Editorial

Conflicts of interest

We are faced daily with conflicts of interest in the profession. Some are serious, some are innocent. Some are very difficult to overcome, some are easy to overcome. For example, a lecturer has a close affiliation to a product, either through invention, ownership, or investment in the producing company; a researcher, who has a lifetime invested in a particular area of research, designs, carries out, and presents a study that ends up supporting his previous opinion and position; and, yes, even an editor wears two hats. All of these conflicts can be reasonably overcome by a simple step—full disclosure of the conflict so the listener or reader can evaluate the potential impact of the conflict on the comments and opinions of the lecturer, researcher, or editorial writer. It is more difficult, I believe, with clinical conflicts of interest since they involve a much more immediate and direct financial incentive, and once the treatment is rendered, the evidence of the conflict may have been eliminated.

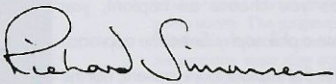
One of the overriding assumptions that is frequently voiced in the present-day discussions on the changes looming in the US health care system is that patients will be undertreated and/or that the quality of care will depreciate. It is claimed that shortcuts in treatment or denial of treatment, "necessitated" by inadequate fee structures, will occur and lead to lowered standards of care. Could it not be true that accepting this undertreatment assumption means that patients in the present fee-for-service system are, perhaps, overtreated?

It is clear that a practicing dentist, who must produce a certain income for paying office overhead and for providing a reasonable standard of living concomitant with his or her educational level or "value" to society, may not be able to spend the time necessary for first-class care for a particular patient, when it is legislated that the fees paid to him or her will not be adequate to support the time needed for that standard of care. It is equally clear, however, that in the present US system of fee-for-service, dentistry fees can be set for certain procedures that make it very tempting to give preference to some procedures over other, less remunerative yet perhaps equally (or even more) effective, treatments.

An example could be the placement of a full gold or porcelain crown when a more conservative restorative procedure would not only suffice, but may be indicated. The problem is the conflict of interest between time and complexity—the crown, or even the extraction, may be faster and easier to do while the more conservative restoration may be more clinically challenging, more time-consuming, and less remunerative. Who is to say patients will get the best—to which they are ethically entitled—rather than the most expensive treatment in this case? Both options may provide an excellent service. But has the clinician disclosed to the patient that there may be an inherent financial conflict of interest in the recommendation of treatment choice?

I would like to propose the argument that decreased quality of care as a result of potential economic gain is just as likely as decreased quality of care from potential economic loss. If you say the one does not happen now (decreased quality of care as a result of overtreatment, a clinician choosing a more remunerative treatment option), then why should the other happen (decreased quality of care from undertreatment, a clinician struggling with a fixed-fee structure)? Maybe we should recognize that both conflicting situations are likely and address both issues and our responsibilities as health care professionals to provide the very best treatment for every patient.

I don't buy the argument that decreased quality of care will necessarily result only from the spread of managed care. But the danger is there. The temptation is there. And the conflict must be resolved.



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