TIM HOFF: Welcome to another episode of the Author Interview series from the American Medical Association Journal of Ethics. I'm your host, Tim Hoff. This series provides an alternative way to access the interesting and important work being done by Journal contributors each month. Joining me on this episode is Dr Sunita Sah, director of Cornell University’s Academic Leadership Institute and a professor in the Management and Organizations Group at Cornell University’s College of Business in Ithaca, New York. She’s here to discuss her article, “How Should the US Federal Government Oversee Clinicians’ Relationships With Industry?,” in the March 2023 issue of the Journal, Clinicians in Government. Dr Sah, thank you so much for being on the podcast. [music fades]

DR SUNITA SAH: Thank you, Tim. It’s great to be here.

HOFF: So, what’s the main ethics point of your article?

SAH: So, the key question in this article is about how we can manage conflicts of interest in physicians, particularly physicians who work for government and may have extended reach and influence. And I discuss the case of a physician called Dr M who consults and serves on speaker panels for industry, as well as being the chair of a national commission that reviews government care programs that also involve products made by the same companies Dr M consults with. Now, Dr M believes these financial relationships are not an issue for a variety of reasons, the main ones being that Dr M disclosed the conflicts and that Dr M believes the conflicts were not substantial enough to warrant concern. Both of these statements represent an inaccurate mental model of how conflicts of interest work.

So, first, with regards to disclosure, I’ve conducted extensive research into disclosing conflicts of interest, and I’ve shown that such disclosures are insufficient. So, simply put, disclosure does not solve the biasing influence of conflicts of interest, it does not manage the conflicts of interest, but mainly identifies the existence of such conflicts so that institutions can then decide how to deal with them. And disclosure itself can actually lead to a number of unintended consequences. Across many studies I’ve conducted over the last 15 years, I’ve documented how disclosures can change the behavior of physicians themselves, as well as their patients. And in certain situations, disclosure can actually make matters worse, for example, by increasing unjustified trust in those that disclose their conflicts.
Now second, the statement that the conflicts are too small to warrant concern is also problematic. We often make the mistake of assuming that the size of a gift or a conflict of interest is what influences us, but research shows that even very small gifts such as a lunch or stationery can influence the decision making of physicians. In fact, I argue that small gifts may be even more pernicious than large ones, as they may go unnoticed by physicians. If doctors hold the belief that they are too small to matter, they often allow them to bypass scrutiny. So, the only effective way to manage conflicts of interest is through sincere attempts to eliminate them, regardless of size.

HOFF: And so, what’s the most important thing for health professions students and trainees to take from your article?

SAH: It’s a great question. In my research, I’ve uncovered what I call the professionalism paradox. Often, we see physicians and other professionals taking great offense at the notion that they might possibly be biased or influenced by financial incentives. And that reaction reveals yet again the wrong mental model of conflicts of interest: that influence is within our conscious control. And although a sense of professionalism might help defend against intentional corruption, it does not mitigate unintentional or implicit bias arising from conflicts of interest. So, a high self-concept of professionalism often coexists with a shallow notion of the concept and can paradoxically lead to detrimental outcomes such as greater unethical behavior and increased vulnerability to conflicts of interest. So, how does it do that? Well, first of all, those with a strong but shallow sense of professionalism may more readily accept conflicts of interest because of their high confidence in their ability to control for any biasing influence.

And we’ve seen this in the domain of overeating and smoking, that if we have a strong belief in our own regulation, we won’t remove high-calorie foods from our house or a cigarette packet from our pockets, so we’re more likely to lapse and eat more and smoke more than we want. And in the same way, those with a high sense of professionalism could be more willing to accept gifts precisely because they feel they won’t be influenced by them. And second, once a conflict of interest has been received, a high sense of professionalism may reassure a physician that they’re capable of warding off influence. So, they actually work less hard than others to correct for potential bias, ironically leading to a greater acceptance of conflicts of interest and more bias.

So, what’s needed is what I call deep professionalism rather than shallow professionalism. Shallow professionals fail to understand the risks of undue influence, and they rely on their own subjective feelings, which can be wholly inaccurate. Deep professionals, however, recognize the risks, and they avoid exposing themselves to conflicts of interest in the first place. They embrace continued ethical training to help embed principles, and they display their deep professionalism with repeated ethical behaviors. So, we need both deep professionalism and clear policies and procedures in place to eliminate or at least mitigate conflicts of interest, especially before physicians assume public roles such as advising governments.
HOFF: And finally, if you could add a point to this article that you didn’t have the time or space to fully explore, what would that be?

SAH: I’d say we need a different way to professionalize medical environments. We need to teach the concept and importance of deep professionalism at medical schools and in medical organizations and select positive role models into public roles that model deep professionalism: so, physicians who are high in humility, who understand the limits of their own ability to regulate bias, and who repeatedly reject conflicts of interest. And I propose that professionalism be redefined not as an individual characteristic or a feeling, but as a set of observable, repeated practices that demonstrate a deep understanding of the concept and promote outcomes in the interests of patients. [theme music returns]

HOFF: Dr Sah, thank you so much for being on the podcast today and thanks for your contribution to the Journal this month.

SAH: Thank you, Tim.

HOFF: To read the full article, as well as the rest of this month’s issue for free, visit our site, JournalofEthics.org. We’ll be back soon with more Ethics Talk from the American Medical Association Journal of Ethics.