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Perspective

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Serving Two Masters — Conflicts of Interest in Academic Medicine

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In January 2010, Boston-based Partners HealthCare, which includes some of the nation's leading teaching hospitals, began sharply limiting the amount of compensation institutional officials may receive for serving on boards of directors of biomedical companies or companies that are likely to do business with Partners.[1] Declaring that "compensation [for board service] should be capped at a level befitting an academic role,"[1] Partners limited payments to $5,000 per day for the time spent at board meetings and prohibited equity compensation. Partners officials may donate additional compensation to a charitable organization that is not affiliated with Partners. The Partners conflict-of-interest committee will review all such arrangements. The press reported that several Partners officials have received more than $200,000 a year as directors of companies that sell pharmaceutical or medical products — a standard level of compensation for directors.[2] The chair of the committee that recommended the new policies reportedly cited 2009 policy changes that prohibit faculty members from serving on speakers' bureaus of drug companies, suggesting that it would seem unfair to restrict the income of junior faculty in this way while refraining from limiting the outside income of senior officials serving on boards.[2]

Relationships between academia and industry have both benefits and risks. Close collaboration between academia and industry has facilitated the development of many new drugs.[3] This is an area in which key interests may be aligned: the public seeks effective new therapies, academia wishes to translate basic discoveries into treatments, and industry wishes to develop new products. As the Partners policy notes, both academia and industry may benefit when academic leaders serve on company boards. Companies may benefit from the wisdom of senior academic physicians and learn about emerging trends in basic research and health care. Academic leaders may learn innovative approaches to organizing scientific research teams or running large, complex organizations, and their networking with other board members may enhance fund-raising.

However, the mission of academic health centers (AHCs) may diverge from that of for-profit medical companies in important ways (see table). Whereas AHCs are driven largely by the goals of deepening our understanding of health and disease and providing

Missions of Academic Health Centers and Medical Companies.

Mission of Academic Health Center	Mission of Drug, Medical Device, or Biotech Company
Conduct basic research to understand the mechanisms of disease and human functioning	Develop new products that will generate profits for the company
Train graduate students and fellows to become independent investigators who can compete effectively for funding from the National Institutes of Health	Encourage graduate students and fellows to carry out research on the company's promising products for development
Promote evidence-based medicine and independent critical judgment by physicians	Develop marketing strategies to improve sales and profits
Provide cost-effective care to patients and achieve a profit margin from clinical care that can be used to subsidize other activities	Increase profits through increased sales of products
Improve public health, global health, and care for orphan diseases for which patients seek care at the hospital	Work on issues of public health and global health and on treatments for orphan diseases if it fits the company's business model or plan for charitable giving or enhances its reputation

high-quality care, companies need to develop profitable new products; this means, for instance, that while AHCs seek to improve public health as an end in itself, for-profit companies tend to undertake public health work only if it enhances their profits or reputation or conforms to their plan for charitable giving. The divergence of these missions suggests that in addition to concerns about academic leaders' receiving undue personal income — concerns that apparently animated the Partners policy — important concerns about the responsibilities of academic leaders and directors should be addressed. A director of a for-profit company has a fiduciary responsibility to the company, owners, or stockholders to increase profits.[4] A dean or department chair at an AHC has a responsibility to advance the academic institution's mission.

These responsibilities may be irreconcilable in some situations. For instance, if a company is funding a research partnership with an AHC, directors should strive to advance the company's interests by controlling the scientific agenda and focusing on product development. However, a leader of an AHC, whose mission is to promote innovative basic research, should want academic scientists to set the agenda. Similarly, if a company is developing a global health partnership in a resource-poor country, directors should focus on promising new markets and discourage the development of unprofitable vaccines and drugs. An AHC, however, may be committed to reducing the global burden of disease and reducing social determinants of poor health — for example, through microfinancing loans. In such situations, a director who votes for an approach that benefits the company may undermine important interests of the AHC, and vice versa, and a person of integrity may not be able to serve both institutions. These conflicts of responsibility may be particularly serious when the leader of an AHC has a substantial financial interest in being asked to continue serving on the board of the company.

The resulting institutional risks to the AHC and the company may be asymmetric. If a few academic leaders serving on a company board give priority to the interests of their academic institution, the other board members are likely to dominate the vote and protect the company's interests. In contrast, academic leaders typically have considerable power and discretion in running their own institutions. If their decisions at the AHC are unduly influenced by the interests of a company on whose board they serve — an influence that may be subconscious — there may be no checks and balances.

Sound conflict-of-interest policies require careful analysis of the benefits and risks of a relationship between academia and industry. Several questions should be asked. First, after service on a board is disclosed, can situations be identified in which academic leaders who are board members face a sharp divergence between the interests of the AHC and those of the company? Second, in such situations what strategies might be adopted to reduce the risks to the AHC to an acceptable level? For example, should leaders of the AHC recuse themselves from board votes on such issues? Third, could the interactions between academic leaders and industry be restructured in such a way as to preserve the mutual benefits of the relationship while greatly reducing the risks? Perhaps leaders of AHCs might serve as consultants or nonvoting board members, rather than as officers who assume fiduciary responsibility to companies.

Fourth, several financial questions must be addressed. Annual payments to directors that are of the same order of magnitude as AHC salaries present a problematic risk of undue influence on the AHC. What amount of money

in directors' fees may the AHC leader retain? The Partners policy caps payments on the basis of the number of hours spent at directors' meetings and apparently does not allow compensation for preparation or committee work. An additional safeguard would be to limit the compensation that officers retain to some percentage of the AHC salary — perhaps 10%. Should there be restrictions on how leaders of AHCs may dispose of the remaining fees? Donation to the AHC or an affiliated nonprofit foundation might also be an undue incentive. Because the leader is benefiting the AHC through such donations, he or she might rationalize making decisions that benefit the company but work against some interests of the AHC. Therefore, excess compensation should be donated to nonprofit organizations that are not connected with the AHC. To allay concerns about "shadow foundations," such donations should be disclosed to the AHC and to the public.

Fifth, is effective oversight in place at the AHC? A recent report on conflicts of interest from the Institute of Medicine (IOM), which I coauthored, recommended that such relationships be reviewed and approved by the board of trustees of the AHC, not by the committee that oversees conflicts of interest of faculty members[3] — a committee that is typically composed of physicians and staff members. It is unrealistic to expect such employees to oversee institutional leaders to whom they report in other contexts.

The new Partners policy, as well as the IOM report,[3] a consensus report by the Association of American Medical Colleges and the Association of American Universities,[5] and revised policies at other AHCs, should inspire additional academic health centers and professional societies to reconsider this and other conflict-of-interest issues, including those related to continuing medical education and the development of practice guidelines. The public grants the medical profession considerable discretion in setting its own standards because it trusts that physicians will place patients' interests ahead of their own or those of third parties. To maintain this trust, AHCs should take the lead in addressing conflicts of interest in medicine, rather than merely responding to government requirements and adverse publicity about troubling cases. Taking the initiative will promote a culture of accountability and a commitment to professionalism.[3] In their roles as clinicians and researchers, physicians tackle difficult, complex problems, clarify countervailing interests and values, make tradeoffs explicit, develop innovative approaches, and rigorously analyze the advantages and disadvantages of various options. Physicians should apply these skills to help improve conflict-of-interest policies for AHCs and professional societies.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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Avoiding Side Effects in Implementing Health Insurance Reform

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All U.S. health insurance reform proposals currently being discussed now include changes in the way insurers treat some people with above-average health risks. In most states, insurers who sell policies directly to individuals now charge premiums based to some extent on characteristics thought to predict the risk of high-cost conditions; insurers also exclude some or all preexisting conditions from coverage and simply refuse to cover some people. Without such "risk rating" and coverage exclusions, insurers would be subject to substantial adverse selection — that is, consumers would seek them out primarily if and when they became ill and therefore represented higher risks to insurers — which could lead insurers needing to cover their costs to