13. Professional Conflicts of Interest for VHA Clinicians

Clinicians employed by VA facilities have a potential conflict of interest intrinsic to the care of their patients. On the one hand, clinicians such as physicians, dentists, nurse practitioners, clinical nurse specialists, physicians' assistants, and clinical social workers have the ethical responsibility to make health care decisions that represent the best interests of their patients, without regard for how such decisions impact on VHA. This ethical duty arises from the fiduciary responsibility of clinicians as professionals to grant primacy to the best interests of their patients.

On the other hand, as employees of a fixed-budget health care organization, VHA clinicians have the administrative duty of stewardship: to act responsibly to conserve scarce medical resources to preserve the good or equality of all patients within the system. If, in an attempt to "do everything possible" for a given patient, a clinician were to use the system's scarce medical resources irresponsibly, other patients within the system might no longer be able to receive a needed resource and be harmed. As a result, even though one patient might receive a marginal benefit, more net harm than good could result to the totality of patients within the system. Therefore, such an action, even though beneficently motivated by a clinician in an individual case, could be viewed as unethical.

The conflict of interest becomes most explicit in the situation in which a clinician believes that an expensive and scarce test or therapy has a small, marginal value to a given patient, but knows that the

system cannot afford to provide the test or therapy to all patients in similar situations. To provide the test or treatment of small, marginal value fulfills the clinician's fiduciary duty to the patient but simultaneously violates the clinician's stewardship duty to the system. To which master—the patient or VHA—does the clinician owe primary allegiance? How should such conflicts of interest be resolved?

Charge

The Subcommittee on Professional Conflicts of Interest for VHA Clinicians was charged by the VHA Bioethics Committee to consider how and by what criteria VHA clinicians should resolve intrinsic professional conflicts of interest between their fiduciary duties to individual patients and their stewardship duties to the population of patients. The subcommittee restricted its scope to professional conflicts of clinicians that occur within the VHA system.[1]

Definition of a Conflict of Interest

One commonly accepted definition provides: "A person P has a conflict of interest if and only if: 1) P is in a relationship with another requiring P to exercise judgment on another's behalf and 2) P has a (special) interest tending to interfere with the proper exercise of judgment in that relationship."[2] Another definition that focuses on the subset of financial conflicts of interests provides: "A conflict of interest is a set of conditions in which professional judgment concerning a primary interest (such as a patient's welfare) tends to be unduly influenced by a secondary interest (such as financial gain)."[3] The primary interest for clinicians is dictated by professional duties. In the case of the physician, it is clear from codes of professional ethics that the physician's primary interest should be the welfare of the patient.[4] Indeed, one of the features that distinguishes medicine as a profession and not a business is the primacy of the patient's interests over the proprietary interest of the professional.[5] Because non-physician clinicians function in essentially the same clinical role as do physicians, they have the same primary professional fiduciary duty to patients.

Secondary interests of clinical professionals include personal

financial interests, administrative institutional duties, teaching and research duties, public health duties, and duties to self and family. These are legitimate, necessary and desirable interests. It is only when they conflict with the primary duty to patients that they become a problem for the clinical professional. Lesser degrees of conflicts of interest may arise when the secondary duties conflict with each other.

In this report we use the term "conflict of interest" in its broadest sense according to the first definition. Thus, the term does not refer solely to financial conflicts of interest in which a clinician stands to gain monetarily by a certain course of actions, but includes conflicts of professional role responsibilities and conflicts of professional obligations. Indeed, the conflicts of professional roles and obligations are a more common and vexing source of conflicts of interest for VHA clinicians than the more narrowly defined financial conflicts. For the sake of simplicity, we will use the term "conflicts of interest" to refer to all of these concepts.

Roles of a VHA Clinician

Clinicians in VHA facilities simultaneously may assume a number of different roles and responsibilities during the course of their employment.[6] In addition to providing health care to patients, the clinician is an employee of VHA and of the Federal government. Clinicians also may teach, conduct research, and serve in various administrative capacities in the medical center and affiliated medical or professional school. These multiple roles are usually complementary and compatible but may compete and conflict in certain situations.

1. **Patient care provider** – In providing health care, a clinician has the professional responsibility to act in the best interest of the patient. Clinicians are fiduciaries and so have fiduciary professional responsibilities.[7] The role of patient care provider encompasses not only providing conscientious and competent health care, but also communicating to the patient the available diagnostic and treatment options (including options that are available outside the VA system), and recommending those that the clinician believes are

best for the patient. Through a process of shared decision-making the patient and clinician arrive jointly at the optimum care plan. A clinician's fiduciary duty to patients is the foundation of the clinician-patient relationship and is independent of the patient's socioeconomic, physical, or mental status.

2. **Clinical professional** – Clinicians have a professional duty to maintain the integrity of the clinical professions. For example, physicians and other clinicians have the duty to identify and report impaired physicians, both to promote their rehabilitation and to protect patients who may be harmed by them. Similarly, physicians have the duty to report fraud, professional misconduct, clinician incompetence, and patient abandonment.[8] Physicians and other clinicians have a professional duty to maintain the quality of medical care for the betterment of patient welfare.

3. **Patient advocate** – Patient advocacy is a role distinct from that of patient health care provider. The role of patient advocate encompasses the duty to assist the patient to receive equitable treatment in the patient's dealings with the VA bureaucracy, health insurers, lawyers, disability determination bureaus, community health care resources, and other administrative bodies. Often, the duty of patient advocate requires close communication with the patient's family.

4. **Employee of VHA and the Federal government** – As an employee of a VA facility, the clinician is obligated to follow the rules and regulations of the institution and the agency. Many rules are designed to equitably distribute scarce medical resources to patients, or to provide such resources in compliance with applicable law. At times, such rules may limit or proscribe the tests or treatments available to a specific patient and thereby create a conflict of interest. Clinicians need to be aware of potential conflicts between institutional policy and the best interests of individual patients. Specific inducements in the system that reward hospitals that increase outpatient care, for instance, could influence judgments concerning the need for inpatient care in individual cases. VHA clinicians also may be required to make medical

decisions that influence administrative determinations about compensation or benefits. At times, such decisions may limit access to certain care, treatment or service. Such decisions may conflict with a clinician's role as patient care provider and patient advocate.

5. **Protector of public health** – Clinicians have a professional responsibility to promote public health. The protection of public health encompasses efforts to contain and cure communicable diseases; to prevent abuse and violence; to enhance home, workplace, and transportation safety; to enhance food, water, and air purity; and to protect third parties known to be at risk. The responsibility to contain communicable diseases and to protect third parties known to be at risk for contracting a disease from an infected patient may at times conflict with the duty to maintain patient confidentiality, one of the primary patient care responsibilities of clinicians. The obligation to inform public health officials about a patient's infection with a communicable disease, whether or not consent has been provided, conflicts with the duty to maintain patient confidentiality.

6. **Researcher** – VHA clinicians participating in research have an obligation to ensure the integrity of the research and, in the case of human subjects research, to follow established guidelines for engaging in human experimentation. Conflicts may arise when what is best for the research project is not in the best interest of the patient. A conflict may also arise when the only way to access an emerging treatment is through a research protocol. This may present a problem if a patient seeks a particular treatment and may benefit from the treatment, but is not an appropriate candidate for the research protocol. A financial conflict may be present if a clinician has an economic interest in obtaining subjects for a research protocol.

7. **Responsibility to advise on procurement of equipment and medications** – A VHA clinician may have a responsibility as an expert to recommend the selection of equipment or medications to be procured. Examples are the chairperson of the Pharmacy and Therapeutics Committee or the chief of a specialty service such as

radiology. This expert role exposes the clinician to subtle and/or monetary influences in attempts to unduly influence the decision. Acceptance of gifts or gratuities or favors from any manufacturer represents a conflict of interest if the clinician is in this key role.[9]

8. **Prescriber of drugs and equipment** – The VHA clinician routinely prescribes drugs and orders equipment such as prosthetic devices. A conflict of interest may exist between what is the best drug or piece or equipment for the patient and the inclinations of the clinician as influenced by various experiences including possible favors, meals, trips, and honoraria given by manufacturers in order to promote their products. This situation is exaggerated by the absence of adequate funds within the VA to conduct educational programs. As a result, pharmaceutical companies now often play an important role in funding educational events, increasing the opportunity for inappropriate influence on VHA clinicians.[10]

9. **Educator** – Many VHA clinicians are faculty members at affiliated medical schools or other professional schools. A clinician, functioning in the role of an educator, has a set of responsibilities and obligations to students, faculty colleagues, and the school administration. Such roles, at times, may conflict with clinicians' primary responsibility to patients' welfare if the time commitments or loyalty between the medical/professional school and VHA conflict.

The national focus on managed health care delivery has had a significant impact on the various roles assumed by VHA clinicians. For example, clinicians have an explicit responsibility to use scarce resources efficiently, particularly in a setting where the institution mandates certain procedures or approaches to health care. Yet, the clinician maintains the primary responsibility to provide the best care possible to his or her individual patient. VHA clinicians must strike a balance between following institutional procedures to avoid waste, use scarce resources efficiently, and maximize the care provided to the veteran population as a whole, while providing the best care possible to an individual patient.[11]

Ethical and Legal Duties

Both ethical and legal principles require that certain interests or obligations take precedence over others. Therefore, when conflicts of interest and obligations develop, it is helpful to review the ethical principles and legal obligations that underlie professional duties. This section briefly discusses the similarities and differences between ethical and legal duties.

Four principles guide traditional medical ethics: the principle of nonmaleficence, prohibiting the commission of harmful acts; the principle of beneficence, encompassing an obligation to help others further their interests; the principle of autonomy, recognizing the individual's right to evaluate and choose his or her own course of action; and the principle of justice, encompassing concepts of fairness and desert (i.e., deserved reward and punishment).[12]

Ethical standards for physicians generally dictate that their primary ethical duty is to further the best interests of the patient, embodying the principles of autonomy, nonmaleficence, and beneficence.[13] For example, the American Medical Association Code of Medical Ethics states that "[a] physician has a duty to do all that he or she can for the benefit of the individual patient."[14] Similarly, the Code states that patient welfare should take priority in situations where a hospital's economic interests conflict with patient welfare, and that the physician's primary consideration should be the care of the patient. It follows that other non-physician clinicians who are acting in expanded roles to provide health care to patients are bound by the ethical duty to place the best interests of the patients ahead of other conflicting interests.

Similarly, the law provides that a clinician's primary legal duty is to place the best interests of the patient over all competing considerations. This legal obligation is based on the development of the standard of care in medical malpractice claims. There is no absolute standard of care against which a clinician will be evaluated during the course of a medical malpractice claim. Rather, the legal standard of care to which a

clinician is held is developed during the course of a trial on the basis of the expert testimony provided.[15] Although this legal standard of care can vary from case to case, the standard that is ultimately developed at trial always is oriented to the interests of the patient, and it requires the clinician to place the patient's interests above any competing interests and to exercise due care in providing services to the patient.[16]

The standard of care also is based on the idea that a physician or other clinician is acting as a fiduciary to the patient. The fiduciary relationship requires the clinician to act in the patient's best interests and to put such interests above most other considerations. The role of a fiduciary prevents the clinician from paying excessive attention to the societal interest in conserving resources when caring for a patient.[17]

There may be a question as to whether a particular course of treatment is beneficial, or whether a clinician's actions reflect the level of skill required to meet the community standard of care. However, the legal standard generally will not allow for withholding beneficial treatment or treatment that has at least a reasonable probability of benefiting the patient. A standard of care that allowed the withholding of beneficial treatment "would be a stark and unacceptable departure from the requirement that the physician exercise a certain level of skill and care in the treatment of patients and act in their best interest."[18] Thus from a legal as well as an ethical point of view, a clinician has a duty to act in the best interests of the patient and to give primacy to the role of patient care provider.[19]

Certain ethical and legal duties are also imposed on employees of the Federal government by statute and regulation. Specifically, as employees of the Federal government, VHA clinicians are required to comply with ethical rules governing employees of the executive branch of government. These rules govern a wide range of activities and topics, including accepting gifts, conflicting financial interests, impartiality in performing government service, misuse of government position, use of government property and official time, and activities outside of one's government employment.[20] A number of criminal laws pertaining to bribery, graft, and conflicts of interest are also applicable to certain employees of the Federal government.[21]

When the Roles Conflict

Usually, the multiple roles of VHA clinicians are compatible and do not conflict. The following examples may help clarify the nature of the conflicts when they do occur.

Rationing of MRI Scans

Confirmation of the clinical diagnosis of suspected epidural spinal cord compression from metastatic carcinoma is best accomplished by obtaining MRI scanning of the spine. In centers where MRI is available, it has essentially replaced myelography for this indication because MRI is less invasive, safer, and more diagnostically sensitive and specific than myelography.[22] However, many VHA facilities do not have on-site MRI units. In such VHA facilities, clinicians ordering tests to confirm the clinical diagnosis of epidural spinal cord compression from metastatic carcinoma must decide whether to send the patient off-site for MRI or to ask an on-site radiologist to perform myelography. Because acute spinal cord compression is a medical emergency, most often there is not time to travel to a VHA regional MRI facility so a community MRI must be obtained on a fee basis. The budget for community fee-basis MRI is severely limited, and most VHA facilities require approval of the chief of staff before permitting the test. Clinicians, therefore, are asked if the test is absolutely necessary or if myelography would suffice. In many cases, clinicians decide to opt for myelography because it is available, even though it is less desirable than MRI.

In these VHA facilities, oncologists, internists, neurologists, orthopedists, and other clinicians facing this dilemma frequently come to understand that MRI is rationed and to subsequently incorporate that fact into their practices. In these settings, they may alter their ordinary practices and order myelography routinely. Such decisions represent a conflict of interest (obligation) because that which is best for the system (conserving scarce financial resources) may not be that which is best for the individual patient. Residents rotating successively through VHA facilities and university hospitals often can see such dual standards of practice most starkly.[23]

Choosing a Less Expensive Drug

The pharmacies of VHA facilities have limited budgets. Pharmacy and therapeutics (P&T) committees of each facility have the difficult task of choosing those medications to place on the formulary and to be made available to patients. P&T committees often choose medications within similar classes that are less expensive.[24] Most facilities have in place a process to allow clinicians to request a drug that is not included on the facility formulary.

For some therapeutic indications, expensive non-formulary medications may have marginal benefits over less expensive formulary medications. For example, valproate and divalproex are both preparations of the anticonvulsant valproic acid. Divalproex produces less gastrointestinal irritation than valproate, but costs significantly more.[25] Many VHA pharmacies stock valproate but not divalproex because, in the opinion of those on the P&T committee, the marginal benefit does not justify the extra cost. Clinicians choosing valproic acid in this situation must compromise and prescribe valproate, knowing that divalproex is likely to be marginally better for the patient. This action represents a conflict of interest (obligation) between the clinician's fiduciary and stewardship duties.

Academic Responsibilities vs. Patient Care Duties

VHA is actively involved in the education of health professionals as part of the mission of the agency. The majority of VHA patient care facilities are affiliated with at least one medical or other health professional school. Nationwide, over 1,000 professional schools of varying types are affiliated with VHA facilities.[26] Many VA clinicians serve as faculty at a professional school. In many cases, the clinician's salary is shared between the VHA facility and the professional school, in recognition of the dual responsibilities. VHA clinicians serve important professional school functions, such as teaching students, preceptoring, supervising residents, conducting research, and serving on professional school committees. It is generally accepted that such affiliations improve the quality of patient care by attracting a higher

quality of clinician to VHA facilities than otherwise might be recruited. However, the dual roles of a VHA clinician can represent a conflict of interest (role or obligation) when time devoted to professional school responsibilities must be shared with patient care duties.

Financial Interest in Research

A clinician's research responsibilities and associated financial interests may either conflict, or present the appearance of a conflict, with the clinician's obligations to the patient. This is a conflict of interest in its narrower, financial sense. The potential for such a conflict is demonstrated in a case where a patient alleged that a physician breached his/her fiduciary duty by failing to disclose his/her potentially conflicting research and economic interests in the patient's cells.[27]

A patient with hairy-cell leukemia was evaluated by a physician who collected blood and tissue samples and confirmed the diagnosis. The physician recommended a splenectomy, which was subsequently performed. The patient returned to the physician for follow-up visits that involved the collection of additional blood and tissue samples.

Unbeknownst to him, the cells that had been removed from the patient were being used for research. The cells were unique and had potential scientific and commercial value. The research resulted in the development of a potentially lucrative patented cell line. The court's opinion states that the physician benefited financially from the development of the cell line.[28]

When the patient learned of the research, he sued the physician, the regents of the university, a university researcher, and the licensees of rights to the patented cell line and its products. The patient alleged, among other things, that the physician and other defendants failed to disclose their research and economic interests in his cells before obtaining his consent for medical procedures. The California Supreme Court held that the lower court could proceed on that aspect of the lawsuit alleging a breach of fiduciary duty. The court specifically held that: "[a] physician who is seeking a patient's consent for a medical

procedure must, in order to satisfy his fiduciary duty and to obtain the patient's informed consent, disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment."[29] This case exemplifies a situation where a patient believes that a clinician's fiduciary duty conflicted with the physician's research and financial interests.

Resolution of the Conflicts

The resolution of a VHA clinician's professional conflict of interest has three dimensions: 1) avoidance of the conflict when possible; 2) disclosure to the patient when the conflict cannot be avoided; and 3) development of practice guidelines both to minimize the occurrence of unnecessary professional conflicts and to maximize the disclosure to patients of necessary conflicts.

The narrower financial professional conflicts may be avoided by strictly adhering to a code of professional conduct that forbids unethical behavior. For example, most codes of clinical professional conduct regulate or forbid clinicians from accepting gifts, gratuities, or kickbacks from agencies with whom the clinician interacts in the care of patients.[30] Conflicts of accepting gifts, of financial interests, of impartiality in performing government service, of misuse of government position, of use of government property and official time, and of activities outside of one's government employment can be avoided by adhering to the *Standards of Ethical Conduct for Employees of the Executive Branch*.[31] Clinicians can avoid conflicts of teaching vs. patient care responsibilities by scrupulously protecting the time that is supposed to be devoted to patient care or by providing appropriate compensatory patient care time when the clinician must spend time away from patient care.

Some conflicts, such as those between clinicians' fiduciary and stewardship duties, remain unavoidable, especially as we move into the managed health care delivery model. Here, clinicians have the duty to disclose the conflicts to patients. Patients should be told in advance that VA is moving into a managed health care delivery model, and that

this new focus on managed health care delivery, when combined with fixed institutional budgets, necessitates rationing of some types of expensive, scarce tests and treatments. Patients should be notified that certain elements of their diagnostic testing or treatment may be different in VHA from what they might be in some other practice setting. For example, a patient in a managed health care delivery system such as VA may not have access to certain drugs or procedures that would be provided in other settings. The marginal utilities of the rationed items should be described, particularly where such items would be available in other health care settings. Patients should be notified when as a result of the managed care practice certain procedures are provided selectively, so they are informed and can take necessary action to procure alternative medical care if they are able and so desire.

Clinicians within VHA should work to develop institutional guidelines aimed at minimizing the conflicts and disclosing them effectively. The guidelines should be developed by clinicians, with physicians playing a leadership role. Development of guidelines should be an ongoing process. The guidelines should be based upon accepted standards of medical practice as articulated through clinical practice guidelines developed or endorsed by medical societies. The guidelines should take into account evidence-based outcomes of medical treatment and aim to maximize the quality of care provided by clinicians.[32] Physicians and other clinicians should be presented with these guidelines on beginning employment at VHA and endorse them as a condition of accepting employment. Patients should be aware that their clinicians, in caring for them, will be following practice guidelines based upon efficacy and cost.

Recommendations

1. VHA clinicians should avoid financial and other conflicts of interest in their practice of patient care, education, and research. Many such conflicts can be avoided by adhering to codes of professional conduct and codes of ethics accepted by their profession, and by following the requirements of the *Standards of Ethical Conduct for Employees of the Executive Branch*.

2. In cases where financial and other conflicts of interest involving patients are unavoidable, the conflict should be disclosed to the patients. For example, if a local policy restricts or limits the availability of a particular treatment or therapy, the patient should be informed of the restriction.

3. VHA facilities should use clinical practice guidelines or critical pathways developed by medical specialty societies that are evidence-based, appropriately consider efficacy and cost factors, and are designed to improve the quality of care. There are clinical situations that occur commonly in VHA facilities for which nationally accepted practice guidelines or critical pathways do not exist. In these situations, VA should develop appropriate clinical practice guidelines.

4. Clinicians working at VHA facilities should be involved in the development and implementation of clinical practice guidelines and should be willing to endorse the clinical practice guidelines and critical pathways they will be expected to follow.

5. A system is already in place to educate employees regarding their obligation to avoid certain conflicts of interest under the *Standards of Ethical Conduct for Employees of the Executive Branch*. The areas covered by these regulations include accepting gifts, conflicting financial interests, impartiality in performing government service, misuse of government position, use of government property and official time, and activities outside of government service. These regulations, however, do not address many of the conflicts of obligation or role that are unique to clinical settings. VHA should develop a mechanism to alert and educate clinicians about the

existence of conflicts of role and obligation and the appropriate means of resolving such conflicts. This could be achieved through an information bulletin, a satellite conference, or in a workshop setting. Ethics Advisory Committees at VA facilities could be a potential resource to help resolve issues that arise in clinical settings.

Notes

1 The broader subject of professional conflicts of interest among physicians in other health care settings was recently the subject of a thorough scholarly analysis. See Rodwin MA. *Medicine, Money and Morals: Physicians' Conflicts of Interest*. New York: Oxford University Press, 1993.

2 Davis M. "Conflict of Interest Revisited." *Business and Professional Ethics Journal* 1993(winter);12:21-41.

3 Thompson DF. "Understanding Financial Conflicts of Interest." *N Engl J Med* l993;329:573-576. A more general and rigorous definition of conflict of interest was provided by Davis, as noted above.

4 See American Medical Association. *Code of Medical Ethics*. Chicago: American Medical Association, 1994; and Noy S, Lachman R. "Physician-Hospital Conflict Among Salaried Physicians." *Health Care Manage Rev* 1993;18(4):60-69. Nurses and social workers have similar codes of ethical obligations to patients. See American Nurses' Association. "American Nurses' Association Code for Nurses," in Benjamin M, Curtis *J. Ethics in Nursing* 3rd ed. New York: Oxford University Press, 1992; National Association of Social Workers, Inc. *Code of Ethics of the National Association of Social Workers*. Silver Spring, MD: National Association of Social Workers, Inc., 1990.

5 Reed RR, Evans D. "The Deprofessionalization of Medicine: Causes, Effects and Responses." *JAMA* 1987;258:3279-3282.

6 Mirvis DM. "Physicians in Organizations. Dilemma of the Academic VA Staff Physician." *Arch Intern Med* 1990;150:1621-1623.

[7] Marc Rodwin recently analyzed the fiduciary role of physicians and the conflicts of obligations of physicians as fiduciaries. See Rodwin MA. "Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System." *Am J Law Med* 1995;21:241-257.

[8] These duties are described in detail in, for example, American College of Physicians. *American College of Physicians Ethics Manual*, 3rd ed. *Ann Intern Med* 1992;117:947-960.

[9] *The Standards of Ethical Conduct for Employees of the Executive Branch*, as well as certain criminal laws, may be violated by the acceptance of gifts and gratuities. 5 C.F.R. Part 2635; 18 U.S.C. §§ 203, 208. The procurement integrity laws may also be implicated if a clinician, acting as a procurement official, accepts gifts and gratuities. 41 U.S.C. §§ 401-424. See discussion, *infra* notes 20 and 21.

[10] See discussion, *infra* notes 20 and 21.

[11] See Kassirer JP. "Managed Care and the Morality of the Marketplace." *N Eng J Med* 1995;331(1):50-52. Menzel PT. "Double Agency and the Ethics of Rationing Health Care: A Response to Marcia Angell." *KIEJ* 1993;3(3):287-292; Angell M. "The Doctor as Double Agent." *KIEJ* 1993;3(2):279-286.

[12] Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 4th ed. New York: Oxford University Press, 1994.

[13] See Stilling WJ. "Who's in charge: the doctor or the dollar? Assessing the relative liability of third party payers and doctors after Wickline and Wilson." *J Contemp Law* 1992;18:285-307; Hirshfeld EB. "Should Ethical and Legal Standards for Physicians Be Changed to Accommodate New Models for Rationing Health Care?" *U Pa Law Rev* 1992;140:809-846; and Furrow BR. "The Ethics of Cost Containment: Bureaucratic Medicine and the Doctor as Patient-Advocate." *J Law Ethics Public Pol* 1988;3:187-225.

[14] Council on Ethical and Judicial Affairs, American Medical Association. *Code of Medical Ethics*. Chicago, IL,1992; § 2.03.

[15] Hirshfeld, *supra* at 1831-1834; *see also* Furrow, *supra* at 192, note 13 (referencing the Restatement (Second) of Torts and noting that the standard of medical care also takes into account the location or type of community in which a clinician is practicing).

[16] See 61 Am Jur 2d Physicians, Surgeons, and Other Healers §§ 166-168; see also Keeton, et al., *Prosser and Keeton on the Law of Torts*, 5th ed. 1984; § 32.

[17] Hirshfeld, supra at 1838-1839.

[18] Hirshfeld, *supra* at 1838. The legal standard of care is fluid. It is conceivable that this patient-oriented standard of care could be modified in order to accommodate rationing. However, Hirshfeld sets forth compelling arguments against implementing such a change.

[19] There may also be a legal duty to *disclose* to the patient the existence of any roles that conflict significantly with the clinician's role as a health care provider. See generally *Moore v. The Regents of the University of California, et al.*, 51 Cal. 3d 120, 793 P.2d 479, 271 Cal Reptr 146(1990), *cert. denied*, III S.Ct. 1388 (1990).

[20] 5 C.F.R., Part 2635, *Standards of Ethical Conduct for Employees of the Executive Branch*. Under certain circumstances, VA clinicians acting as procurement officials may also be subject to the procurement integrity laws. See generally 41 U.S.C. §§ 401-424. These laws prohibit certain actions involving soliciting, accepting or discussing future employment or business opportunities, soliciting or receiving money, gratuity or anything of value, or disclosing certain proprietary or source selection information. VA employees may seek advice regarding these ethics laws and regulations from the designated agency ethics official. This official can be contacted through the General Counsel's office or, in the field, through the appropriate Regional Counsel's office.

[21] The criminal statutes pertaining to bribery, graft, and conflicts of interest are set forth in 18 U.S.C § 201, *et seq*. These statutes include, for example, a statute pertaining to certain acts affecting employees' personal financial interest. 18 U.S.C. § 208.

[22] Kent DL, Haynor DR, Longstreth WT Jr., et al. "The Clinical Efficacy of Magnetic Resonance Imaging in Neuroimaging." *Ann Intern Med* 1994;120:856-871.

[23] Professional conflicts of interest related to expense and scarcity of medical care are by no means unique to VA. Similar conflicts occur in non-VA health maintenance organizations and managed care networks. See, e.g., "American Medical Association Counsel on Ethical and Judicial Affairs. Ethical Issues in Managed Care." *JAMA* 1995;273:330-335; and Stoeckle JD, Reiser SJ. "The Corporate Organization of Hospital Work: Balancing Professional and Administrative Responsibilities." *Ann Intern Med* 1992;116:407-413. Even in fee-for-service medical settings, patients must use their own discretion and judgment to decide if the marginal benefit accrued to them by an expensive test or treatment justifies the extra cost that may be imposed on them.

[24] Hochia PKO, Tuason VB. "Pharmacy and Therapeutic Committee: Cost-Containment Consideration." *Arch Intern Med* 1992;152:1773-1775. P&T committees do not always save money, however. See Sloan FA, Gordon GS, Cocks DL. "Hospital Drug Formularies and Use of Hospital Services." *Medical Care* 1993;31:851-867.

[25] Wilder BJ, Karas BJ, Penry JK, et al. "Gastrointestinal Tolerance of Divalproex Sodium." *Neurology* 1983;33:808-811.

[26] Hollingsworth JW, Bondy PK. "The Role of Veterans Affairs Hospitals in the Health Care System." *N Engl J Med* 1990; 322:1851-1857.

[27] *Moore v. The Regents of the University of California, et al.*, 51 Cal. 3d 120, 793 P.2d 479, 271 Cal Rptr 146 (1990), *cert. denied*, III S. Ct. 1388 (1990).

[28] The Regents applied for a patent on the cell line, and listed the physician and the researcher as inventors. The court's opinion notes that under established policy [presumably, policy of the University], the regents, the physician, and the researcher would share any royalties or profits arising out of the product. *Moore v. The Regents of the University of California, et al.*, 51 Cal. 3d at 127, 793

P.2d at 481-482, 271 Cal Rptr at 148-149. The court also notes the following:

With the Regents' assistance, Golde [the physician] *negotiated agreements for commercial development of the cell line and products to be derived from it. Under an agreement with Genetics Institute, Golde "became a paid consultant" and "acquired the rights to 75,000 shares of common stock." Genetics Institute also agreed to pay Golde and the Regents "'at least $330,000 over three years, including a pro-rata share of* [Golde's] *salary and fringe benefits, in exchange for … exclusive access to the materials and research performed," on the cell line and products derived from it. On June 4, 1982, Sandoz "was added to the agreement," and compensation payable to Golde and the Regents was increased by $110,000.*

51 Cal. 3d at 127-128, 793 P.2d at 482, 271 Cal Rptr at 149.

29 51 Cal. 3d at 147, 793 P.2d at 496, 271 Cal Rptr at 163.

30 See, e.g., Bernat JL, Beresford HR. "The American Academy of Neurology Code of Professional Conduct." *Neurology* 1993;43:1257-1260.

31 5 C.F.R. Part 2635, *Standards of Ethical Conduct for the Executive Branch.*

32 For a defense of how clinical practice guidelines can both save money and improve the quality of medical care, see Rosoff AJ. "The Role of Clinical Practice Guidelines in Health Care Reform." *Health Matrix* 1995;5:369-396. For a discussion of how practice guidelines impact on professional liability, see Havighurst CC. "Practice Guidelines as Legal Standards Governing Physician Liability." *Law Contemp Prob* 1991;54:87-117.

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