any conflicts in medical settings in general. In other words, professionalism would be an effective tool to cope with conflicts of interest. When professionalism is central, it overrides the existing legal standards and third-party oversight; as a result, physicians are able to regain professional trust, have autonomy, and practice at best without obstacles, then conflicts, in turn, will be relieved.[26] The argument is supported by the principle of cooperation. When the physician confronts the financial conflicts of interest with their professionalism at best, he or she still maintains the objective of his or her being as a physician. Any decision made out of the conflicts would be justified because the physician involves in a licit material cooperation.

2. 3. The current solutions to the conflicts of conscience

As the above discussion, professionalism plays a significant role in appropriately adjusting the personal and professional conscience because it is the essential component of physicians' conscience. Four models of medical professionalism have been suggested in attempt to justify for conscientious refusal by physicians. The four models consist of the consent model, the patient-centric model, the physician-centric model, and the gatekeeper model.

The consent model was established in the context of exploring physician responsibilities during epidemics. According to this model, physicians voluntarily choose to be physicians, which means that they voluntarily accept their professional role, thereby they voluntarily give up their autonomy. Joining in the medical professionals team entails physicians consent to confront any risks in the professional field, including physical and moral risks. However, physicians usually understand the notion of acceptance of personal risks as physical risks and some simple moral risks. The levels of moral risks that physicians are supposed to confront are not clear. The consent model is not convincing since it does not elucidate the normative standards for the professional obligations and the correlations between the obligations in the past and in the future which the physicians consent to.[27] The model fails to remedy the conflicts.

The patient-centric model supports the argument that physicians must provide all medical services within their capabilities. Physicians totally lose their paternalism, autonomy, and cannot involve their morality in the medical services. For this model, physicians merely assist patients in technical matters, provide patients with facts without judgment, and give directive in accordance with the patients' decisions. This approach has received criticism for it eliminates important care role of physicians. Applying this model enables physicians to avoid making refusal, but it inappropriately treats doctors in the medical settings. It leaves doctors no room for their autonomy and moral integrity. [28]

The physician-centric model is in opposite side of the patient-centric model. It encourages the right to conscientious objection for professionals. Conscience is an intrinsic notion that cannot be adjusted according to the situations. Physicians must have freedom on conscience as long as it accommodates the patients' interest. Still, this model possibly deprives the patients' autonomy since they cannot impose their views on the physicians. [29]

The gatekeeper model is considered as the best, most pragmatic and most widely accepted model for medical professionalism. The model defines physicians as social gatekeepers. The model provides protections the most to both patients and physicians. Physicians are responsible for the services to be available to patients, and prevent conscientious refusal from burdening patient access, yet they are not forced to sacrifice their moral autonomy except when absolutely needed. They can refuse to provide objectionable services but should clarify the alternatives to the patients; thereby, patients know that other physicians may be able to satisfy their requests. The interests of both physicians and patients are balanced in this model.[30]

The last model is appropriate because it leaves room for physicians' conscientious refusal, as a result they are able to think harder about their actions and imposes a greater sense of moral accountability in the practice of medicine. In this model, when a wrongdoing occurs, it is more convenient to justify for the physicians' decisions since the physicians do not intend to commit to the wrongdoing, their actions are directed by their conscience.

Conclusion

The financial conflicts of interest and the conflicts of conscience occurring within healthcare organizations have impact not only on physicians, but also patients and the success of the organizations. Professionalism is the core value to relieve the conflicts. It is an important factor for physicians and policy makers in confronting the conflicts.

End Notes

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