ARTICLE
INVITED SUBMISSION

By What Authority? Conflicts of Interest in Professional Ethics

Louis Charland PhD
Departments of Philosophy and Psychiatry & Faculty of Health Sciences, University of Western Ontario, Canada

I. Does the Ethical Emperor have Clothes?

Paradoxically, the profession whose primary mandate is to instruct and comment on matters of ethics spends inordinately little time reflecting on its own ethical practices. Consider the fact that while professional ethicists of all stripes crusade to expose and denounce conflicts of interests in all other branches of the health care system, they typically fail to pay much attention to their own potential 'ethical' conflicts of interest. Admittedly, there have been some efforts to address the problem. However, despite laudable intentions, they are highly unsatisfactory. Unenforceable 'model' draft codes of ethics on professional websites,[1] and obscure addenda to technical reports that are only available at a cost,[2] do not constitute acceptable responses to this predicament. This is a problem of profound social importance, a matter that threatens the very foundation, integrity and accountability of one of the most powerful forces in the modern health care system.

There is of course an expectation that, like other health care professionals, ethicists should abide by and declare all potential or actual conflicts of interest. But the point is that professional ethicists are subject to special conflicts of interest that are not covered by traditional guidelines and regulations. These conflicts arise directly from their professional mandate, which is to provide ethical expertise and advice. It is surprising that these special 'ethical' conflicts of interest in professional ethics attract so little attention. Neither professional ethicists nor those they serve seem very concerned. It is time we pay more attention to these potential 'ethical' abuses and risks of the ethics profession. This problem appears to be another case of the proverbial 'elephant in the room'. Everyone knows there is a problem, and a big one. But everyone pretends not to notice. To use another memorable metaphor, this may well be a case where the ethical emperor has no clothes!

II. Why Conflicts of Interest are Ethically Objectionable

Most health care professions have codes of ethics or conduct that are meant to govern the behavior of their members. Those codes usually have explicit provisions that address conflicts of interest that are specific to the practice of that profession. What counts as a conflict of interest varies across professions, as do sanctions and disciplinary measures. The nature of conflicts also varies. Some revolve around abuses of power or other kinds of inequalities. Some involve money or other financial interests and incentives. Nonetheless, despite these different varieties of conflicts and interests, it is still possible to venture some general remarks as to why conflicts of interest are thought to be ethically objectionable.

Consider the fact that most health care providers are usually not allowed to accept personal financial gifts from their patients. Nor are clinicians supposed to favor and recommend therapies or products because they stand to benefit from them. Many medical journals and research organizations now have provisions to protect against conflicts of interest. It is now widely accepted that clinical researchers engaged in testing and evaluating pharmacological agents must declare any financial ties or other obligations they have to the companies that produce and market those products.[3]

In many cases, it is the fact that interests are disguised or kept hidden that is thought to be ethically objectionable. Thus one reason why conflicts of interest are thought to be ethically objectionable is that they often introduce a hidden or disguised bias in the recommendation or provision of a product or service. This is not the only reason why conflicts of interest are thought to be ethically objectionable. But it is an important one. The worry is that such hidden biases do not serve the interests of consumers. Instead, they serve the interests of the persons, institutions, or industries, that provide the products or services in question.

So what is often thought to be especially ethically pernicious about conflicts of interest is the fact that they are hidden or disguised. Once a conflict has been exposed or declared it may still constitute a conflict. However, ethically at least, it has been attenuated in an important way. Consumers can then sometimes make a fairer and more informed decision, or simply abstain. At minimum, everyone involved is now aware that there is a conflict. Note that even the perception of conflict is often enough to require remedial measures. Here as well, when a conflict is declared or exposed, ethical worries are sometimes attenuated. At least the fact that there is a conflict has been rendered transparent for all to see.

III. Ethical Conflicts and Interests in Professional Ethics

What then are the special 'ethical' conflicts of interest that threaten the ethics of professional ethics? A preliminary analysis suggests that they may occur on a variety of levels, ranging from ethics education, clinical ethical consultations, and special ethical advisory boards and committees.

Ethics Education

Ethical education in health care contexts requires the deployment of ethical expertise. That requires a knowledge of ethics and ethi-

© 2008 Journal of Ethics in Mental Health (ISSN: 1916-2405)

cal assumptions. Such assumptions are often innocent enough; for example, explaining what a given ethical code or guideline says, describing relevant ethical precedents surrounding a case, or simply examining a situation from the point of view of different ethical theories. All of this can be done more or less 'objectively', let us grant. The problem is that in practice ethics education is not always so ethically innocent. In difficult and problematic cases, the manner in which one 'describes' a case usually involves important assumptions that invariably accompany the use of technical terms and explanatory notions. The 'facts' that are thought to be relevant are not usually simply out there, ready to be described, but rather actively selected from a variety of possible alternate descriptions.

So even at this ostensibly 'objective' level of ethical practice – ethical education – the practice of professional ethics may be subject to ethical biases that inadvertently direct the audience one way rather than another. Admittedly, it may be hard to present an ethical case study intelligibly and at the same time question and criticize the terms used to 'describe' that case. It is as if one were asked to saw off the branch on which one is asking the audience to sit. No doubt, philosophical pundits will insist that impartiality and objectivity in ethics education may be dangerous myths of their own. This may very well be true at more highly refined levels of case presentation and philosophical analysis. However, it does not nullify the value of impartiality or objectivity as laudable philosophical goals at many levels of ethics education.

Note that in ethics education in religious health care institutions, conflicts of interest may actually be mandated by the employment contracts of professional ethicists. Specific ethical viewpoints are promoted in accordance with the religious mission of that institution. Though such conflicts are often transparent and openly known by all involved, they may constitute conflicts nonetheless. For example, they may be judged to be ethically pernicious by outsiders or dissatisfied insiders. Such mandated ethical directives may also extend to the provision of clinical services, which can impact directly on the provision of ethical services in clinical ethics consultations.

Clinical Ethics Consultations

Suppose that after discussing their case with a clinical ethics consultant and agreeing to withdraw life-sustaining treatment for a loved one, a family later discovers that the ethicist who advised them is an ardent supporter of euthanasia and assisted suicide. In an informal discussion with other patients in the waiting room, they discover that this particular ethicist has a reputation for always 'pushing' for withdrawal of treatment and not presenting alternative options fairly or at all. That would certainly be grounds to suspect an 'ethical' conflict of interest on the part of the ethicist in question. The problem is that professional ethics currently has no satisfactory means for addressing or redressing such clinical ethical conflicts of interest.

Clinical ethics consultations can also raise difficult issues of conscience. There can be cases where ethical conflicts exist between an ethicist's personal views and the ethical mandate or orientation of the institution they work for. In cases where certain procedures are simply not made available in a given institution, an ethicist may choose to refer patients to another institution. A variety of different ethical conflicts of interest may be at play in such circumstances. Such issues raise difficult 'dilemmas' of their own. There can even be cases where patients may be consulted by ethicists representing different ethical interests. These can occur in large medical complexes that offer and combine services across different hospitals.

Ethical Advisory Boards and Committees

Consider now the conflicts of interest that may arise when professional ethicists are asked to provide ethical expertise or advice to boards and committees. Conflicts of interest of an ethical nature can also occur in this setting. Since these are settings where consumers and other professionals often expect impartial 'professional' advice from ethicists, it is extremely important that such conflicts be declared at the outset. The provision of such impartial ethical expertise and advice must be sharply distinguished from cases where ethicists are required or invited to express their own 'personal' ethical opinions. There is nothing necessarily ethically objectionable with the provision of such personal ethical advice, so long as it is not surreptitiously disguised as impartial professional advice intended to present ethical options without bias.

Suppose that unbeknownst to their fellow committee members, an ethicist has a vested interest in taking a specific ethical stance on a policy question. Perhaps this is because of a hidden personal ethical agenda. Or because they and some other party stand to gain from manipulating the outcomes of the committee or board towards a particular ethical end. It is hard to deny that such conflicts of interest may occur in professional ethics and that they are ethically objectionable. The possibility of ethical conflicts of interest on granting bodies and agencies is an especially important worry in this regard. Empirical research on conflicts of interest in other areas of the health care system has been revealing. 3 It is interesting to ponder what similar research might uncover in the area of professional ethics.

In response to these worries, it seems reasonable to suggest that ethicists who are being considered for advisory boards and committees should be compelled to declare any potential 'ethical' conflicts of interest of this sort *before* they are appointed, a suggestion that is likely to make many professional ethicists bristle.

IV. Diagnosis and Tentative Suggestions

One can only speculate why so little attention has been paid to the study and regulation of ethical conflicts of interest in professional ethics. Certainly the theoretical and practical difficulties involved in regulating the ethics of professional ethics are considerable. The question how exactly to distinguish legitimate personal ethical commitments from illegitimate personal ethical biases and agendas is sure to pose especially difficult challenges. So are the complex funding formulas according to which professional ethicists are sometimes remunerated in large institutions.

Making changes will be difficult. Professional ethics is already a thriving industry. To make changes we must rebuild the ship while keeping it afloat. One problem is that raising such issues might undermine the authority of the ethics profession. What, after all, gives anyone moral authority over the ethics of anyone else? There is therefore a risk that the ship might sink as we try and repair it. Or that it may drift aimlessly at the mercy of external forces. And let us not forget the politics of ethics. This is the problem of conflicting

© 2008 Journal of Ethics in Mental Health (ISSN: 1916-2405)

ethical agendas, where different factions seek to impose their own vision of ethics on others. In the end, there is no escaping the fact that professional ethics is a profession whose own ethical house is woefully in need of order and scrutiny.

No doubt, many ethicists will balk at the suggestion that their professional activities might be morally tainted by their own undeclared or partisan ethical biases and agendas. Some may dismiss the suggestion that ethicists should be required to declare such conflicts with disdain and superiority. But ethicists are not ethically superior to anyone else in the health care system. Quite the contrary. Ethicists must be ethically accountable to those they serve. That means they must declare any ethical conflicts of interest they may have. And so, in the spirit of good faith, let me begin here, with my own tentative disclosure of ethical interests.

'Model' Personal Declaration of Ethical Interests.

The present writer is a philosopher and former 'bioethics consultant' with a strong personal philosophical commitment to pragmatism in epistemology and anti-theory in ethics, as well as a strong skepticism about the philosophical credentials of 'bioethics'. The author is also a religious believer brought up in the Roman Catholic tradition, but one who no longer believes or adheres to many tenets of that faith. On the matter of specific ethical issues relating to health care, the present writer remains ethically open to the moral permissibility of the following medical interventions: abortion, euthanasia, assisted-suicide, the use of assisted reproductive techniques for gay couples, and properly administered safe injection sites for treatment refractory addicts.

Notes:

1. See for example the Model Draft Code of Ethics available on the website of the Canadian Bioethics Society at http://www.bioethics.ca/draftcode.pdf .

2. See for example 'Core Competencies For Health Care Ethics Consultation' posted on the site of the American Society for Bioethics and Humanities at http://www.asbh.org/publications/core.html .

3. Trudo Lemmens, Conflicts of Interest in Medical Research: Historical Developments. In Ezekiel Emanuel, Christine Grady, Robert A. Crouch, Reidar K Lie, Franklin G. Miller, and David Wendler (Eds.). The Oxford Textbook of Clinical Research Ethics, Oxford: Oxford University Press, 2008, pp.747-757.

4. The View From Here: Bioethics and the Social Sciences. Raymond De Vries, Leigh Turner, Kristina Orfali, & Charles Bosk (Eds.). Oxford: Blackwell Publishers, 2007.

Acknowledgements: *The present article is a revised version of a previous publication by the author entitled, 'Ethical Conflicts of Interest' (Canadian Psychiatry Aujourd'hui, Vol. 4, no. 5, October 2008). The author wishes to thank the editors of Canadian Psychiatry Aujourd'hui for permission to republish this article with modifications.*

Competing Interests: *as declared above*

Address for Correspondence: *charland@uwo.ca*

© 2008 Journal of Ethics in Mental Health (ISSN: 1916-2405)