Managing
Conflicts of Interest
in Medicine

Dr YEOH Swee Choo
FRCOG; DPhil (Oxon)
the Obstetrics and Gynaecology Practice
3 Mt Elizabeth #13-13 Mt Elizabeth Medical Centre
Singapore 228510
Structure of the talk

1. Financial Conflicts of Interest in Clinical Practice
2. Conflicts in Institutional Private Practice
3. Issues related to Health Screening
4. Financial Pressures
5. Principles of Medical Practice
SMC
Ethical Code and Ethical Guidelines
4.6.1 Disclosure of interest

A doctor shall not exert undue influence upon a patient in relation to transactions in which he has an interest.

If a doctor has a financial interest in an organisation or service to which he intends to refer patients for admission, treatment, investigation, or for the purchase of any drugs, medicine or service in the course of treatment, he shall always disclose his interest to the patient before making a referral.

A doctor shall not let financial considerations imposed by his own practice, investments or financial arrangements influence the objectivity of his clinical judgement in the treatment of his patients.
4.6.2 Financial conflicts in clinical practice

A doctor shall refrain from:

a. Improperly obtaining money from patients

b. Improperly prescribing drugs or appliances in which he has a financial interest

c. Fee sharing or obtaining commissions from referral of patients
4.6.3 Relationship with medical companies

4.6.3.1 Sponsored educational events and research

A doctor may be invited to participate in medical events... sponsored by companies marketing pharmaceutical or medical products.

The doctor shall ensure that his participation does not occur in such a way as to appear to endorse such products, or to persuade patients or members of the public to use the products.

Apart from identification and establishment of credentials, no details of services provided by the doctor or service details shall appear in any way in relation to such participation.

A doctor who is sponsored by a company to participate in an educational event, or who reports research sponsored by a company, must declare all such potential conflicts of interest to the audience.

4.6.3.2 Inducements

A doctor shall not ask for gifts, hospitality or other inducements that may affect or be seen to affect his judgment in making decisions about patients’ treatment. A doctor can receive small, insubstantial gifts which cannot be regarded as inducement.
Structure of the talk

1. Financial Conflicts of Interest in Clinical Practice
2. Conflicts in Institutional Private Practice
3. Issues related to Health Screening
4. Financial Pressures
5. Principles of Medical Practice
What defines Institutional Practice?

1. Subsidized patient care
2. Teaching of undergraduates
3. Supervision of post-graduates
4. Research
The Sessions Scheme
Late 1980s

11 sessions per week
Each session of 4 hours duration (9am – 1pm and 2pm – 4pm)

Minimum of 7 sessions per week for:
● subsidized in-patient and out-patient clinical care
● clinical teaching
● research
● administrative duties

Maximum of 4 sessions for private practice
● maximum of 2 sessions of private outpatient clinics
● generate 2 sessions of private surgery and inpatients
Institutional Private Practice

Benefits and Concerns

1. institution, subsidized patients, teaching, research protected
2. self-interests vs commitment to institution
3. consultant role modelling
4. increase private work ?decrease clinical / surgical training
5. strict enforcement
6. scheduled fees lower than prevailing SMA recommendations
7. perceived remuneration inequalities narrowed
8. departments benefitted financially
Structure of the talk

1. Financial Conflicts of Interest in Clinical Practice
2. Conflicts in Institutional Private Practice
3. Issues related to Health Screening
4. Financial Pressures
5. Principles of Medical Practice
“Health screening is essential for the early detection of diseases and conditions that cause disability and death.”


At NUH, we believe in the importance of preventive medicine to help you stay in the pink of health. Some medical conditions are not obvious to the untrained eye so early detection can make all the difference. With regular health screening and proper medical advice, diseases can be averted and medical conditions better managed.

are the most common. The ratio between prevalence and incidence is an indicator of prognosis; thus, breast cancer is the most prevalent cancer in the world, despite there being fewer new cases than for lung cancer, for which the outlook is considerably poorer.
CA125 elevated in:

**79% ovarian Ca**  

**50% early stage ovarian Ca**  

**Ca endometrium, breast, lung, some GI**  

**Endometriosis, menstruation, pregnancy, PID, cirrhosis, DM**  
Mammogram Screening*

Reduces breast cancer deaths 40 - 70 years
Greatest benefit >50 years
No benefit <40 years old

Misses 10% or more of breast cancers

False negatives delay treatment, promote false sense of security.

False Positive Mammograms

Community-based, every two years over a 10-year period:
- 24% ≥1 false positive mammogram
- 13% ≥1 false positive breast examination
- 32% ≥1 false positive result for either test

For every $100 spent for screening additional $33 spent to evaluate false positive results

Generating:
- 870 outpatient appointments
- 539 diagnostic mammograms
- 186 ultrasound examinations
- 188 biopsies
- 1 hospitalization

Elmore JG et al, Ten-year risk of false positive screening mammograms and clinical breast examinations; NEJM 1998; 338 (16) p1089-0196
Concerns

CA125

- health screen tumour marker for ovarian cancer
- low sensitivity and specificity
- frequent false negatives, false reassurances
- false positives cause undue alarm.

Mammograms

- save lives
- create market for further radiological screening and breast biopsies.
Potential Conflicts in Health Screening

- Well-intentioned, but followed by unexpected problems

- Doctors may benefit financially stakeholders, employees

- Potential for financial conflicts of interest more tests, more revenues more false positives → appointments / procedures.
Doctors have a duty of care to:

- get the **right messages** across to the public
- set **boundaries** between general and sophisticated tests
- provide **individual consultations**
- be the **gatekeepers**, regardless of personal gain
  - what is necessary, what isn’t
- **Conversely**, doctors subjected to patient pressure and autonomy “**do everything**”
Structure of the talk

1. Financial Conflicts of Interest in Clinical Practice
2. Conflicts in Institutional Private Practice
3. Issues related to Health Screening
4. Financial Pressures
5. Principles of Medical Practice
Fees for Services
Financial Pressures
<table>
<thead>
<tr>
<th>NUS (5 yrs)</th>
<th>Oxford Univ (6 yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$115k (Singapore citizen)</td>
<td>$320k (International)</td>
</tr>
<tr>
<td>$160k (PR)</td>
<td>+ $270k living expenses</td>
</tr>
<tr>
<td>$230k (International)</td>
<td></td>
</tr>
<tr>
<td>Cost of living not included</td>
<td>$600k total</td>
</tr>
</tbody>
</table>
Graduate Employment Survey 2011

Av Gross Monthly Salaries (brackets 75th-percentile)

NUS LLB (Hons) $5,037 ($5,075)
SMU Systems Mgmt (cum laude) $4,294 ($4,783)
NUS MBBS $4,016 ($4,500)

Median monthly income from work $7,570 in 2012

Further Costs

Specialty training  4 - 6 years

Sub-specialty training  2-3 years

working full time
long hours
night calls
study
research
cost of examinations
cost of travel
**Setting Up Private Practice**

**General Practice**
HDB and other property rents
Average GP consultation, with medicines, $20 - $30.

**Specialist Practice**
Rentals MEMC $18 to $28 psf
Consultation rm + share reception $6-10000 pm
Purchase $7500 psf (500sq ft unit $3.75 million)

**Staff costs**
Other high capital cost: renovations, equipment

**Medical Indemnity Insurance**
Obstetrics, medical indemnity insurance $30,000 2013-14
MOH related costs: prof/clinic regn, raft of regulations
Pressure of High Costs

• earlier entry into private practice
• more treatments
• cost recovery
Financially related issues (1)?

1  **GP aesthetics**
remunerative imbalances to the detriment of health care in the community

2  **Over-servicing**
PET scans & small elevations in tumour markers
CT coronary angiograms and chest discomfort
Myomectomy for asymptomatic fibroids
Tonsillectomy - can junior keep his adenoids?
Financially related issues (2)?

3 Non-speciality over-reach?
plastic or general surgeon liposuction

IN THE past four years, two people have died in Singapore while undergoing liposuction treatment — a purely cosmetic treatment catering to vanity and not because they were sick and the treatment was medically necessary. Both were still young, aged 44, at the time of death. They have, unfortunately, raised the turf fights between plastic surgeons, who see themselves as the only people properly trained to undertake such treatments, and other doctors offering the service with a Ministry of Health (MOH) approved. The first patient was Mr Franklin Heng, the head of a property firm, in December 2009. He had wanted to sculpt his tummy and the operation was done by a general practitioner in his clinic. The coroner’s inquest found that he had died from too much anaesthetic, which made him unable to breathe on his own. No anaesthetist was employed to provide the service.

Before that, an autopsy has found multiple punctures in Mr Heng’s intestines caused by the doctor during the treatment. Although this was not the reason Mr Heng died, it gave plastic surgeons ammunition for calling for stricter guidelines on who should be allowed to perform liposuction.

The MOH issued the call and tightened guidelines in November 2010. The guidelines had been established in 2008.

Last month, Madam Mandy Yeo Eng collapsed at the end of the treatment, while still on the operating table. The results of the inquest into her death have not yet been made public.

In her case, she had woken up and actually sat up before coughing and collapsing. The procedure was done by a general surgeon in an unlicensed operating theatre, with only sedation and local anaesthesia used.

Plastic surgeons. The Straits Times spoke to have maintained that liposuction can be dangerous in the hands of people not trained in plastic.

Some members of the public are asking if the MOH is too lax in its guidelines.

But in fact, in coming up with the guidelines, the MOH has already gone beyond the norm. In Singapore, as in most other countries, doctors are expected to know what they are capable of doing and sticking to it.

There is legally nothing stopping a general practitioner from doing breast surgery. Doctors are regarded as professionals who should be aware of their own abilities and mindful of patients’ welfare. So there are very few areas where the MOH steps in to specify the procedures doctors may or may not do, liposuction being one.

The MOH has intervened in these cases as they are a medical condition that needs to be treated, but rather a choice that people make for non-medical reasons.

Rather than limit even further who can perform the procedure, efforts should go instead to educating people desiring cosmetic treatments that they are not risk free.

According to the United States Food and Drug Administration, there are numerous reports of deaths related to liposuction in the US. There, any doctor is allowed to carry out the procedure.

The FDA tells patients that studies show that deaths occur from a low of three per 100,000 cases to as high as one per 1,000.

It added: “Even the best trained patients under the care of the best trained and experienced surgeons may experience complications as a result of liposuction.”

Instead of trying to limit the procedure to just one, a group of doctors — especially when the origins...
Financially related issues (3)?

4. non-pharmaceutical items
   association and marketing

5. employer or payor pressure
   “collusion between doctors and employers is conduct simply too callous to go unpunished.” Editorial, Straits Times 13 July 2013
Financially related issues (4)?

6 Big Pharma, Medical Devices, Biotechnology etc

physicians collaborate with industry
develop beneficial health products

influence professional judgments
integrity of scientific investigations
objectivity of professional education
quality of patient care
public’s trust in medicine
Structure of the talk

1. Financial Conflicts of Interest in Clinical Practice
2. Conflicts in Institutional Private Practice
3. Issues related to Health Screening
4. Financial Pressures
5. Principles of Medical Practice
Principles of Medical Practice

1. Respect for **autonomy** (*Voluntas aegroti suprema lex*)
   - the right to refuse or choose treatment

2. **Beneficence** (*Salus aegroti suprema lex*)
   - practitioner should act in patient’s best interests

3. **Non-maleficence** (*primum non nocere*)
   - first, do no harm

4. **Justice**
   - distribution health resources (fairness and equality)

*Tom Beauchamp and James Childress in “Principles of Biomedical Ethics”*
SMC Ethical Code and Ethical Guidelines

A doctor is expected to:

Maintain the highest standards of **moral integrity and intellectual honesty**

Treat patients with **honesty, dignity, respect and consideration**, upholding their right to be adequately informed and their right to self-determination
Goals of conflict of interest policies

1. protect the integrity of professional judgment
2. preserve public trust
Managing Conflicts of Interest

1. Act in the patient’s best interests

2. Physician’s interests should not be in conflict with patient’s interests

3. Physicians are entitled to income. Where conflicts of interest arise, the patient’s best interests are paramount

4. Bad apples

Thank you