

Books

Review

Marc A. Rodwin. *Conflicts of Interest and the Future of Medicine*.
New York: Oxford University Press, 2011. 375 pp. \$29.95 cloth.

In this rich and learned analysis, Marc A. Rodwin extends his work on conflicts of interest by directly comparing both problems and policies in the United States, France, and Japan. Although he has already published leading work in this field (Rodwin 1993), readers, I suspect, will learn a lot from this comparison, which builds on the analytic baseline from that previous work. A reader interested in conflicts of interest and seeking an introduction to the field could surely use this book for that purpose. It lays out issues and then demonstrates them in a wide range of contexts. Because of its comparative approach, however, the book also has advantages over any single-country study.

Looking at different countries expands the number of cases for observation. This in turn increases the possible range of variation on the dependent variables of interest (the results we want to understand) and the possible independent variables (the candidates to explain the phenomena or, if one is a policy maker, the levers one might use to try to change the results).

An American analyst, for example, might believe he or she has seen virtually every imaginable permutation of entrepreneurial behavior and

gaming by members of the medical industry. Yet the Japanese show that this is not just a matter of American ingenuity. When the Japanese Ministry of Health and Welfare sought to reduce prolonged hospital stays after a set number of days, hospitals invented “playing catch with patients,” in which “the hospital discharged the patient and a cooperating hospital admitted the patient at the highest reimbursement rate. The cooperating hospital returned the favor by sending the referring hospital one of its patients” (187). Japanese billing is not as specific as U.S. billing, so to inhibit utilization review even further, “it is standard practice for physicians to list four or five diagnoses without indicating which treatments are paired with which diagnoses” (189). To avoid controls on the profits of physician-owned medical corporations, some of those “facilities purchase medical supplies or services at high prices through corporations or subsidiaries nicknamed tunnel companies. The practice allows physicians to distribute some income through the tunnel corporation’s dividends” (193).

These particular examples illustrate an advantage of cross-national comparisons in general. It is easy to imagine that a given behavior is due to unique conditions; yet if one finds similar patterns in settings that are as different as France, Japan, and the United States, one has to suspect that they are based in some fundamental patterns of human behavior. Physicians, given any opportunity at all, appear to be highly entrepreneurial. Similarly, that organized medicine worldwide has resisted restrictions on physicians’ freedom to do what they want at the price they choose is not a new story (Glaser 1991). Yet this book’s account strongly reinforces that message.

At the same time, observing a much wider range of cases raises the odds that one will run across promising policies. Rodwin highlights how France restricts entrepreneurship in private practice: “Insurers generally do not reimburse diagnostic and laboratory tests performed, or drugs and vaccines dispensed, by physicians or physician-owned facilities” (221). When I needed a laboratory test in Paris while on sabbatical, my doctor would refer me to a freestanding facility. This was a bit of an inconvenience—but it also meant both that my doctor made no money from referrals and that I would not want him to refer me unless he was pretty sure it was necessary.

The study begins with a chapter that defines the topic and some of what is known about it. The following three sections discuss, in sequence, France, the United States, and Japan. Within each section, chapters provide accounts of the history and current state of conflicts of interest in the country and then evaluate existing policies (public and private) for

coping with physicians' conflicts of interest. The concluding section includes chapters on reforms and the prospects for professionalism to play an important role in governing medical care systems. An appendix provides more background on legal concepts of conflict of interest within each country, particularly the broader context of understandings about fiduciary or agency relationships.

The histories of how each medical economy developed are impressive. I will consult the accounts and some of the wide variety of sources when I next write about France or Japan. At a few points, however, completeness of review reduces the focus on the book's central theme: how economic arrangements influence the patient-doctor relationship.

"At the core of doctoring," Rodwin writes, "lies tension between self-interest and faithful service to patients and the public" (8). Yet one of the most useful aspects of the book is how it goes beyond self-interest of practitioners in its discussion of economic arrangements. Much of Rodwin's discussion addresses how pharmaceutical companies pursue profits.

Physicians often are given direct economic incentives to prescribe. This has been particularly true in Japan, where physicians have long earned much of their income from selling drugs, and the companies have ensured this by manipulating wholesale prices to guarantee good profits to physicians who sell at the retail price. Although government policies over the past two decades have sought to reduce the incentive for doctors to push prescriptions, the incentives remain substantial (190–191).

Yet there are other ways that both pharmaceutical and device companies seek to influence what physicians recommend to patients, and some of them involve indirect or no financial incentives to the prescribing physician.

Pharmaceutical sales forces attempt to persuade doctors in all three countries to prescribe their products. Both drug and device companies in all three countries like to provide "gifts" of one sort or another to physicians, which is certainly a direct economic incentive even if entirely unstated (64–69, 151–154, 196–197). And professional organizations in all three countries may claim to want to discourage such activity but resist doing anything that is likely to involve sanctions—member protection comes first. Yet even without gifts, pharmaceutical marketing can affect decisions simply by distorting the information received by busy practicing doctors.

Companies also seek to influence research and publications in many ways. Although that can implicate researchers in conflicts of interest, it works mainly by biasing information to practitioners who are not receiv-

ing payments. Companies become major sources of revenue for medical journals, either through advertising (in the United States) or through direct support (in France), and that too influences the flow of information to doctors. In both the United States and France, companies are deeply involved in continuing medical education (CME). Sometimes the companies pay for the doctors' attendance at the CME, but it also can work through the companies simply controlling the content of the education, in both the United States (135–37, 155–157) and France (64). In one chilling example, CME courses promoted the use of calcium channel blockers after heart attacks, which is estimated to have killed tens of thousands of patients (136).

In essence, “when physicians prescribe drugs, devices, and treatments and choose who supplies these or refer patients to other providers, they affect the fortunes of third parties. As a result, providers, suppliers, and insurers try to influence physicians' clinical decisions for their own benefit” (8). The fact that physicians can be more or less willing or conscious conduits for conflicts between other parties' interests and those of patients makes dealing with the full set of economic incentives to poorly serve patients more difficult.

Among this study's core concerns are how society can best promote “what is best in medical professionalism” and what role physicians and organized medicine should play in the medical economy (9). There is plenty of evidence for skepticism about giving authority over the medical economy to organized medicine or expecting medical professionalism to control conflicts of interest. This study adds to the previous work of Glaser and others in illustrating how organized medicine emphasizes the economic interests of individual physicians despite occasional claims to self-regulate to ensure ethical behavior. Physician organizations in France and the United States have demonstrated little interest in enforcing any stated policies about reducing conflicts of interest—and in Japan, little interest even in having policies. Yet Rodwin argues that there is a place for professionalism nonetheless, and one reason this should be considered is that physicians may share interests with patients *vis-à-vis* the other actors in the system.

This carefully argued book makes useful distinctions and generalizations. For instance, Rodwin distinguishes between conflicts based on financial incentives for physicians to overtreat or undertreat patients, and conflicts based on divided loyalty or dual roles (16). The latter pattern may deserve even more discussion than he gives it. Medical research continually poses the problem, both because of the need to ensure that patients are

available for research and, in some cases, doubts about the ethics of giving a placebo. Medical ethicists and cost controllers are continually promoting conflict by demanding that physicians think about resource allocation for the society as a whole, rather than just the needs of the patient being treated at the time. Rodwin is careful to provide cautions about his major arguments, such as when public provision of services can go wrong and when market forces can be helpful.

If the book has weaknesses, they are the flip sides of the treatments' strengths. The discussion of conflicts of interest directs attention to a wide range of concerns and so is more useful than the common focus on the incentives for providers created by payment systems. Yet in some ways the concept is too capacious. As soon as physicians are paid at all there is a conflict of interest, because physicians will normally want to be paid more and patients to pay less. We might ask for a principle of selection, specifying which conflicts are worse than others. One answer would be to say the difficulty arises when economic factors provide an incentive to make flawed treatment decisions. If this is the major problem, however, physician efforts to control prices would not be a concern. Yet the book does treat physician control of fees as an issue (237).

In reviewing a remarkable range of relationships and their conflicts, this book exacerbates a further difficulty. To prioritize problems one would need to measure the harm done by different forms of conflict. That, however, is far beyond the scope of this and perhaps any study. In the absence of any measurement, one may ask how bad the "problem" really is. For example, which country has the worst conflicts? Just from the description, Japan seems to have even more scope for abusive behavior than the United States. Yet the system is cheap, and people live a long time—one might ask if that suggests that conflicts of interest are not one of the more important problems to address. Moreover, if we cannot measure results, how are we even to say that a particular measure justifies its cost of implementation?

On balance, the evidence here convinces me and might convince most readers that even though Japan is cheap and healthy, the medical system could use some improvement. Conflict of interest provides a lens to identify concerns that might not be so obvious from topline data. Despite the lack of measures, it is also possible to evaluate some policies and judge their effectiveness. Rodwin updates a previous analysis, for example, to craft a devastating critique of disclosure (215–219). Yet the sheer scope of the enterprise does make one yearn, hopelessly for sure, for a shared metric to make sense of it all.

This study's extensive discussion ends with a series of recommendations that, based on the nonquantitative evidence available from the three countries studied, appears reasonable. It should be hard, from the range of behaviors described across very different countries, to disagree with such conclusions, as "physicians ought not claim that only they should oversee their conflicts of interest since they have not done so effectively" (247). Yet it is fair to say that inculcation of professional values of service must be part of any set of policies, flawed though that may be. There appears to be a case for greater public authority, and that includes greater reliance on public facilities—so long as efforts to reduce government funding do not lead to giving private practice rights that create incentives to favor patients who pay physicians directly. Excessive entrepreneurship can be restricted by banning some kinds of ownership and contract relationships (248).

The current system for funding medical research (and publication) in the United States just begs for abuse. Much more extensive regulation, likely accompanied by public funding and management of some trials, would address much of that problem (249). There are compelling arguments for some sort of collective funding for CME and other developmental activities within the medical profession (249). The Japanese demonstrated one approach by requiring that drug companies contribute to two regional funds, for which they are assessed in proportion to their market shares. The management structure of these funds leaves a lot to be desired, but that is not inherently difficult to solve (225–226).

Most of all, *Conflicts of Interest and the Future of Medicine* demonstrates convincingly that "self-regulation, disclosure, and minor tweaking of legal rules" (249) are highly unlikely to resolve the problems created by conflicts between the interests of those who make their living from medical care and those who need medical care to live. The "future of medicine" does not depend on doing better. But the future of some patients will.

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**CONFLICTS OF INTEREST AND THE FUTURE OF MEDICINE:
THE UNITED STATES, FRANCE, AND JAPAN**

Marc A. Rodwin
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In 1949, AS PART OF ITS CAMPAIGN OPPOSING PRESIDENT TRUMAN'S national health insurance plan, the American Medical Association sent physicians posters with the caption "The Doctor: Keep Politics Out of This Picture" to display in their offices. In the 1990s and early 2000s, many states enacted patients' bill of rights statutes intended to limit the power of managed care organizations over physicians' decisions. Most recently, critics of the health care reform legislation passed by Congress in 2010 claim that it constitutes a "government takeover of health care."

These episodes spanning more than 6 decades illustrate the persistence of a certain image of the patient-physician relationship in US health care politics. That image is of a physician disposed to serve only the patient's needs, provided that the physician can be shielded from the efforts of government or insurance company bureaucrats to deny treatment as a means of cutting costs. In *Conflicts of Interest and the Future of Medicine*, Marc Rodwin shows that this picture is far too simple, not just in the United States but also in France and Japan. The simple picture of patient and physician vs insurer fails to capture many other influences affecting physicians' decisions—eg, the interest of manufacturers of health care products in increased sales and the interest of physicians in increasing their own compensation—that often push physicians in the direction of offering more, not less, treatment. This is not always beneficial to patients, nor are the risks of iatrogenic harm and useless expenditure always fully recognized.

The book provides case studies and analyses of the complex forces affecting physicians' decisions in these 3 countries and the responses to these forces by both government and the medical profession. Like *Medicine, Money and Morals: Physicians' Conflicts of Interest*, published by the same author in 1993, *Conflicts of Interest and the Future of Medicine: The United States, France, and Japan* focuses on conflicts of interest affecting physicians and the profession, as opposed to manufacturers or researchers, but it updates that work and significantly expands it by offering a comparative perspective. This perspective enables the author to show that despite divergent historical and cultural backgrounds, organized medicine in all 3 countries has adopted strikingly similar positions on policies relevant to conflicts of interest.

In each of the 3 countries, it has been argued that physicians should be free to control treatment decisions with-

out interference by health insurance administrators. In all 3 countries, the leading medical societies have strenuously advocated fee-for-service reimbursement for physicians—and therefore opposed prepaid or group practice—and they have taken a lenient approach, at least initially, to gifts to physicians from pharmaceutical companies and other medical suppliers. Similarly, the medical profession in all 3 countries has relied heavily on commercial sources of funding for continuing medical education. On the other hand, the book demonstrates that when physicians' economic roles in health care delivery in these countries differ, treatment decisions also tend to diverge with them. For example, hospital length of stay in Japan is markedly higher than in the United States and France. It is unlikely to be a coincidence that physicians are also owners of hospitals in Japan to a much greater extent than in the other 2 countries.

The author notes how the reliance of the medical profession on commercial funding in these countries has created a symbiotic relationship that is resistant to change. As another example, also from Japan but indicative of a general pattern, gifts received by physicians "from outside companies reduce pressure for hospitals to increase physicians' salaries, giving administrators an interest in avoiding taking measures to end the exchange of gifts" (p 196). The list of strategies used to curb these influences is quite long. In the United States alone they include use of varied physicians' compensation structures, gatekeepers for treatment, drug formularies, pharmaceutical benefits management, disclosure rules, patients'-rights laws, statutes against kickbacks, and malpractice litigation. As with similar efforts in the other countries, these measures also have been in a near-constant state of flux. This is the result of something like a game of "cops and robbers" (p 145) in which legislators and regulators make one move, to which physicians and the profession respond, followed by another regulatory move, and so on.

Three of the book's 5 parts are each devoted to a single country. These parts are preceded by an introduction and followed by a final section describing reform efforts, some relatively successful, some less so. In light of the limitations of external regulation of the patient-physician relationship, one chapter in this final part examines the extent to which a renewed emphasis on professionalism can be an effective tool for addressing the problems from within. The book likewise includes a brief but interesting appendix concerning the concept of conflicts of interest and its roots in fiduciary law.

The book does have some shortcomings. It provides an impressive amount of historical detail, but the comparison of both history and the present state of affairs in the 3 coun-

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tries might have been aided by greater side-by-side presentation of information in text and in tables. It also fails to pursue in any depth the extent to which differences in patterns of treatment in these countries actually make a difference in outcomes for patients—a critical question. The reforms proposed in the conclusion are useful and wide-ranging, but they lack a more explicit analytical framework that reflects the challenge, if not impossibility, of designing incentives that encourage neither overtreatment nor undertreatment.

As a consequence, *Conflicts of Interest and the Future of Medicine* breaks no major new ground in the conceptual understanding of the problems it addresses. By providing a wealth of data demonstrating that these problems are by no means confined to the United States, however, it will be helpful to scholars as well as intriguing to readers new to the subject.

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BOOK REVIEW

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Money And Influence At The Bedside


BY M. GREGG BLOCHE

CONFLICTS OF INTEREST AND THE FUTURE OF MEDICINE: THE UNITED STATES, FRANCE, AND JAPAN

by Marc A. Rodwin

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The first rule of residency training, one learns early on, is to go along with all the unwritten rules. So I tested my luck one day, years back, when a drug company rep showed up to serve lunch—and to set up posters touting his product's purported triumphs. We were psychiatry residents, not surgeons, so lobster bisque wasn't served; we had to make do with turkey on rye. I was supposed to enjoy my sandwich and suppress unpleasant questions, but I couldn't resist being at least a bit bothersome. So I asked the drug rep how his company kept track of sales impact—of how lunches like this influenced our decisions to prescribe.

He became flustered, and I figured I was in for it. Sure enough, a day later, the director of residency training called me to his office to explain to me, tersely, that this was no way to treat a guest. I should have been grateful for the rep's generosity, not curious about his company's strategy. We were all ambassadors of the department, and I was expected to act like one.

In the nearly twenty-five years since, the medical profession has become more aware that gratitude of this sort

comes with a cost. For this, legal scholar Marc Rodwin deserves no small share of the credit. His 1993 book, *Medicine, Money, and Morals*, rigorously synthesized state-of-the-art knowledge about doctors' conflicts of interest and their impact on patient care. More visible authors, including three former editors-in-chief of the *New England Journal of Medicine*, also raised the profile of physicians' financial conflicts, but no one has tracked them as unrelentingly as Rodwin.

He's now tracked them on three continents (if Japan counts as Asia), and in his latest book, he reports the dismaying results. *Conflicts of Interest and the Future of Medicine: The United States, France, and Japan* details medicine's struggles with myriad temptations. Prescribing drugs, implanting devices, ordering tests, making referrals, and putting patients in hospitals all carry potential for rewards and penalties. And many see these rewards and penalties as legitimate. What's payola in the eyes of some is smart policy in the minds of others. Public officials, health policy wonks, corporate leaders, and many others have embraced the muscular use of "incentives"—to do less, to do more, or to do things differently—as tools for improving outcomes and controlling costs.

Some condemn such incentives as expressions of contempt for the Hippocratic ideal of uncompromising fidelity to patients. Others say this ideal is impractical, obsolete, or a thin veil for doctors' pursuit of financial advantage. To his credit, Rodwin offers a more nuanced appraisal. Incentive-free clinical practice is impossible, he points out; even salaried practice (urged by longtime *New England Journal of Medicine* editor Arnold Relman, among others) tempts and penalizes. And financial rewards for adhering to best practice or to agreed-on balances between cost and benefit have a place in policy makers' efforts to maximize the value that medi-

cal care yields. Rodwin concedes this—even embraces it. But he is methodical in his portrayal of medical commerce run amok.

His review of medical conflicts of interest in the United States covers familiar ground—drug and device companies' dominant role in continuing medical education (CME), doctors' ownership of diagnostic labs and imaging equipment, and distortions introduced by both fee-for-service and managed care's inducements to conserve resources. But he covers this ground so well that I will assign this part of his book to law students in my health policy course. Rodwin writes clearly, and he is soft-spoken but stinging in his account of organized medicine's resistance to limits on self-referral, enticements from Big Pharma, and other flows of lucre.

The medical profession's persistent defense of its opportunities to cash in is a distressing motif throughout Rodwin's book. French physicians have fought disclosure of patients' diagnoses to National Health Insurance funds for oversight purposes, and they've resisted their national legislators' efforts to stop drugmakers from offering expense-paid CME junkets. Japanese physicians have battled reformers' attempts to stop doctors from dispensing drugs and profiting from hospital ownership.

The book's focus on France and Japan as they contrast with the United States could fairly be called idiosyncratic. It arises from Rodwin's experiences living and studying overseas; he doesn't try to make the case that French and Japanese health care yield unique lessons about conflicts of interest. Yet he uses the contrasts to powerful effect, as a way of showing that conflicts of this sort cut across cultures and health systems. American medicine, Rodwin demonstrates, has no monopoly on avarice, and public insurance is no panacea against it.

He could have strengthened his message with some primary-source report-

ing on doctors' rapidly changing temptations. Investigative reporting on this subject (and many others) is on the wane, a victim of journalism's economic free fall. Unless scholars like Rodwin fill this gap—becoming producers, not just consumers, of probing inquiries into real-world practice—we will know less about tomorrow's financial advantage taking than we do about yesterday's. Temptation is fluid: Rewards and penalties keep changing as hospitals and insurers, drug and device makers, group practices, and many others adjust to shifting legal requirements and market conditions.

Here in the United States, the Affordable Care Act of 2010 presents a raft of possibilities for troublesome financial influence on professional judgment. Accountable care organizations, created with the goals of quality and efficiency in

mind, may offer new opportunities for doctors to profit from unseen skimming. Comparative effectiveness research, to be overseen by a board composed in part of health care industry stakeholders, presents fresh opportunities for distorting clinical investigation to serve purveyors of pricey tests and treatments. And patients' rights, granted by the Affordable Care Act, to external review of insurers' coverage denials could be undermined by a rarely noted conflict that Rodwin points out: The medical review firms that states employ to perform these reviews also vie for contracts with insurers to oversee their making of coverage decisions.

So I hope Rodwin sticks with this issue and inquires more aggressively into doctors' changing temptations. He has written an important book on an urgent topic, neglected by both political parties

in the ongoing battle over health care reform. There's no easy fix. Plainly, as he's shown, the medical profession can't be relied upon to police its own conflicts of interest or to push back against the blandishments of others in the health care industry. Perhaps the best we can hope for is the approach that Rodwin suggests—mixed oversight by the profession, the market, and the state, each with some power to check the others' excesses. ■

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Book Reviews

Review of Marc A. Rodwin, *Conflicts of Interest and the Future of Medicine: The United States, France and Japan*¹

Reviewed by Stephen R. Latham, Yale University

Health policy scholars often struggle with the question of what we can hope to learn from doing comparative research. As the editors of a recent book on comparative studies in health policy² point out (Marmor, Freeman, and Okma 2009, 10–11), it is one thing to learn about how other countries' institutions work and why they take the forms they do. It is quite another to attempt to glean domestic policy lessons from that kind of learning. Foreign practices, even when we can adequately describe and understand them, are sometimes too deeply rooted in culture and institutional history to permit their transplantation. It can be quite difficult to sort the kinds of national differences that are merely interesting from the kinds that might actually be useful to us here at home. Marc Rodwin's *Conflicts of Interest and the Future of Medicine* succeeds admirably both at helping us learn about other countries and at helping us learn from them.

Rodwin's topic is conflict of interest in medical practice. He addresses a broad range of types of conflict, including those created by various physician payment and incentive systems, by physician investment and self-referral, by financial ties to hospitals and insurers, and by professional (and professional-association) entanglement with drug and device firms. He does not pursue physicians' conflicts outside of medical practice, for example, in research or in management.

At the core of Rodwin's book are separate but parallel sections devoted to France, the United States, and Japan. Each section begins with a comprehensive, historical account of the evolution of each country's health care financing system. This is followed in each case by a separate chapter devoted entirely to historical description of the various strategies used by each country to limit, mitigate the effects of, or compensate for damages caused by medical conflicts of interest. These "case-study" chapters are copiously researched, and in his acknowledgments Rodwin notes that each was reviewed by an advisory board of experts from each country, as well as by numerous friends and associates from universities in each. The attentive reader will come

away from these chapters with a sophisticated and complex understanding of the evolution of the healthcare financing system in each of the countries. If these chapters have a fault, it is that Rodwin does not stray for a moment from his core topic. The legal and policy analysis might have been leavened pleasantly (and lent some useful context) by a few more sidelong glances toward simultaneous developments in each nation's history.

The case studies are, for anyone not already familiar with the French and Japanese medical systems, full of surprises. The prevalence of physician-owned health care facilities and self-referral in Japan will amaze a physician raised under the American Stark and anti-kickback rules. The fact that French physicians' code of professional ethics ("Medical Deontology") is enforceable as law will surprise Americans who know that the AMA Code of Medical Ethics has no legal force, unless a state medical licensing board or a judge voluntarily opts to enforce its standards in a particular case. The case studies also reveal a fair number of striking similarities among the countries: Sadly, it seems that physicians everywhere are reluctant to give up the practice of accepting gifts from pharmaceutical representatives, and that professional associations everywhere are completely reliant upon "pharma" money to fund continuing medical education (CME).

After the "case study" sections come two chapters designed to synthesize lessons learned from the earlier comparisons. One is an overview of a number of common approaches to conflict-of-interest control. Rodwin pulls no punches, announcing that the experiences of the three countries have led him to conclude that a number of traditional reforms aimed at conflict of interest in medicine just don't work. These include replacing investor-owned firms with nonprofit or physician-owned firms; deferring to professional self-regulation; relying on market competition; publicly employing all physicians; increasing physician liability; and disclosing conflicts. More promising approaches include increasing the amount of medical care supplied

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outside private practice; restricting entrepreneurship within private practice; overseeing entrepreneurial physicians; regulating incentive payments; regulating and limiting ties to third parties, including drug companies; and protecting professional judgment from interference by cost-conscious insurers and employers. Rodwin supplies detailed arguments for each conclusion, based on the evidence gathered in his national case studies.

Rodwin devotes a separate, and very interesting, chapter to the analysis of professionalism and professional self-regulation. The experiences of Japan, France, and the United States seem to indicate that complete deference to professional self-regulation is a nonstarter; Rodwin recognizes, however, the importance of self-regulation in reducing and mitigating conflict-of-interest problems if that self-regulation is channeled and prodded by regulatory and market forces.

The book will be of great interest to health policy analysts, health lawyers, physician leaders, regulators, and bioethicists. It is a model of descriptive and analytical comparative analysis. One complaint: The book is anchored in the intuition that conflict of interest can be dangerous and costly, and that it is therefore good to find strategies to eliminate it where possible, and to limit its impact otherwise. While most readers will share this intuition, the book would have been strengthened if Rodwin had spent more time with data showing the real impact of conflicts on patient care and on health care costs. His analysis seems rather abstract at times; the occasional reminder that conflicts of interest can

really hurt people both medically and financially would have assisted in grounding the analysis and sustaining the reader's interest in it.

And it is necessary, alas, to register one final, small, technical complaint about this otherwise fine book. The production values of university presses simply are not what they used to be. The book—and particularly its notes and index—could have used some serious copy-editing and proofreading. Former AMA President Nancy Dickey becomes Nancy Dicey; JAMA editor and historian Morris Fishbein is sometimes Morris Fischbein; bioethicist Haavi Morreim is sometimes Haavi Morrein; medical historian Richard Shryock is sometimes Richard Shyrock. A book by Paul Starr has a different name on page 281 than on page 283. Eliot Freidson's name is spelled two different ways within a single footnote to chapter 11. In that same chapter, the first, second, and fourth references to one of Freidson's books include his first name, but the third and fifth do not—and so on. In such a densely researched book—the endnotes, bibliography, and index combined take up more than a hundred pages—there will inevitably be a few mistakes. Unfortunately, in the scholarly machinery of Rodwin's book, there are many more than just a few. ■

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Marmor, T. R., R. Freeman, and K. G. H. Okma, eds. 2009. *Comparative studies and the politics of modern medical care*. New Haven, CT: Yale University Press.

1. Bloomington: Indiana University Press, 2009. 147 pp. \$19.95.

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Conflicts of Interest and the Future of Medicine. Marc A. Rodwin. Oxford, UK: Oxford University Press, 2011. 392 pp. \$29.95 (cloth).

This book, which includes an impressive collection of advanced praise, is a comparison of how conflicts of interest in medicine manifest themselves in the United States, France, and Japan. It aims to address a considerable problem—how physicians cope with the pressures of the entrepreneurial role they are often asked to take, the increased influence from “big pharma,” and their increased employment in investor-owned firms, as well as balance these areas of their work with the loyalty to their patients and their professional identities. Marc A. Rodwin shows that these conflicts may be most obvious in the United States but are also very apparent in France and Japan as well, though the interplay of the medical profession, the market, and the state filter conflicts of interest and give rise to different strategies for coping with them.

Rodwin begins with a brief statement outlining the background and context of his book. He then discusses the evolution of medicine in each country under study, followed by an account of the particular conflicts of interest each has led to. The treatment of the United States is most fulsome, stretching to four chapters, whereas France and Japan get only two each, with this being due to the more nuanced nature of account of the evolution of U.S. medicine. U.S. medicine is sorted into "before 1950"—the protected medical market, 1950–1980—the commercial transformation, and 1980 to the present—the logic of medical markets.

Once Rodwin presents his accounts of the three nations, he is able to draw implications from his analysis, exploring the nature and type of the reforms in each country as well as the implications for medical professionalism. He then concludes by suggesting some ways forward for dealing with conflicts of interest in the future.

It is hard not to be impressed by the depth of learning shown in this book. Rodwin presents a coherent account of the development of medicine in three countries, drawing relevant comparisons as he does so, identifying key sites where conflicts of interest are likely to arise. He is able to show how those sites vary from country to country and explore how they arose through the distinctive evolutionary path of medicine in each. This is a major scholarly achievement.

Any criticism that I make of the book has to be contextualized in light of how good a piece of comparative research it is—but I do have a few concerns. First, I think that the author takes a rather conventional view of professionalism, utilizing as we might expect authors such as Freidson, when considering more recent scholarship that explores the performativity of professionalism might have provided an opportunity for demonstrating how ideas about professionalism have changed in the period Rodwin studies. This would have made his account of professionalism potentially even more compelling—there is a slight sense that it is the context within which medical professionalism has to work that has changed, when it is also surely the case that the way professionalism is conceptualized that has undergone a significant change too.

A second criticism is that Rodwin gives himself so little space to explore the "the way forward" in his book—less than four pages. He clearly has a great deal to say on conflicts of interest in medicine, and I would have liked to see him develop his arguments more at the end of the book, picking up particularly on the way he argues in his accounts of the development of different countries that their unique contexts have framed conflicts of interest there. Rodwin gives us parallel accounts of the development of conflicts of interest but presents us with only one clear outline of a solution. His solutions are all very sensible, but surely they also need to be contextualized in terms of their potential success in each of the countries studied rather than concluding with a one-size-fits-all approach? The last chapter is very United States centric, while the proceeding gains its strength through a comparative approach. This is a shame.

These relatively minor quibbles aside, this is a very good book indeed. I would have no problems recommending it for courses on health policy, but I also hope it will be used in medical schools to explore the kinds of challenges the profession faces in relation to conflicts of interest.

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Conflicts of Interest and the Future of Medicine: The United States, France and Japan. By Marc A. Rodwin. New York: Oxford University Press, 2011. 392p. \$29.95 cloth, \$24.95 paper. doi:10.1017/S1537592713002673

— Miriam J. Laugesen, *Columbia University*

Marc A. Rodwin's new book explores how Japan, France, and the United States sometimes succeed, but often fail, to address conflicts of interest in medicine. Since Rodwin's first book on the United States was published (*Medicine, Money and Morals*, 1993), more scholars have explored the collision of physicians' clinical and pecuniary interests. This expanding body of research has led to more awareness of conflicts of interest, and may have helped focus congressional attention on the need for new policies. Starting in 2014, the Physician Payment Sunshine Act will require pharmaceutical companies to publicly report payments made to physicians.

Much of this book focuses on financial conflicts of interest, where financial rewards rather than patient needs can influence treatment. Rodwin also addresses conflicts that arise from divided loyalties, such as instances of physicians treating patients who are participating in their research trials; these loyalties can also be influenced by financial incentives. Financial conflicts vary depending on physicians' ability to increase or substitute the services they provide, refer patients to facilities they own, choose self-employment over salaried employment (although salaried physicians can receive incentives that create conflicts of interest), and whether they receive payments on a fee-for-service basis. Organizations can provide financial incentives, either directly (via fees and consulting arrangements, for example) or indirectly (by sponsoring a medical society's conference).

Financial conflicts of interest are rife worldwide. A similar entrepreneurial itch afflicts physicians everywhere: Physicians in prestigious public hospitals in Japan apparently receive cash payments from patients (patients reportedly pay around a month of their salary), even though such payments are banned. Media cartoons in the book indicate that cynicism regarding the monetization of medicine transcends national borders, even if policymakers often look the other way.

This is an important contribution to our understanding of institutionalized conflicts of interest in medicine, and it contributes to our understanding of health-care politics and comparative health policy. In all three countries, physicians' associations have opposed and secured independence from regulation (though less so in France) by leveraging their professional status. They have successfully claimed that the profession, not government, is the best arbiter of conflicts of interest. In contrast to most comparative work on physician political power, which frequently focuses on organized medicine's role in fighting national health insurance, Rodwin's vantage point provides

insights into the politics of private-sector medicine and the broader political economy of health care. We learn about long-standing disagreements over physicians' rights to refer patients to physician-owned facilities in the three countries.

Physicians' associations have employed Cassandra-like warnings of negative patient impacts when regulations are proposed. French physicians successfully fought early efforts by insurers to review the services they provided to individual patients on the grounds that it would compromise patient privacy. Privacy of medical records was protected, while scrutiny of physicians was conveniently removed. Opposition to salary-based compensation was justified on the grounds that it would create conflicts of interest for physicians and harm patients. Physician organizations argued against limits on pharmaceutical funding because attending (generously funded) meetings would benefit patients—physicians said they could learn about the “latest” and most advanced treatments.

Rodwin reels in considerable information about the current delivery systems, financing, and broader policy issues in each country. His account of Japanese health care is particularly welcome, given relatively fewer English-language books available. He also reviews current physician–government relations in France and gives a full account of recent changes in physician reimbursement policies there.

The book captures the relative lack of attention paid to conflicts of interest by policymakers compared to other policy goals; health policy reformers are more likely to give priority to cost containment or quality improvement, and overlook conflicts of interest. Therefore, new policies inadvertently create new conflicts of interest. For example, policies mandating continuing physician education (to improve the quality of care) opened the door for pharmaceutical companies to fund continuing medical education courses.

The pharmaceutical industry is not the only generator of conflicts of interest, even if drug companies are frequently discussed in the media. Rodwin is equally concerned with the insidious and seemingly innocuous everyday conflicts of interest in physician practices. The medical treatment we receive is molded by the national regulatory framework, or lack of it. When conflicts of interest are weakly regulated, physicians may recommend or provide unnecessary care, which raises the potential for medical errors or false-positive results. Physicians in Japan and the United States can refer patients to imaging centers and other physician-owned facilities, and arrange for physician-administered drugs. France is stricter, and these kinds of services are usually not reimbursed. However, Rodwin also acknowledges that patients can benefit from some of these arrangements: In-office testing provides real-time information and convenience. He argues, therefore, that conflict-of-interest policies must weigh the likelihood

of conflict of interest occurring and its costs against benefits to the patient.

Physician organizations cannot adequately address or substitute government oversight of conflicts of interest. While professional organizations sometimes discourage unethical practices, historically their concern has been only a veneer, and weak “ethical” codes of conduct are perfunctory. Likewise, we can infer from the book that universal coverage is likely to be a necessary, but not sufficient, condition for eliminating conflicts of interest, Japan being a clear example. It may be preferable, on balance, since a lack of universal coverage seems to provide the conditions for an unregulated private health-care sector. This can also lead to contradictions later if government develops its own programs. Rodwin contrasts the robust U.S. anti-kickback laws that apply to Medicare (although they are relatively recent) with the lack of protection for privately insured patients. Universal coverage is not sufficient for eliminating conflicts of interest (e.g., Japan); the key intervention is limiting the independence of professional associations. In France, the historic regulation of guilds and associations constrained professional power, although France still falls short by keeping professional disciplinary proceedings secret and failing to regulate privately paid physician services.

Rodwin reviews various policy solutions, including converting for-profit to not-for-profit organizations, increased professional self-regulation, more market competition, salaried government physicians, higher malpractice liability penalties when physicians refer patients to their own facilities, and stronger disclosure laws. He raises important questions about the value of disclosing financial conflicts of interest. For example, when and how should information about financial incentives be provided to a patient? Should physicians provide disclosures to patients directly? Given that people exhibit cognitive dissonance in that most patients will not want to see *their* physician as compromising their treatment for financial incentives, can disclosure be effective? For the United States, Rodwin recommends more public employment of physicians, tighter controls on entrepreneurial behavior, and more regulation of financial ties with third parties. He advocates engaging professional medical judgment in the defining of clinical criteria, but under conditions of transparency and independence. Scholars of bureaucracy and politics might add that formal institutional responsibility, in the federal government, is also needed for regulating conflicts of interest, not only in the public sector but also in the private sector.

Among political scientists, *Conflicts of Interest and the Future of Medicine* is likely to be of most interest to those who study the politics of health care. The book does not seek to advance theories of policymaking or interest-group behavior. Political scientists might interpret Rodwin's findings through the lens of interest-group politics, or suggest that concentrated interests are more likely to

triumph against patients, who naturally have fewer incentives to mobilize. Indeed, physicians' political successes do reflect their steadfast and stubborn protection of their turf. But these explanations do not completely account for the larger puzzle of why the medical profession has enjoyed a long-standing and persistent independence from government. Perhaps the answer is that legislators have significant trust in physicians and physician organizations. A high level of trust might lead legislators to discount potential conflict-of-interest issues, such that they do not gather momentum. And while there is generalized cynicism about the role of money in health care, policymakers, like patients, may not *want* to see physicians as influenced by financial incentives. However, legislators in the United States are taking small steps to address conflicts of interest, and attitudes might be shifting. This book provides thoughtful insights on past, current, and future conflicts of interest in medicine for scholars and policymakers alike.

Book Reviews

Conflicts of Interest and the Future of Medicine: The United States, France, and Japan. By **Marc A. Rodwin**. New York, N.Y.: Oxford University Press. 2011. 392 pp. \$29.95 (paper).

The U.S. health care system is becoming increasingly compromised as conflicts of interest tempt physicians away from their primary duty of providing health care determined by the needs of the patient. The entrepreneurial system that is generally so healthy in the marketplace has become remarkably unhealthy for the relationship between physicians and patients. Doctors find themselves influenced inappropriately in their clinical decisions, not covertly, but in an explicit manner by pressures connected with big pharma and biotechnology companies, the insurance industry, investor-owned companies selling medical devices, and other financial incentives. Not surprisingly, patients across the nation are perplexed about the shocking range of conflicts of interest that undermine the loyalty and independence of physicians.

The public is now sufficiently aware of and appalled by the egregious practices that have caused this astounding professional compromise on the doorsteps of our health system. The pressure from providers, suppliers, and insurers generates a pervasive and utterly unacceptable tension between the physician's self-interest and the physician's fiduciary obligation to the patient. Medical professionalism and financial incentives in the medical economy are at war in modern health care. An ethical analysis of this national concern

is overdue to restore and foster trust. Marc Rodwin embraces the challenge in an exemplary study that addresses head-on the conflicts of interest that physicians encounter daily in the U.S., comparing our scorecard with what is occurring in France and Japan, countries that adopt similar approaches to the delivery of medicine. Of course, it is unlikely that there could be a single solution for every nation. Rodwin appropriately considers in a nuanced way a range of measures in the public and private sectors to assess the relative effectiveness of alternative strategies to address physician conflicts of interest. He seeks to protect medical professionalism by mitigating these conflicts through reform and regulation of health policy, and better connecting the market, the government, and the medical profession.

In general, conflicts can be associated with two related but distinct roles of the physician, and each needs to be rigorously scrutinized if we are to make the dramatic improvements that are needed. On the one hand, financial conflicts of interest occur when incentives bias the physician's service, for instance, when providing treatment contrary to the patient's needs or against the criteria of good medical practice. On the other hand, divided loyalty can generate conflicts when a physician has overlapping or dual roles, which occurs when a patient under treatment is involved in a clinical research trial that provides financial gain to the physician. Here is the insidious problem about both types of conflict of interest. Both dual roles and financial incentives can actually be helpful for patient care when properly

managed; for example, when incentives focus on objective measures for medical outcomes, quality improvement, or patient satisfaction, or when a patient nobly participates in a clinical trial (without financial gain to the physician), understanding that the trial's benefits are focused upon other patients and society. However, the problem of conflict of interest arises because what could be constructive for patient care becomes destructive of the medical covenant when physicians lose sight of their professionalism by yielding to lucrative revenues that they may accrue.

Rodwin presents a tour de force by arguing against a hefty and dominant body—the medical profession—to dramatically diminish the conflicts of interest that pervade the medical culture today. Insightfully, and indeed courageously, he advocates for reforms and policy strategies to accomplish laudable goals: to prevent, as much as possible, doctors and organized medicine from entering situations that pose conflicts of interest; to require disclosure of such conflicts (when they do arise) so that those who are affected can take protective measures; to regulate or supervise physician conduct in order to reduce such conflicts from breaching trust or abusing medical discretion; and to penalize physicians who violate patient trust, especially when harm is caused, by imposing sanctions and requiring restitution. The measures he advocates include daunting changes—for instance, exhorting physicians to rely more on government and lay oversight, such as having third-party organizations directed by nonprofessionals manage their conflicts of interest.

In general, Rodwin adopts a posture similar to the longstanding debate about decreasing medical errors to support patient safety: build systems and do not rely on the individual practitioner. However, there is a surprising omission in Rodwin's analysis insofar as he seems to overlook the crucial significance of endeavors to foster ethical virtue among physicians and health care organizations. Certainly, he advocates that physician organizations should develop ethical standards and policies for medical practice, continuing medical education, and so forth. But much more is needed to design systems that foster individual and

organizational virtue as an explicit enterprise of ethics education in medicine.

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MARC A. RODWIN, *Conflicts of Interest and the Future of Medicine: the United States, France and Japan*, Oxford University Press, New York, 2011, Hardback, 384 pp., £18.99.

Conflicts of interest in medicine are inevitable and pervasive in medical practice, institutions, publications, and research.¹ The evolving structural changes in healthcare delivery and organisations have added new potentials for conflicts to emerge. Preventing conflicts of interest is paramount to ensure that the vulnerable party does not become a victim to the conflict and that their interest will be protected. Conflicts may arise from, for example, receiving pharmaceutical companies' sponsored gifts, conference attendance, or research grants. Although various measures have been proposed to minimise conflicts, including conflict disclosure,² state oversight,³ and internal regulation, it still persists. Among these measures, conflict disclosure and the call for stronger regulation have often been assumed as effective in countering conflicts of interest.⁴ However, the relationship between physicians and pharmaceutical companies, for instance, can never be completely eliminated,⁵ and any conflict cannot be resolved simply by disclosure because patients may not adequately possess the tools to process the information and decide the gravity of the conflict affecting the physician's judgement.⁶ Likewise, stronger sanctions and regulatory oversight may 'only [be] a partial answer to managing conflicts of interest' and 'ethical

¹ LK Stell, 'Two Cheers for Physicians' Conflicts of Interest' (2004) 71 *Mount Sinai J Med* 236.

² BM Dickens and RJ Cook, 'Conflict of Interest: Legal and Ethical Aspects' (2006) 92 *Int J Gynecol Obstet* 192.

³ DW McFadden, E Calvario, and C Graves, 'The Devil Is in the Details: The Pharmaceutical Industry's Use of Gifts to Physicians as Marketing Strategy' (2007) 140 *J Surg Res* 1.

⁴ B Lo, 'The Future of Conflicts of Interest: A Call for Professional Standards' (2012) *J Law Med Ethics* 441.

⁵ JS Alpert, 'Doctors and the Drug Industry: Further Thoughts for Dealing with Potential Conflicts of Interest?' (2008) 121 *Am J Med* 253.

⁶ SJ Immelt, VA Gaudiani, and RM Sade, 'Should the Financial Link between Industry and Physician Consultants be severed?' (2011) 92 *Ann Thorac Surg* 781; RS Foster Jr, 'Conflicts of Interest: Recognition, Disclosure, and Management' (2003) 196 *J Am Coll Surg* 505.

ideals cannot be legislated'.⁷ This is important because conflicts of interest involve professional conduct and its effect on the patient, which originates from a moral code. Thus, there may be situations where it is difficult to legislate morality in order to solve conflicts of interest.

Rodwin's latest work on conflicts of interest and the future of medicine continues from his previous work on conflicts of interest in medicine.⁸ The current book consists of eleven chapters divided into five parts, and provides an insight into how the US, France, and Japan approach conflicts of interest and provides an assessment of the effectiveness of the strategies they have adopted. Managing conflicts of interest is vital because 'medical professionalism has a moral core that both justifies physician authority over medical practice and regulates these conflicts. But physicians' conflicts of interest compromise medical practice and undermines the credibility of physicians and professionalism' (p. 9). In Part I, comprising the Introduction and Chapter 1, Rodwin points out that practice arrangements affect the doctor-patient relationship (p. 7). He illustrates this via three patient stories, each suffering from heart attack yet treated differently by their physicians who were influenced by a network of medical, legal, and political systems. Conflicts of interests arising from the interplay of this network implicate the post-treatment risk of complications and future cardiac problems (p. 6). This thesis is developed in Chapter 1, where Rodwin cautions that the failure to cope effectively with conflicts of interest undermines the credibility of physicians and medical professionalism. In pursuing this theme, he examines the political economy of the US, Japan, and France because these countries are 'post-industrial democratic societies, which demonstrates how differences in the roles of organised medicine, markets and the state affect the existence and resolution of physicians' conflicts of interest' (p. 9). Rodwin asks 'in what context can physicians be trusted to act in their patients' interest? How can society promote what is best in medical professionalism? What roles should physicians and organised medicine play in the medical economy? What roles should insurers, the state, and markets play in medical care? The future of the medical profession will be shaped largely by how society answers these questions.' (p. 9).

He identifies two overlapping sources of conflicts of interest; financial and divided loyalty (p. 15). He explains that 'financial conflicts of interest arise from incentives that bias physicians-increasing or decreasing services, provide one over the other while divided loyalty occurs when physician perform roles that interfere with their acting in their patients' interest or when their loyalty is split between the patient and third party', for instance, 'conducting experiments on new drugs while simultaneously treating patients.' (p. 16). He argues that the six common remedies for physician's conflicts of interest (which include replacing investor owned firms with physician owned or physician directed organisations or not for profit organisations, and organised medical profession being granted greater authority in overseeing medical

⁷ RS Foster Jr, 'Conflicts of Interest: Recognition, Disclosure, and Management' (2003) 196 J Am Coll Surg 505, 515.

⁸ MA Rodwin, *Medicine, Money and Morals: Physicians' Conflict of Interest* (OUP, Oxford 1993).

practice to eradicate external influences on physicians) were inadequate from the experiences of the three countries (p. 21). Meanwhile professional monopoly is replaced with promoting market competition and employing all physicians as public servants to eliminate profit motives. Furthermore, the court is tasked with making physicians legally accountable as fiduciaries. Rodwin argues that a popular strategy, disclosure of conflicts of interest, in fact, neither solves the problems nor provides safeguards (p. 21). For example, although the French Drug and Medical Product Safety Agency requires experts serving on its advisory panels to disclose their financial ties to pharmaceutical firms, these experts rarely recuse themselves, resulting in an outcome where conflict is considered disposed when it is disclosed (p. 56).

Having framed the issues in Part 1, Rodwin considers the presence of conflicts of interest and the strategies used in France in Chapters 2 and 3. He notes that in France rigorous state intervention in managing physician conflicts of interest has been adopted, and all physicians are prohibited from earning income by prescribing ancillary services they supply. French policies on conflicts of interest require that public employees serve the state's mission rather than private interest. However, private practitioners in entrepreneurship, fee-for-service payment, and financial ties to commercial interests, particularly in drug and medical device firms, are liable to have conflicts of interest (p. 27). The state, in turn, restricts the scope of entrepreneurship within private practice by controlling the licensing, planning, and regulating the operation of private hospitals (p. 12). However, the state has, thus far, been unsuccessful in ensuring that physicians only supply appropriate services. Apart from state control, other measures to cope with conflicts of interest include professional self-regulation, regulation of gifts and funding (p. 64), and continuing medical education (p. 69). Unlike in the US and Japan where medical codes are voluntary, medical codes in France have the status of law governing the relations among physicians and between physicians and third parties (p. 62).

Part III, consisting of Chapters 4–7, is lengthier than the preceding parts and provides an in-depth examination of the evolution of medicine in the US and the strategies employed in containing conflicts of interest. A distinctive feature of the US health system is the dominance of markets and the private sector. However, market freedom appears to enhance the variety and scope of physicians' conflicts of interest resulting in government interventions which 'have had only minimal effects because of the remarkable adaptability of entrepreneurs' (p. 12). Investor-owned insurers and medical facilities control a much larger market share in the US compared with France or Japan; thus, Rodwin points out that the sources of conflicts of interest are deeply embedded in the primacy the country gives to entrepreneurial private practice and market freedom, together with its reluctance to impose public oversight (p. 144). In responding to the challenges posed by conflicts of interest, the American Medical Association maintains 'that insurers should not control physician payment or clinical choices and [adopt] insurance principles that [preclude] National Health Insurance, prepaid group practices and private insurance that paid physicians directly rather than reimbursing

patients' expenses' (p. 141).⁹ Fee-for-service payment and activities that encourage physicians to recommend services create conflicts of interest, and this has been countered by managed care financing and organisation (p. 142). Although 'practice guidelines, gate keeping and utilisation review can serve as alternatives to financial incentives that create conflicts of interest', this does not necessarily result because they are subject to the aims and content of practice guidelines (p. 143). Rodwin argues that the cooperative effort among professional and industry self regulation, managed care organisation oversight and the law sometimes undermines the efforts and authorities of the others (p. 159). Indeed, the failure of professional self-regulation in coping with systemic conflicts of interest have led the state and insurers to intervene (p. 159). For example, insurers were authorised by the state to oversee private practice, and the state intervened by 'moderately regulating physician self referral', setting 'quality standards for tests performed in all physician office laboratories' (p. 159). The federal government, however, plays a limited role in overseeing health issues, and Medicare and Medicaid are the main vehicles for regulating physicians via the Medicare and Medicaid Anti Kickback Act, Stark Law, Civil Monetary Penalties Law and the Food, Drug and Cosmetic Act and tax law. In contrast, state laws oversee not-for-profit and for-profit corporations, health care institutions, professional licensure, and accreditation, insurance, and managed care. However, regulation only addresses the issue partially because of the modest goals it sets and the ways in which laws are easily flouted (p. 144). For example, while the Anti-Kickback Act prohibits kickbacks, 'some providers disguised kickbacks by claiming that payments were for services rendered, or used in-kind payment rather than cash' (p. 145).

In Part IV, Chapters 8 and 9, Rodwin examines the Japanese medical culture and the presence of conflicts of interest. The Japanese medical economy allows doctors to dispense drugs, perform clinical tests, and supply ancillary services, while medical suppliers pay physicians kickbacks to induce sales (pp. 7, 195). Private practitioners simultaneously prescribe and provide services, and this compromises their ability to make unbiased treatment decisions (p. 201). However, physicians in public hospitals on a fixed salary have no incentive to make particular clinical choices. Furthermore, while publicly employed physicians can be criminally prosecuted for accepting kickbacks, their counterparts in private practice cannot (p. 194). The Japanese state operates public hospitals with employed physicians, thus avoiding entrepreneurial and payment conflicts. It also regulates physicians, hospitals, and the pharmaceutical and medical device industries in the private sector (p. 184). In response to conflicts of interest arising from supply services and physician entrepreneurship, legal reforms have been introduced to restrict the ability of physicians in owning medical corporations and hospitals, and to prohibit publicly employed physicians from accepting kickbacks and gifts (p. 184). Similarly, while promoting open markets and attempting to reduce conflicts of interests, the Japan Fair Trade Commission

⁹ American Medical Association House of Delegates, 'Sickness Insurance Problems in the United States' (1934) 102 J Am Med Assoc 2200.

permits pharmaceutical companies to collectively fund professional medical activities but prohibits individual payment of premiums to physicians (p. 184). Other strategies to reduce conflicts include reforming payment (p. 185), restricting physician dispensing and ancillary services (p. 190), reforming hospitals and professionalising practice (p. 192), as well as overseeing gifts and commercial funding to physicians (p. 194). With regards to reforming payment, this could include paying only for preferred treatment in some diagnoses, and Rodwin cites the example of stomach ulcer treatment where payment is made for antibiotics as the preferred treatment instead of alternative medications which are more expensive (p. 185). Unlike in France and the US, in Japan organised medicine plays no role in overseeing conflicts of interest or other aspects of practice through ethical codes, professional discipline, or practice guidelines. Rodwin argues that the strategy of banning investor-owned firms in Japan does not resolve conflicts because despite the absence of investor-owned clinics, physicians were still caught in conflict owing to the (limited) ability to dispense drugs, supply ancillary services, and own most of the hospitals and clinics (p. 211). In respect of reforms in collective funding, Rodwin suggests that the industry has the flexibility to decide the type of medical activities to fund, and this enables them to promote activities that highlight drug therapy rather than other important medical practice issues (p. 15).

The fifth and final part of the book addresses physician professionalism as a reform measure. In Chapter 10, Rodwin identifies four key policy strategies in his reform proposal which are preventive in nature: (i) prohibiting individuals from entering situations that pose conflicts of interest, (ii) requiring disclosure of conflicts of interest, (iii) regulating conduct to reduce opportunities for physicians with conflicts of interest to breach trust or abuse discretion, and (iv) imposing sanctions on individuals who violate trust and require restitution (p. 207). Using the three countries as examples, Rodwin demonstrates the inadequacy of conventional reforms. For example, he points out that replacing investor-owned firms with physician or not for profit-owned entities in Japan, professional self-regulation in France, US, and Japan, relying on the open market in the US, publicly employing all physicians in France, US, and Japan (p. 210), holding physicians to fiduciary standards and increasing their liability for patient injury in the US, and disclosing conflicts of interest do not sufficiently manage conflicts of interest (p. 211). He argues, instead, that the combined lessons drawn from the experiences in France, US, and Japan reveal six strategies in coping with physicians' conflicts of interest; 'increase medical care outside of private practice; restrict entrepreneurship within private practice; oversee entrepreneurial physicians; regulate payment incentives; restrict and regulate ties with third parties, and protect professional judgement' (p. 219).

In Chapter 11, he further explains his reform proposal by reconsidering medical professionalism. He argues that professionalism is but one way of mitigating conflicts of interest (p. 241). As physicians have been ineffective in resolving their own conflicts of interest, they should accept state intervention in reforming the medical economy and be prepared to participate in broader change through professional organisations and civic engagement, and the public should also reform federal health policy, citing the US as an example

(p. 247). Structural changes are significant in addressing conflicts of interest (p. 248), and he suggests expanding the public and not-for-profit sectors. Proper management of publicly owned medical facilities diminishes physician conflicts of interest and leads to excellent care provision. In order to achieve this, Rodwin proposes that the US federal government must make public employment more financially attractive, regulate the size of the entrepreneurial medical sector, and subsidise the growth of not-for-profit practices to ensure alternatives to the public and entrepreneurial sectors. For the US, he suggests that 'Congress should also extend its regulations of kickbacks, false claims and gifts in the Medicare and Medicaid programs so that they apply universally'. In addition, 'it is unnecessary for the law to define these organisations or their employees as fiduciaries to patients; it only needs legislation to impose certain legal obligations for them to act in patients' interests-or to not harm their interests' (p. 246). Rodwin's reform proposal appears to emphasise a public-led initiative as an effective reform measure. For example, he proposes that a way to eliminate potential conflicts of interest is to allow practice guidelines to be made under the domain of public auspices instead of commercial firms with financial motives in mind. Likewise, decisions about whether certain types of treatment are classified as necessary or experimental when disputes arise between insurers and patients should be overseen by public authorities. In addition, public authorities should raise and allocate funds for crucial medical activities instead of relying on commercial medical firms and insurers. In respect of accreditation for continuing medical education, public funding derived from a tax on the industry, medical institutions, and physicians should eliminate the conflicts of interest which arise from sponsorship by commercial firms. Laws, on the other hand, 'should require that the evidence used to evaluate applications for marketing products come from studies conducted independently of firms that patent, develop or sell the product and that the studies are conducted under FDA oversight. When firms wish to conduct phase III clinical trials, they should supply the funds to a subsidiary of the FDA, which would contract with independent firms to design, and conduct the evaluation. Individuals who perform this work should be barred from employment with affected commercial interests for several years' (pp. 248–249).

One of the strengths of this book lies in the fresh, practical approach Rodwin proposes in which conflicts of interest in medicine can be managed. The suggested reform measures provide an alternative approach in conflict management, drawing from the experiences of the three countries he examines. His book and the relevance of the topic will appeal to policy-makers, practitioners, and scholars interested in solving the thorny problem of conflicts of interest. The bibliography, together with an extensive literature and notes to the chapters, provide a rich source of reference for those seeking to investigate this area further. One minor weakness is that due to the detailed historical contexts in each chapter, readers may, at times, feel dissociated with the issue Rodwin tries to highlight. However, the arrangement may appeal to scholars interested in the medical history of the three countries as they have been carefully documented and referenced. French terms, which are used throughout Chapter 2, are explained in a glossary in English, which is helpful to readers interested in pursuing that area

further. Furthermore, the appendix contains a short description of the origins and applications of conflicts of interest to physicians in the three jurisdictions surveyed, and this brief account provides a helpful context for readers in locating the issues identified in the book. Overall, Rodwin has made another important contribution to the rich discussion on conflicts of interest in medicine.

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Book Review

Marc A. Rodwin, *Conflicts of Interest and the Future of Medicine: The United States, France and Japan*, Oxford: Oxford University Press, 2011. Pp. ix-375. £29.95. ISBN 978 0 19 975548 6.

Comparative histories of any subject, including medicine, are of enormous value, yet most of us lack the patience or energy to do such work. Thus we have all the more reason to be grateful to those scholars who do, among them Marc A. Rodwin, whose book *Conflicts of Interest and the Future of Medicine* provides a comparative perspective on a particularly challenging subject: economic conflicts of interest in medical practice. By comparing how conflicts of interest and their regulation have evolved historically in France, the U.S. and Japan, Rodwin provides a fascinating, well-informed account of the changing economics of modern medicine.

Building on his 1993 book *Medicine, Money, and Morals* (Oxford University Press, 1993), which looked at the United States, Rodwin broadens his analysis to include France and Japan, two postindustrial democracies with very different traditions of medical organisation. For each country, he provides a historical overview of the medical profession, with special attention to the evolution of financial incentives that often compromise clinical standards. These arrangements include physicians who own hospitals or testing facilities and thus profit by referring their patients there, physicians who receive gifts from drug companies to influence their prescribing patterns, and physicians who receive fees for recommending patients to other doctors. Historian readers should be forewarned that Rodwin, who holds both a JD and a PhD in policy analysis, approaches history with a definite policy objective in mind, namely to discover the best ways to regulate physician conflicts in the future. But unlike many works of policy analysis that present only a thin veneer of history, this book has a solid historical foundation. Rodwin has spent extended periods in both France and Japan conducting archival research as well as doing interviews, so the comparative material is rich as well.

Far from being unique to the United States, as American scholars tend to assume, Rodwin reminds us that physician conflicts of interest exist in all developed nations. How they play out differs according to how the medical profession is regulated and how health care is financed. By comparing conflicts of interest in three very different settings, Rodwin attempts to isolate the specific political, legal and professional factors that shape how they develop. In the process, he provides many interesting insights into the economics of medicine. To give but a few choice examples, the Order of Physicians, the main professional association of French physicians, has retained far more power than either its American or Japanese counterpart. Until 2004, the organisation successfully blocked efforts to put patients' diagnoses on their bills, effectively blocking the kind of utilisation review common in the U.S. since the 1970s. In Japan, physicians retained the role of dispensing drugs to a much greater degree than in France or the U.S., creating an 'unhealthy relationship' (p. 190) between physicians and drug companies. As a result, Japanese drug consumption is higher than most other countries and almost a third of its health care costs go to drugs compared to only ten percent in the U.S. In the U.S., the emphasis on private insurance plans has created a whole raft of

distinctive problems. Ironically, Rodwin notes, some measures adopted to reduce the conflicts of interest produced by fee for service medicine have 'created new ones in their place' (p.139), as in the growth of Managed Care Corporations whose profits derive from reducing the use of medical care regardless of its necessity.

For historians interested in policy debates, the final two chapters offer an insightful discussion of possible reform strategies. As Rodwin observes, 'many Americans believe that self-regulation, disclosure, and minor tweaking of legal rules are adequate safeguards for physicians' conflicts of interest' (p. 249). His analysis suggests otherwise. 'Structural and institutional reforms are necessary to curb corrosive influences,' he concludes, and are the only way 'to ensure patient safety, preserve the integrity of medical practice, and promote professionalism' (p. 250).

Rodwin's lucid, learned summary of physician conflicts of interest will be enormously useful to historians, particularly those concerned with the post-1970 period. The book's extensive footnotes and bibliography provide a guide to relevant sources in the fields of law, economics, sociology, and policy, and an appendix offers a short legal history of the concept of conflicts of interest and its evolution from Roman fiduciary law to modern civil law. This is a fine piece of work that will be of great use particularly to historians of twentieth century medicine.

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Book Review

Conflicts of Interest and the Future of Medicine: The United States, France and Japan by Marc A. Rodwin

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Over the last two decades much has been written about conflicts of interest in medicine. With a quick glance over my book shelves I can spot at least a dozen books explicitly on financial conflicts of interest (FCOI) and several dozen more that tangentially touch upon this topic. What makes Marc Rodwin's book quite valuable is the scope of what is considered under the rubric of FCOI, the multi-national comparisons, his in-depth consideration of the historical context in which FCOI has developed, and the chapter dedicated to reforms aimed at limiting physicians FCOI.

First, the scope of this book is useful in that it takes an expansionistic perspective of several forms of FCOI in medicine. To date most research in this area has focused on physicians' financial relationships with drug and device companies (bribes, kickbacks, consulting payments, stock, etc.). Rodwin explores other types of FCOIs that have historically received less consideration including: (1) direct payments to physicians for provision of medical services, (2) physician ownership of medical facilities, (3) physician employment by organizations that provide health care, and (4) physicians' financial ties to third parties. Each of these forms of FCOI is created by the complex and inevitable interplay between organized medicine, markets, and the state in the organization health care.

This conceptualization provides a very useful framework through which to view FCOI.

Second, this book is unique in that it considers FCOI in France and Japan in addition to the United States. Also unique is the way that Rodwin explores FCOI within the context of the development of each nation's medical system. This transnational perspective is a nice addition to a literature that has focused almost exclusively on the United

and regulation of ties to third parties. What is very important to remember is that each of the reforms can have positive and negative effects on the overall costs of care, the quality of care, access to care, patient satisfaction, physician satisfaction, and the financial health of entire sectors of our economy.

At least one additional lesson of this book is worth considering. Throughout the American experience, Rodwin consistently demon-

Overall this book is interesting and well done and will likely contribute to the ongoing debate about the causes and cures of FCOIs in the United States, Japan, and France.

States. From a health care policy perspective, this is very valuable because it puts the U.S. experience with FCOI into a global perspective — especially with regard to interventions designed to limit FCOI.

Third, Chapter 10 is especially interesting because it synthesizes the historical experience of each country with respect to FCOI and "...draws lessons from common reform efforts that are inadequate and reveals several measures that have proven effective." Among the historically ineffective reform efforts are replacing investor owned firms with physician owned entities, allowing physicians to regulate themselves, relying on market competition, public employment of physicians and simple disclosure of FCOI. The most effective regulatory mechanisms are increasing the amount for health care provided outside of private physician-owned practices, restricting entrepreneurial activities within private practices, increasing oversight of entrepreneurial physicians, payment regulation,

and regulates that organized medicine (i.e., the American Medical Association and specialty organizations) is as economically motivated and complicit in FCOI as are other organizations such as drug companies, insurance companies, and other for-profit organizations. This finding raises the question, Can anyone trust physicians and their organizations more than these other, often much-maligned organizations? In the least, it should be accepted that the profession of medicine is not able to regulate itself with respect to FCOI, and the norm of professional self-regulation with respect to FCOI does not appear to be real.

Overall this book is interesting and well done and will likely contribute to the ongoing debate about the causes and cures of FCOIs in the United States, Japan, and France. In the least, it makes a significant contribution to the overall literature on the nature, extent, and consequences of FCOI in medicine today.

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Conflicts of Interest and the Future of Medicine: The United States, France, and Japan

Marc A. Rodwin, 2011, Oxford University Press (Oxford, 978-0-19-975548-6, 392 pp.)

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As the promise of health care reform in the United States continues to face political and legal hurdles, few questions evoke as heated a debate as those surrounding cost control. Though most stakeholders agree that too many dollars change hands in the U.S. health care economy, politically tenable solutions to the problem have been elusive, as evidenced by the paucity of substantive cost-control measures in the current reform efforts. At the heart of the debate are fundamental tensions between patient choice and societal cost, between autonomous physician decision-making and adherence to clinical guidelines, and between free health-care markets and government oversight of those markets.

This past spring, the Independent Payment Advisory Board (IPAB) was introduced in the United States as a key component of the deficit reduction plan and was designed as a neutral body with the authority to cut Medicare spending if the federal health insurance program exceeded certain targets. A predictable back-and-forth ensued. Opponents invoked the “rationing”

defense, arguing that clinical care would suffer as independent physician decision-making was limited by government intervention, while supporters maintained that Medicare cannot afford to keep paying for health care at its current levels (Pear 2011).

Though reform efforts such as the IPAB have focused on payment, critical to this discussion is the contribution of physician behaviors to the cost of care (Krugman 2011). Specifically, while most people assume that physicians are ordering only what is necessary for patients according to their professional ethics, sometimes other factors, including financial incentives, drive their decisions (Grande et al. 2009; Wazana 2000). Some of the more powerful financial incentives in medicine include financial ties to companies (for example, honoraria, consulting fees) and the payment incentives from fee-for-service clinical practice. The existence of these incentives—and the conflicts of interest they create—is the subject of Marc Rodwin’s new book, *Conflicts of Interest and the Future of Medicine*. In his history-heavy analysis of the growth and symbiosis of medicine and industry in the United States, France, and Japan, Rodwin chronicles the cultural, legal, and institutional factors that have contributed to each country’s current landscape of financial incentives in clinical medicine. Each tells a different story of how organized medicine, professional self-regulation, market competition, and payers affect contemporary physician behavior and provides insight into the relationship between this behavior and health care cost.

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Rodwin's work emphasizes the striking international variation in how clinical medicine is practiced and regulated. Among the three countries he features, one particularly notable difference is the degree of physician entrepreneurship permitted in each health care system. At one end of the spectrum is France, where the government has taken a prominent role in controlling physicians' revenue-generating activities. Since 1975, the National Health Insurance (a national single-payer system) has not reimbursed for diagnostic, clinical, or laboratory tests, nor ancillary services performed by physicians or physician-owned facilities. Virtually all of these services are provided by independent testing centers, leaving no financial incentive to prescribing physicians. This division of practice and payment stands in stark contrast to the physician-owned facilities seen in both the United States and Japan.

The entrepreneurial spirit is most evident in the United States, where physicians have long enjoyed practicing in what Rodwin describes as a "protected medical market." This notion was crafted and defended over the last 150 years primarily by the American Medical Association (AMA), and the end-product is a system where U.S. doctors practice much more freely than their colleagues throughout nearly the entire developed health care world. The protected medical market was codified in the AMA's 1934 Insurance Principles, which required that "physicians control all phases of medical practice without interference," that "no third party should come between patient and physician," and that there be "no restrictions on physician's choice of treatment or prescriptions except for those devised and enforced by the medical profession." In 1955, bending to pressure from its members, the AMA allowed physicians to dispense drugs and devices if it was "in the patient's best interest," and then in 1959 allowed physicians to own pharmacies if "there is no exploitation of the patient." Over the past 20 years, as France began restricting physician entrepreneurship, the AMA's judicial council moved in the opposite direction, allowing physicians the right to invest in nursing homes and to own diagnostic equipment.

Permitting physicians to blend financial interests with clinical practice is one of the key drivers of the United States' current cost problem. It also may explain part of the geographic variation in spending. In the United States, research shows that Medicare spending varies significantly by geography, as does the extent to which physicians adhere to evidence-based

prescribing practices and the discretionary ordering of diagnostic tests (Song et al. 2010; Sirovich et al. 2008; Zhang et al. 2010a, b). In higher spending areas, physicians see patients more frequently, have different propensities to intervene, and recommend more MRIs and other studies with unclear benefits (Sirovich et al. 2008). Though research in geographic variation is still evolving, the literature suggests the variation is out of proportion with levels of physician demand or patient illness and perhaps more likely to be related to local medical "climates," affected by malpractice patterns, patient expectations, and, as suggested by Rodwin's account, financial incentives in clinical care that arise from physician entrepreneurship.

Though politically challenging in the United States, divorcing physicians from a fee-for-service model is a key feature of France's health care system and a direct consequence of French reforms implemented decades ago. The most sweeping modern reform in France began in 1995 by then-Prime Minister Alain Juppé, whose plan capped spending by private practitioners, mandated compulsory practice guidelines, accredited an agency to evaluate medical therapies, and encouraged experimentation with provider networks and delivery systems. It is not difficult to see the analogy with the current efforts in the United States, as policymakers decide how to curb Medicare spending in a way that physicians and patients find acceptable, increase funding for comparative effectiveness research to assess diagnostic and treatment modalities by both clinical and cost outcomes, and investigate new delivery systems such as Accountable Care Organizations in which bundled payments may relieve the spending spurred on by fee-for-service.

Of course, governmental reform is not the only instrument available to manage the cost of conflicts of interest. Rodwin concludes with a quote from Eliot Friedson: "Perhaps the most important [parts of professional codes of ethics] ... are those that deal with ... conflicts of interest. ... This is the critical test of professionalism in that in order to justify a monopoly over practice it must be assumed that it will not be used for selfish advantage." In Rodwin's assessment, physicians and physician organizations need to do a more rigorous job of self-regulation. As evidence of progress in this management strategy, he cites the professional recognition of conflicts of interest research as a respectable academic pursuit. He also points to examples of professional groups that

have taken steps to insulate physicians against conflicts of interest, including *Prescrire*, a French medical journal that accepts no advertisements or corporate funding; U.S. grassroots organizations such as “No Free Lunch” that have advocated against gift-giving by pharmaceutical companies; and medical schools that have restricted the access of pharmaceutical sales representatives to their campuses.

While arguing for increased professional responsibility, Rodwin also acknowledges that professional oversight is not enough. To the extent that physicians’ relationships with private industry will continue, structural and legal reforms should ensure that these ties do not trump the interests of patients. With a nod to successful features of the systems in France and Japan, he briefly describes the key steps toward implementing this vision in the United States, including enhanced reimbursement for publicly employed physicians; provision of ancillary services, drugs, and tests independent of physician practices; and funding of Continuing Medical Education not linked to industry. Among his most far-reaching proposal is an intermediary between private companies and biomedical research such that the individuals who design, conduct, and interpret trials have no financial ties to commercial funding sources. In short, Rodwin advocates for a fundamental revision of the financing and organization of medical practice in the United States to more closely approximate aspects of the French and Japanese models and is pessimistic that self-regulation and disclosure will suffice as the only management strategies.

Certainly, most of these reforms are not imminent. In the meantime, policy-makers emphasize physician and industry disclosure of financial ties to manage conflicts of interest. Disclosure is an important tool; for example, in the realm of clinical trials, it can help patients and research subjects make more informed decisions (AAMC Task Force on Financial Conflicts of Interest in Clinical Research 2001; Department of Health and Human Services 2004). Patients by and large favor disclosure and are concerned about physician financial ties, whether or not their decision-making behavior is affected (Licurse et al. 2010; McCarthy 2010). But it is also not a complete solution, as patients may not fully understand or appreciate the information disclosed and—as Rodwin highlights—few patients are in a position to use that information to efficiently search for alternative options. As national disclosure databases are implemented and more details about physician–

industry relationships are made public, more research will be necessary to further understand how people think about and use this information. Indeed, in 2010, the *Physician Payments Sunshine Act of 2009* in the United States made nearly all payments physicians receive from private companies available in a public database. A month later, the nonprofit, investigational reporting organization, ProPublica, released a similar database on its website (McCarthy 2010). Time will tell what impact this level of transparency will have on physician–industry dynamics and whether it will dampen the more ethically troublesome relationships (for example, pharmaceutical manufacturer speaker’s bureaus).

Debates about the effect of physician behavior on health care costs will continue to gain momentum as a research and policy interest. Current reform efforts such as the IPAB are aimed at reducing Medicare expenditures but may do little to reduce overall costs. Though far more politically challenging, real change likely will need to come in the way physicians order drugs, tests, and services for their patients and not just how these products are paid for. As the histories of other developed and successful health care economies make clear, the systems in which physicians practice affect their relationships with industry, how they generate revenue, and the cost of their care. The history of these systems—and the conflicts of interest therein—is intertwined with the history of cost control. As the United States looks to reduce costs, factors that affect physician behavior, including relationships with industry and the financial incentives of fee-for-service, will need to lead the way.

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Books review

Conflicts of interest and the future of medicine: the US, France, and Japan

By Marc A. Rodwin

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In his book Marc Rodwin, Professor of Law at Suffolk University, analyses the regulation of medical interests. He looks more precisely at doctors' conflicts of interest that can have an influence on their therapeutic choices which are not necessarily in the patients' best interest. While society and regulators usually expect doctors to be objective in their therapeutic choices, regulating (or the lack thereof) entrepreneurship of private practitioners, their ownership of medical facilities, their type of employment (private, public or mixed), and forms of remuneration for medical services can create incentives for preferring one medical treatment over another. The initial chapter of the book illustrates these choices by presenting fictional patients from France, the US and Japan who share the same diagnosis, but receive a variety of treatments depending on the economic and regulatory incentive structure of medical practice.

The book's main research question is a normative one, namely how regulation can minimize conflicts of interest between the patients' interest and physicians' entrepreneurial goals. On the basis of a political economic perspective, the book sets out to analyse the interplay between several variables: medical associations' oversight and medical self-regulation, market competition mechanisms, insurance companies' influence over medical practice, and the state's practice of regulation. This analytical framework is developed in chapter 1.

Chapters 2 and 3 deal with France. The development of the relationship between the organized medical profession, insurance companies and the role of the state are traced back from the medieval times onwards in chapter 2. The last section of the chapter

also looks at the influence of European law. Chapter 3 analyses how France aims at avoiding conflicts of interest. The author shows the unusual strength of the French Medical Association and how certain relationships between the pharmaceutical industry and doctors are still tolerated. Rodwin concludes that France only shows limited success in dealing with doctors' conflicts of interest.

Chapters 4–7 form the core of the book and deal with the US. Rodwin distinguishes four phases of the development of the medical economy showing a high variation in tackling medical conflicts of interest. Chapter 4 covers the period before 1950, chapter 5 the period until 1980 and chapter 6 the logic of medical markets from the 1980s onwards. Chapter 7 deals with the ways in which the US cope with conflicts of interests today. The author shows how insurance companies have come to set incentives to reduce medical services and thus create conflicts of interest. Also, the market orientation of the American healthcare system has reinforced ties between physicians and the pharmaceutical industry. Rodwin recommends federal regulation of medical care and health insurance, in order to develop a coherent approach to coping with conflicts of interest.

The following chapters focus on Japan. Chapter 8 depicts the historical development of Japan's medicine and chapter 9 analyses how Japan copes with conflicts of interest. Rodwin exposes the coexistent roles of Japanese doctors as private and hospital practitioners leading to a situation in which Japanese patients stay longer in hospitals than in other nations and also receive more drugs for medical treatment.

Chapter 10 ('Reforms') deals with the implications of the previous findings for regulation. Neither market competition nor pure public employment of physicians alone does necessarily mitigate conflicts of interests of doctors. Hence, both should coexist. Some of the other suggested solutions are strict regulation of entrepreneurship of private practitioners, of ties between

doctors and the pharmaceutical industry, and avoiding intervention of insurance companies in medical standard setting.

Chapter 11 is a more sociology-inspired chapter dealing with the concept of professionalism of physicians and its role to play in reducing conflicts of interest. Rodwin argues that the state, doctors and market mechanisms alike should have authority to regulate conflicts of interests, thus effectively providing for the possibility of 'checks and balances' between them.

The book provides overall a very detailed analysis of the historical and structural sources for conflicts of interest in the three countries presented. The chapter on professionalism complements the political economic perspective and avoids an overly functionalist view of coping with conflicts of interests. The detailed analysis shows that the state and insurance funds are also no 'neutral' actors and develops therefore to the convincing conclusion that conflicts of interest are best dealt with by a mix of market-driven, professional and public regulation. The detailedness of some chapters complicates however the readability and leaves the reader with the question if the same conclusions and recommendations could not have been developed with a more structured presentation of some developments.

While the 'patients' interest' plays a key role for analysis, the book falls short of defining what the patients' interests would be *from a regulatory perspective*. These interests are not necessarily congruent with the individual patient's interest of receiving the best

medical care. From a regulator's perspective patients are one interest group among others, even if they are certainly one of the most important groups given their role as future electors. Yet, their interest has to be reconciled with other legitimate interests. Since the medical profession is the main object of interest for the book, it would also be desirable to inquire about the belief structures of physicians about what their own and what patients' interests are. Using regulatory incentive structures alone does not necessarily explain why certain doctors themselves criticize the ties between the pharmaceutical industry and their profession, even though the same regulatory incentive structures apply.

Thanks to its comprehensive analysis of the three countries and their different regulatory frameworks this book is not only useful for legal or economic scholars/experts who are interested in dealing with conflicts of interest, but also for those who would like to study the healthcare systems of France, Japan and the USA. It is also useful as a starting point for sociologists and political scientists for studying the role of the medical profession.

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Review of Conflicts of Interest and the Future of Medicine: The United States, France, and Japan

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Abstract

This book examines and contrasts the roots of medical conflicts-of-interest in three market economy countries (United States, France and Japan) and provides a wealth of useful background information. The author draws on currently complex and/or non-regulated aspects of medical practice which can give rise to conflicts-of-interest and impact health-care costs and patient health. Remedial and legislative actions are examined and proposed for each country. The author presents an in-depth historical analysis and current situation of the physician patient-centered conflict-of-interest problems in a well-researched and written academic style.

KEYWORDS: physician-patient relationship, entrepreneurship, medical, practice, conflict-of-interest, ethics, guidelines, pharmaceutical industry, policies, practices, Japan, France, U.S.

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The Hippocratic Oath, rabbinic-Christian and Islamic teachings stress the sanctity of life and beneficence. The early Indian and Chinese medical codes also dictate that physicians should act in the best interests of their patients (Jonsen 2000). The first treatise dedicated to medical ethics and physician standards of conduct was written by the medieval Arab physician Ishagh ben Ali Rahawi in the ninth century. The ethics of most cultures promote the notion that patients' well-being must supersede every physician's personal concerns. Sickness and poor health are associated with a unique state of patients' dependence on provider knowledge and should not be exploited in any way (Pellegrino 2005). The Institute of Medicine, National Academies U.S. (IOM), defines medical conflicts-of-interest as "circumstances that create a risk that professional judgments or actions regarding a primary interest will be unduly influenced by a secondary interest." The same report finds that conflicts-of-interest in medical research, practice, and education, in the United States, are widespread (Lo and Field 2009).

Financial or other material arrangements are usually at the heart of many sources of conflicts-of-interest, though on occasion professional ambitions can contribute to the problem (Hurst 2010; Levin, Ganesh, and Al-Busaidi 2011). Modern physicians and healthcare professionals invest significant intellectual and material resources in their education and lifetime learning. Medical education is expensive, opening a practice can be costly, and mandatory continuing professional development (CMD), to ensure skill retention and currency in best practices, is not free of charge (Beran 2009). Those who enter private practice know how difficult it is to get established and acquire enough patients to make ends meet while repaying hefty medical school loans and maintaining professional competence. Reimbursements from health insurance(s) do not always cover the cost of a patient's visits and especially the diagnostic tests and treatment(s). Too often health insurance providers require that the cost of a procedure(s) is justified and approved beforehand. This can be a potential source for conflicts-of-interest if such practices result in denied or rationed healthcare. Malpractice insurance costs continue to rise, especially in the United States. The practice of "defensive medicine", to protect oneself in the event of a malpractice suit, is another modern source of conflicts-of-interest. The difficult relationship between the health profession and the biomedical industry is not new. Many professional societies have developed medical codes of ethics, but continue to accept professional educational sponsorships from the healthcare industry and also paying advertisements in their journals.

In 1997, the American Medical Association (AMA) was rocked by a scandal when it revealed an arrangement with the Sunbeam Corporation, a small-appliance manufacturer, to give the firm's goods an AMA seal of approval in exchange for royalties (Hagland 1998). The American Academy of Family Physicians (AAFP) has been criticized for accepting a large corporate donation from Coca-Cola to fund patient education on obesity prevention (Susman 2009). Such behavior can be a source of confusion as to the boundaries of conflicts-of-interest for many healthcare providers. In 2005 the U.S. Department of Health and Human Services attempted to address the issue of potential conflicts-of-interest in their intramural researchers "consulting" with the biomedical industry. A prohibition against receiving consulting fees from organizations capable of undue influence was enacted, affecting employees' morale as well as research progress (Gottesman and Jaffee 2010; Zinner 2010; Goozner 2010). It would be worthwhile to determine if such regulations could be applied to the practice of medicine or could result in delayed introduction of life-saving technologies and medications as some critics claim.

Accepting gifts, lunches, and educational travel vacations from commercial sources that seek to influence physician practice or organizational behavior is contrary to medical ethics and promotes conflicts-of-interest. Marketing is a major activity for pharmaceutical companies. It is estimated that the pharmaceutical industry spends at least 24.4% of its total sales on promotional activities (York University 2008). Information on the marketing of medical devices and biologics is very sparse. Health advocacy organization (HAO) alliances with pharmaceutical companies, which might influence patient health education, care, and stakeholder lobbying, can further complicate the existing situation and contribute to the insidious spread of conflicts-of-interest (Rothman et al. 2011). Disclosure does not necessarily relieve the HAO, physician, educator, or researcher from ethical obligations and is not a safeguard against personal, professional, or financial transgressions (Kottow 2010). The author of this book and many other experts have been warning of the developing conflict-of-interest problem for more than a decade (Rodwin 1998; Pellegrino 2006; Stossel 2007).

Dr. Rodwin masterfully reviews most of the reasons leading to conflicts-of-interest and draws attention to the similarities and differences between the United States', Japan's, and France's practices for managing this problem. He presents relevant examples, discusses the historical evolution of the medical ethics in each country, and proposes suitable remedial actions. Dr. Rodwin's primary focus is the physician. His book is well organized. He starts by scoping the problem and establishing the global extent of medical conflicts-of-interest which are not unique to the United States. They exist in different forms and manifestations in most countries. He then proceeds to describe the roots of the conflicts-of-interest related to physicians acting as entrepreneurs, developing

material relationships with the medical devices and pharmaceutical industry, and from dependence on government funding (which could also involve educational or research grants). He concludes that such relationships will invariably compromise physicians' loyalty to their patients and their professional independence. The consequences are often devastating for patients and society.

Dr. Rodwin does not believe that professionalism alone can resolve the issue and proposes the development of wide-ranging ethics standards, backed by government regulations and commensurate sanctions and restitutions. This is a well-written and scholastic treatise by an academic who studied and worked in all three countries discussed in this book. Only a very short mention was devoted to conflicts-of-interest for military or government-employed physicians and the emerging problems created by the HAO. These issues should be considered for inclusion in future editions of this book. There are a few minor editorial problems and some paragraphs were difficult to interpret. This is a modestly priced, good source of information on the subject for students, academics, and policymakers.

In conclusion, transparency, competency, devotion, confidentiality, justice, respect, sincerity on the part of the healthcare provider, and a patient's autonomy are the major foundations for ethical physician-patient relationships. Dr. Pellegrino has provided a congenial argument for reshaping professional ethics guided by the medical morality for achieving a true healing relationship between the physician and the patient (Pellegrino 2006). These values need to be emphasized repeatedly in medical teachings, research, and practice (Howard, McKneally, and Levin 2010; Nelson et al. 2010).

I am confident that Dr. Rodwin's book will contribute to the debate on how to best minimize physician-patient conflicts-of-interest.

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Rodwin, Marc A. **Conflicts of interest and the future of medicine: the United States, France, and Japan.** Oxford, 2011. 374p bibl index afp; ISBN9780199755486, \$29.95. Reviewed in 2011jul CHOICE.

Rodwin (Suffolk Univ. Law School) provides significant context for the ongoing debate over health care policy. He posits that "the physician-doctor relationship lies at the heart of medicine," and that this relationship has been strained by conflicts between professional ethics and financial self-interests. These conflicts are interfaced with the main forms of medical practice and their interaction with the influence of organized medicine on private practice; professional self-regulation; market competition; and the roles of the state and insurers. The author presents examples from France, Japan, and the US to illustrate such conflicts and how differently the nations cope with them. Of particular interest to American readers are the chapters on the role of markets, including the commercialization of the American medical economy. Rodwin provides broad, well-documented coverage of financing mechanisms and the competing goals of state and markets. The reforms in the three nations have resulted in some moderation of the conflicts of interest. Readers could gain some perspective on the underlying conflicts between government direction and the role of markets with David Cutler's "Equality, Efficiency, and Market Fundamentals: The Dynamics of International Medical-Care Reform" in the *Journal of Economic Literature* 40 (September 2002): 881-906. **Summing Up:** Recommended. Upper-division undergraduate through professional collections. -- F. W. Musgrave, formerly, Ithaca College

Conflicts of Interest and the Future of Medicine: The United States, France, and Japan
BY MARC A. RODWIN
Oxford University Press, New York, 2011. ISBN 978-0-19-975548-6; \$29.95 (hbk).

Doctors' conflicts of interest and the spill-over effects from markets and politics into medical decision-making are a major concern of health-care policy and patients in many countries. *Conflicts of Interest and the Future of Medicine: The United States, France, and Japan* offers us deeper insights into the complexity of interests that impact in doctors' decisions beyond medical reasons and that may not always benefit patients and the public interest. Marc A. Rodwin contributes to these debates in two ways: first, he clearly highlights that 'conflicts of interests' are inevitably embedded in doctors' decision-making; this creates variations in medical practice that cannot be explained in terms of medical conditions and that are not transparent to patients. These problems can be observed in otherwise different health-care systems, thus creating a broadly similar demand for tighter control of doctors.

Second, the book brings into view that institutions matter and how they create specific forms of 'conflicts of interest' that, in turn, may impact differently in medical decision-making. Using rich case study material, this book helps us to better understand *how* health policy and the institutions of the health-care state may either fuel or reduce doctors' conflicts of interests. Rodwin applies a comparative approach, including the USA, France and Japan, that reflects different health-care systems and regions of the world.

The book is structured around five parts. Part I examines the political economy of medicine in the three countries and explores a range of sources of conflicts of interests, including five salient features: 'which services physicians perform; whether physicians or other parties own medical facilities; whether physicians are self-employed or employed by others; how physicians are paid; which financial ties exist between physicians and third parties' (p. 16). The author highlights that recent transformations of health policy and the objectives to control costs and efficiency all impact in medical decision-making. But policymakers failed to consider how this fuels 'conflicts of interest'; reforms may therefore even undermine the policy goals.

Parts II to IV present the three illustrative country cases that form the core of this book. While the USA (Part III) are the focus of the analysis, the presentation of the case studies follows a similar structure: one chapter traces the historical contexts of the medical economy by focusing on the 'interaction between organized medicine, the market, and the state' (p. 24), while a concluding chapter discusses the coping strategies.

The conclusions and lessons drawn in Part V may be especially interesting for the social policy reader. The author begins by discussing both the problematic effects of common reform efforts in health-care and the 'measures that have proved effective' (p. 24). What follows from this is a chapter on medical professionalism and how it might be reconsidered in the light of the conflicts of interest; a concluding remark sets out the future direction for reducing these conflicts and governing medical practice more effectively.

Rodwin's narratives may not necessarily be new to a social policy audience and this is also true for the health system and policy analysis and the debates on professionalism. The latter ones mainly draw on Freidson's model of 'professionalism as the third logic' next to the market and bureaucracy and the work of other scholars in the USA who focus on 'countervailing powers' between professionalism and managerialism. The arguments are shaped by the regulatory architecture of the US health-care system that heavily draws on market mechanisms and a specific model of state-profession relationship. These conditions are different from classic welfare state models and continental European health-care systems with their overall more integrated governance arrangements; consequently, more recent research carried out in European health-care systems brings different options into view. This is not adequately reflected when it comes to 'reconsidering professionalism' and policy recommendations. Furthermore, an innovative potential of health professions other than medicine is broadly overlooked. It would also be useful to put more emphasis on the role of international organizations, such as the World Health Organization or the international medical associations. Yet overall, the three country cases bring an interesting range of policy options

into view that may help us to identify 'best practices' in order to reduce the 'conflicts of interest' in the future of medicine.

In summary, Rodwin provides comprehensive, yet accessible information on the complexity of conflicts of interest and how they may shape the future of medicine in different health-care systems. This book is well written and highly topical. It will be of interest for all those who are concerned about doctors' conflicts of interest, from policymakers and academics to practitioners and the users of medical services.

Ellen Kuhlmann

List of Reviewers

Rachel Aldred, Senior Lecturer in Sociology, University of East London, UK.

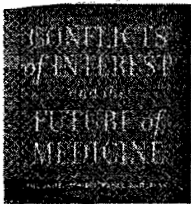
Hartley Dean, Professor of Social Policy, London School of Economics and Political Science, UK.

Ellen Kuhlmann, Senior Lecturer in Sociology and Social Policy, University of Bath, UK.

Robert M. Page, Reader in Democratic Socialism, University of Birmingham, UK.

ethics. Drawing on the lessons learned from this comparative study, Rodwin reviews measures that proved inadequate and others that may have been more effective. He concludes by offering recommendations to safeguard an ethical patient-doctor relationship that he believes lies at the heart of medicine. ■

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Conflicts of Interest and the Future of Medicine: The United States, France, and Japan. Marc A. Rodwin. Oxford University Press, 2011. 392 pages. \$29.95

To illustrate the various sources of conflict present in today's health care system, Marc Rodwin's book starts with the story of a hypothetical patient with chest pain seeking medical help in the U.S., France and Japan. It is a good summary of differences in medical practice in the three countries investigated, and how each country has taken different approaches to deal with conflicts of interest, with varying and, certainly, incomplete results.

For each of the three countries, the author provides an in-depth review of the history of the nation's medical political economy as it has been shaped by organized medicine, the market and the state. He examines how conflicts of interest were influenced by the rise of private and social medical insurance, and by the changing relations between physicians and the pharmaceutical and medical device industries.

The book deals with an important topic that the author thoroughly researched. By reviewing the different strategies developed by each country to respond to physicians' conflicts of interest, Rodwin provides a useful perspective for the ongoing debate on medical

Book reviews

Conflicts of interest and the future of medicine

Deborah Bassett

Conflicts of Interest and the Future of Medicine: The United States, France, and Japan by
Marc A Rodwin

Oxford University Press, New York, 2011, 375 pages, US\$29.95, ISBN 9780199755486

Financial conflicts of interest in medicine, created by the relationships between physicians and commercial industries such as pharmaceutical and medical technologies, pose a significant threat to the integrity of the patient–doctor relationship in countries around the world. More importantly, such conflicts of interest place the safety and well-being of patients at unnecessary risk. Marc Rodwin’s latest book offers a comprehensive historical analysis of medicine and politics in the US, France, and Japan and compares the conflicts of interest that exist in the healthcare systems of these three countries in order to offer some possible solutions to these problems. The book is timely, particularly in the US where debate over healthcare policy and reform continues unabated for the foreseeable future.

Rodwin’s book is divided into five parts. Following an introductory chapter that sets up the book, each nation is presented in a separate part, and the final part offers three concluding chapters as ‘Implications’. An appendix traces the origins of the notion of conflicts of interest, noting that where other professions have historically developed strategies for coping with financial conflicts of interest, the medical profession has only recently begun to do so. The

core of the book is the three case studies on the US, France, and Japan. Each nation’s section is divided into two sections: the history of the medical community and strategies used to limit conflicts of interest.

In Part One: Framing the Issues, Rodwin opens with three stories of fictional heart patients in Boston, Paris, and Tokyo, illustrating a wide range of treatments based on the physician’s financial interests with the manufacturer of the drug or medical device prescribed. Each patient situation is affected by the given nation’s laws, insurance, and medical institutions. This section does a good job of setting up why physicians’ financial ties threaten the patient–doctor relationship, which Rodwin argues ‘lies at the heart of medicine’.

Medical conflicts of interest arise when physicians have financial incentives to make decisions that may or may not be in the best interest of their patients. Rodwin identifies two kinds of conflict of interest: financial incentives for promoting treatment or services and a physician’s loyalty divided between a patient and a third party (such as a pharmaceutical company). According to Rodwin, which services are provided by physicians, physician ownership of medical facilities, self-employment, how physicians are paid, and the financial ties they have with third parties are all sources of potential conflict of interest.

Rodwin discusses six common strategies for dealing with these conflicts and argues that they are all inadequate. These strategies include: replacing investor-owned firms with physician-owned firms, giving the medical profession more authority to regulate itself, increasing market competition, employing physicians as public servants, having courts regulate physician activity, and disclosing conflicts of interest. Instead of these ineffective strategies, Rodwin suggests that the market should be regulated by providing public hospitals and not-for-profit healthcare organizations, in addition to private

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practice, and by not allowing entrepreneurial activities in private practice. By including medical care in both a state and private sector, a system of checks and balances is provided for each. He also advocates the elimination of financial ties between physicians and pharmaceutical companies and other commercial interests such as the medical device industry.

In the final part of the book, Rodwin describes how reforms along all points of intervention in a conflict of interest can prevent, regulate, or sanction a potential or actual violation. His proposed coping strategies include: increasing medical care opportunities outside of private practice, limiting and overseeing entrepreneurial opportunities within private practice, regulating payment incentives, restricting and regulating ties to third parties, and protecting professional judgment. In this section, the three countries are discussed side by side. Rodwin argues that government agencies should oversee clinical trials for firms that seek federal approval to market and sell their products. He also highlights the need for international norms to govern medical conflicts of interest, particularly as pharmaceutical and medical device companies operate on a global level, and suggests that non-governmental organizations such as the World Health Organization might play an important regulatory role in the future of global medicine. Additionally, he discusses professionalism in the form of professional norms developed by professional associations to partially mitigate conflicts of interest. However, he points out that in all three countries, professional medical associations are funded by commercial interests. Public policy is needed to create legal obligations for pharmaceutical and medical device firms, managed care organizations, insurers, and hospitals to act in the best interests of patients.

Rodwin concludes with a proposal that broad reforms should include: the restriction of activities that create conflicts of interest for physicians and their organizations, that physicians participate in professional organizations and develop broad reform themselves, that physician organizations develop ethical standards and policies to address conflicts of interest, and that physicians should be accountable to outside regulation of conflicts of interest that would include public accountability and transparency.

Although the book adequately covers the history of the development of the medical political economy

and subsequent conflicts of interest in each of the three countries, I would have liked more discussion of contemporary health issues in each of these countries. For example, Rodwin noted that the Japanese have higher rates of visits to doctors and medication usage than either the US or France. It would be useful to know if there are differences in disease diagnosis, and treatments prescribed and utilized in each country. Similarly, I would have liked more comparisons between the three countries throughout the book rather than only in the concluding chapters.

Rodwin's recommendations, such as prohibiting pharmaceutical and other commercial interests from giving gifts to physicians, seem relatively straightforward and unproblematic. However, one wonders how easy such reform would be in our current culture where ethically problematic practices and relationships that provide incentives exist in every sector, not only medicine. Additionally, regulation is costly. Who will pay for it? While Rodwin's arguments are certainly convincing, his proposed overhaul of the current system will take many years to develop and institute. Rodwin does not address the challenges that lie ahead. While his primary recommendation is to reduce the private 'entrepreneurial' sector and expand the public sector in healthcare, he only addresses the challenges such a move poses in a cursory way, saying that in order to ensure that 'public medical facilities provide excellent care and become centers of innovation, the federal governments must make public employment more financially attractive through subsidies'. He also does not address public acceptance of such widespread changes to medical care. Effective policy change requires public support and acceptance.

Overall, Rodwin's book is an important and timely call for a broad reform of the policy that regulates the relationships between medical practice and commercial interests not just in the US, France, and Japan, but throughout the world. He effectively argues that disclosure, the current most common regulator of conflict of interest in medicine, is inadequate to prevent conflicts of interest and to protect patients from potential harm. As global medicine becomes increasingly important, so will the need for international norms to regulate the practice, protect patients, and preserve a trusting relationship between patients and their caregivers in nations around the world.

Marc A. Rodwin (2011), *Conflicts of Interest and the Future of Medicine: The United States, France and Japan*. New York: Oxford University Press. £18.99, pp. 375, pbk.
doi:10.1017/S0047279411000924

With its focus on doctors' conflicts of interest, the book addresses a salient yet neglected issue in health policy. Healthcare reform in industrialised countries rarely focuses explicitly on conflicts of interests, at the same time such conflicts are inherent across healthcare systems. This reflects the fact that all health systems, although to different degrees, rely on a combination of elements of the state/public regulation, private industry/the market and professionalism as a form of private interest government. As such, the book addresses a topic which is highly relevant both from empirical and theoretical perspectives, not least also as the author adopts a cross-country comparative perspective and includes the US, France and Japan.

The book starts with fictional patient stories from the three countries. This makes for a powerful illustration of the potentially severe consequences of conflicts of medical interest and thus underlines the concrete relevance of the book. The patient stories also demonstrate the considerable diversity of treatments for the same condition and how system level differences in the organisation of health services shape the regulation of doctors' ties to industry. This is followed by an introduction (Chapter 1), which sets the scene for the subsequent presentation of the country case studies, which constitute the main body of the book. More specifically, the chapter discusses the definition of conflicts of interests and introduces a range of key circumstances under which conflicts of interest occur. France is an example where organised medicine is key, whereas the US is a case where markets dominate, while Japan is an example where doctors own most medical facilities. This shapes the nature and extent of conflicts in different ways. The book presents the countries as separate case studies, following the same two-part structure, looking at the historical evolution of medicine and at the coping strategies for conflicts of interests. In contrast, the more detailed structure of the individual case studies follows the specific characteristics of the respective country, for example with the review of the historical developments going back to medieval times in France and the 1950s in the US. Similarly, the US case study is very detailed and spread over four chapters (Chapters 4–7), whereas the analysis of France and Japan are considerably shorter (Chapters 2–3 and 8–9, respectively). The analysis of the three countries is followed by two chapters grouped together under the heading 'implications', which set the focus on different possible reform measures, which are assessed in terms of whether or not the individual reform measure is likely to reduce conflicts of medical interest. This discussion draws on the preceding country case studies as illustrative examples. In substantive terms, Chapter 10 looks at reform measures concerned with changes in the organisation of health services, readjusting elements of public regulation, markets and private interest government. The latter is dealt with in more detail in Chapter 11, which turns to professionalism itself and discusses how professionalism can be tweaked to minimise conflicts of medical interest. Considering the preceding analysis, it is not surprising that the author rejects relying on professionalism alone, as the early sociology of professions

suggested. Instead, the author advocates an embedded form of professionalism, where both the state and the market provide necessary checks and balances. This provides the springboard for the conclusion, which makes a plea for a division of labour between public regulation and professionalism.

Students and researchers in comparative social policy and health policy will be particularly interested in the discussion of the regulatory challenges involved in balancing public control on the one hand and private interest government on the other; they will also find some of the country case study material useful. However, this audience will miss a number of things: a more explicit and theoretically based framework of the analysis which also structures the analysis itself; a more thorough and critical discussion of the cross-country comparative approach and the choice of countries; a stronger comparative analysis of the country case study material as well as a more systematic identification of similarities and differences across countries and of how contextual factors account for the differences found; and based on these a more critical analysis of the possibilities and limitations of learning across countries. Nevertheless, this is an important book; it addresses a salient yet neglected issue in health policy and which is also crucial for delivering high quality health services. As such, the book will be of particular interest to the medical community as well as political decision makers. The fact that author writes extremely well makes the book particularly accessible to this audience.

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Conflicts of Interest and the Future of Medicine—The United States, France, and Japan, by Marc A. Rodwin. Oxford, UK: Oxford University Press, 2011, xi + 365 pp., £18.99 (hardcover ISBN 978-0-19-975548-6)

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An important outcome of globalization has grown from the notion that approaches and realities outside national boundaries can offer useful lessons within domestic borders. In the field of biomedical

ethics, international comparisons help frame domestic issues and illustrate where alternatives exist when domestic debates seem to have become exhausted. Mark Rodwin's *Conflicts of Interest and the Future of Medicine—The United States, France, and Japan* provides a robust new look at conflict of interest.

As a topic of discussion, conflict of interest in medicine has previously garnered attention, e.g. by Rodwin (1995) in the US and by Akabayashi *et al.* (2005) in Japan. However, a multinational consideration of conflict of interest in medicine has been lacking. Rodwin makes a timely and novel contribution in a three-way international comparison of conflict in medicine by examining the US, France, and Japan. With growing interest in the Patient-Centered Medical Home and patient-physician partnering in care in the US, growing patient dissatisfaction and a medical crisis due to aging of the population and diminishingly small birthrate in Japan, and social changes straining health care financing and access in France, the cross-national comparisons of these three countries seems particularly well timed. Rodwin's analysis represents a well-researched and analytical approach, featuring a high-level understanding of medical care, legal issues, public health, health care policy, and health care finance in his ambitious and informative book.

The challenge of connecting conceptual issues arises for such work. Rodwin hooks the reader initially by bringing in clinical cases, using both intra- and intercountry examples of patients with chest pain to illustrate how conflicts of interest can arise predictably, but differently, within a single country or across multiple countries. Rodwin examines the political economy of medicine in these three countries by focusing on several key questions, e.g. in what circumstances can physicians be trusted to act in their patient's best interest? How can society regulate medical practice and organize it to minimize conflict of interest? How can society promote medical professionalism? How can physicians and their specialty organizations play a role? And, what role do payers, e.g. insurers, the state, and the medical market play in medical care? Using a tiered approach, Rodwin examines conflict of interest using multiple lenses: under medical practice, under physician ownership, through charities and nonprofit organizations, under state sponsorship and public institutions, and through investor-owned firms.

After his introduction laying out the rationale for the work, Rodwin systematically examines the historical and current contexts of each country with a focus on the specifics of conflicts occurring and strategies for minimizing conflicts on a country-by-country basis. Each section is replete with specific examples to illustrate the kind of medical conflicts within each country. Importantly, Rodwin utilizes his assessment of policies from each country to develop a 'lessons learned', both for what has not worked and what does work, for eliminating or mitigating conflict of interest in the medical economy. The separate treatise of each country, followed by the integration of the taxonomy of conflicts elucidated, allows the reader to sink in her/his teeth, bite by bite, country by country, while still getting a taste for the whole stew when Rodwin brings it all together at the end of the book. Rodwin's multinational comparison illustrates that the devil is in the details. Often, conflicts of interest can be subtle and elusive to the unprepared. The very nature of financing, oversight, and regulation in a country determines what specific conflicts of interest will arise and the degree to which they will take on greater, or lesser, importance.

Although the shortcomings are limited, a few merit mention. For starters, Rodwin provides the reader with a description about the similarities and differences between the three countries being compared, but he does not provide a specific rationale for choosing these three countries. The comparisons provided are certainly informative, but why not Cuba, Brazil, Germany, Sudan, or some other country? Can the reader assume saturation has been reached in terms of the exploration of all facets of the medical conflict-of-interest phenomenon?

Next, the cases in the beginning illustrate what happens when the rubber hits the road, and they achieve a connection between day-to-day practice and the conceptual elements. The clinical stories permit the reader to experience firsthand the animosity and confusion patients feel when discovering that their care lies in the hands of a physician financially conflicted. This reviewer would have preferred that the cases (or references to them) be woven throughout each chapter. By the end of the case series in Chapter 1, the reader anticipates that the treatise will focus on the intimacy of the doctor–patient relationship. In the following pages, and throughout the book, the scope expands substantively into issues relevant to third parties, including suppliers and payers, and finally circles back to the clinical cases at the end.

Among the many conflict of interests that can occur in medicine, Rodwin thoroughly examines that which patients particularly care about most directly, namely, physician conflict of interest. In addition to the in-depth analysis of physician conflicts of interest, Rodwin provides assessments of other sources of conflict of interest, though these other conflicts of interest receive less attention. For example, the book covers, on a limited basis, third-party payer conflicts of interest. Disagreement arising from third-party conflict of interest continues as a substantive source of consternation for patients and well-intentioned physicians seeking care for their patients in the US. Day-to-day practice regularly involves physicians advocating to payers patient needs that have been refused. In this reviewer's experience, the refusals seem to benefit shareholders more than patients.

This reviewer would have preferred the scope to extend to conflicts of interest that occur at the government level, as those who are making the rules are not immune to potential conflicts of interest in medicine. Specific issues on conflict of interest concerns by government officials have received significant attention in Japan and the US. For example, advocates for the approval of oral contraceptives for women in Japan faced rejection after rejection over multiple years by the Japanese government despite voluminous data demonstrating safety and efficacy. After a fast-tracked approval of the erectile dysfunction agent sildenafil for men (after only six months and limited data on safety and efficacy), the gender-biased decision makers in the Japanese government were shamed into the acceptance of oral contraceptives for women (Norgren 2001). The horrific case of blood products contamination with the human immunodeficiency virus (HIV; the underlying cause of acquired immunity deficiency syndrome [AIDS]) further illustrates the point. Japanese Government officials had knowledge of the risk of contamination by HIV in factor 8 produced by a domestic company with government ties, but they failed to act (Feldman 2000). In the US, passage of the *Affordable Care Act* was arguably held hostage by Joseph Lieberman, a US Senator from Connecticut. To gain his vote, Lieberman insisted upon removal of a public option for universal coverage. A public option would threaten profits of the private health care industry. According to Harper's magazine, Lieberman received 1 million dollars in campaign contributions from the health care industry and \$600,000 from pharmaceutical and health care product companies, and all the while, his wife served as a lobbyist for a firm representing the health care industry (Horton 2009). Despite the rhetoric providing other intents, it appears that the people's elected representative favored the interests of the insurance industry over the electorate. These examples from Japan and the US illustrate how government officials and representatives have conflicts of interest that affect medicine and speak to significant conflicts of interest that extend beyond physician conflicts of medicine.

Based on the multinational comparisons, Rodwin provides proposals for minimizing conflicts of interest in medicine. For example, Rodwin suggests that an essential element for assessing accountability would be based on evidence of best practice that could be developed by an independent party without a conflict of interest. It appears that the Obama administration agrees, and as such a panel

was included in the creation of the 2009 *Affordable Health Care for America Act* (AHCA). That said, the political attacks during the 2012 US election on the establishment of an Independent Payment Advisory Board to be created under the *Affordable Care Act* illustrates the political challenge of achieving such changes. There are other downsides to decision making based on best practices. A preponderance of evidence supporting specific clinical practices is only available for a minority of clinical questions encountered. There is a lag period between the time when evidence becomes available and when it becomes disseminated. In addition, development of guidelines involves non-trivial costs also. Inevitably, many questions will not be resolved through best evidence, and clinical care will still come down to clinical discretion. One hopes that these judgments will be left to physicians and patients, as proposed by Rodwin, rather than to administrators. Such detractors aside, Rodwin does identify and advocate for the best possible choices.

Another proposal in Rodwin's quest for control of conflict of interest in medicine focuses on greater governmental regulation and oversight. For example, drug and device manufacturers would have to provide greater transparency about the details of design, evaluations, and reporting of results from phase III trials. If implemented efficiently, this tactic could provide further safeguards against the perils of conflicts of interest from private industry. What will remain debated is whether increased oversight will cause unnecessary delays in the availability of treatments of known benefit, particularly for lethal diseases such as cancer and AIDS. Moreover, regulatory changes do not come without financial costs to manufacturers and, thus, consumers. Financial costs and time delays arguably are minimized in Japan by more access to care. Whether the trade-off between less oversight and greater access to care provides a palatable solution remains an important question.

These critiques highlight the complexity of recognizing, managing, and preferably preventing conflict of interest in medicine. This reviewer commends Rodwin's extensive interdisciplinary and international research and exploration of the topic. This book is an important read for many a scholar. The cross-disciplinary nature of this exploration will appeal to those in the fields of bioethics, medicine, law, health care policy, political science, and other disciplines in the humanities. By nature, international comparisons challenge even the most astute scholar, though Rodwin provides a product remarkably well constructed. For the interested reader, Rodwin provides an unusually rich cross-disciplinary and cross-national account, especially with regard to physician conflict of interest. Accolades to Rodwin for a job well done in delving into many salient issues, for articulating that which doesn't and can work, and for underlining actions that show promise.

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doi:10.1017/mdh.2012.98

Marc A. Rodwin, *Conflicts of Interest and the Future of Medicine* (New York and Oxford: Oxford University Press, 2011), 384 pages, \$29.95/£18.99, hardback, ISBN: 978-0-975548-6.

Marc Rodwin is the author of *Medicine, Money and Morals: Physicians' Conflicts of Interest*, first published in 1993. At the time, conflict of interest was not the buzzword it has since become in debates about medical ethics, publication ethics, and health policy. His earlier book set a high standard for the discussion of the role of commercial pressures, ties, incentives and influences in shaping doctors' conduct towards their patients. It was deservedly widely noticed at the time, with considerable praise from influential voices in the medical community. The arrival of his new book, some eighteen years later, is a useful occasion for reflecting on what progress, if any, has been made in tackling the problem of conflict of interest.

As the subtitle indicates, this is a comparative study. Rodwin examines the different ways in which medical care is organised institutionally in three very different health systems in the developed world. He describes carefully the attempts made in each country since the nineteenth century to identify the nature of medical conflicts of interest, and to control such conflicts as they arise in each context. He shows in detail the interactions between the structural organisation of the profession, the policy of the regulatory and professional bodies, the economic organisation of health services, and business practices of professionals, commercial providers of goods and services instrumental to healthcare, and the ways in which conflicts are conceived, arise, and are managed.

I found the book a wearying read. This is not because the author has a difficult prose style – he writes lucidly and for a general readership. The accumulation of detail and the winding path through each country's difficulties is impressive. But it is a profoundly pessimistic book. At each turn, a measure to contain or control conflicts is introduced; it fails; the very mechanism introduced itself becomes a vehicle for conflicts in a fresh form. There is neither a 'land of lost content' to frame the story's beginning, nor much prospect of a 'reformed medicine' at the end, nor indeed any putative location of which we might say 'they do it better elsewhere'. There is just difference.

From a historical point of view, and from a historiographical point of view, this is unsurprising, perhaps. However, from a normative or practical policy-making point of view, it would be useful to know what our expectations of doctors, and healthcare systems, should be, and how they could better be enforced. The concluding pages of the book do offer some proposals, but they involve better ethics statements, more continuing

professional development, a tougher debate within the profession about conflicts. As the history of conflict of interest sketched in his book shows in detail, the ways in which professional ethics and the professional and regulatory bodies more or less thoroughly mystify the operations of conflict of interest by portraying them as legitimate business practice, necessities of good professionalism, and even, on occasion, union rights, this set of proposals does not inspire hope or confidence. Similarly, Rodwin's practical proposals for institutional and structural reform depend on introducing a greater regulatory role for the state, a more thoroughgoing transition of medical care into the public sector, and more scrutiny and oversight by public officials and the courts. Again, his own historical narrative, and the general lessons of the history and economics of regulation, suggest that regulatory capture is just as serious a risk here as in previous generations and under previous forms of healthcare governance.

All of this gloomy reflection noted, Rodwin does us an important service in bringing these issues into clear sight. Too often medical ethics, health policy and indeed history of medicine focuses on the social, normative, and technological side of medical change. The economic and business side is every bit as important and influential. And while we might despair of ways to *improve* the practice of medicine in the face of conflicts of interest, he does show us how it could get *worse* without continuous public and professional efforts to resist the steady pressure of conflicts of interest on good, patient-centred medical practice.

Richard E. Ashcroft

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Analyses de livres

Être médecin de soi-même. Principes pour que chacun prenne soin de sa santé

B. Hoerni

Éditions Glyphe, 2011 : 292 p.

ISBN : 2-35-815-048-7

C'est le titre du dernier ouvrage (Éd. Glyphe, Paris, 2011) du Prof. Bernard Hoerni, oncologue bordelais connu pour ses travaux liés aux rapports soigné-soignant et à l'éthique (il a présidé le Conseil national de l'Ordre des médecins et sa Section de déontologie). Le « médecin de soi-même » est ici le patient – intéressant de noter, avec l'auteur, que deux livres du même titre ont été publiés dans le passé : par Jean Devaux en 1682 et Frédéric Hoffmann un peu plus tard (*De medico sui ipsius*).

Hippocrate déjà disait « Le malade soit s'opposer à la maladie avec le médecin ». On se souvient, au 18^e siècle, de l'« Avis au peuple sur sa santé » du Suisse Samuel Tissot. Plus près de nous, citation de l'éthicien belgo-québécois Jean-François Malherbe : « l'art de soigner ses semblables, c'est les aider à vivre pleinement, les aider à accoucher d'eux-mêmes ».

Il s'agit évidemment de faire référence à l'évolution majeure, depuis les années 1970-80, liée à ce qu'on appelle droits des malades (inscrits, en France, spécialement dans la loi Kouchner de 2002). Avec le changement de paradigme, le mot n'est pas trop fort, décrit ainsi par J.-F. Malherbe : « Écarter le mal d'un patient appartient au médecin mais définir le bien du patient appartient au patient lui-même ». Les professionnels de santé ayant à accepter, sans qu'il s'agisse de contester leurs compétences scientifiques et d'expérience, que le patient est celui qui est mieux à même de savoir ce qui est bon pour lui (pas en termes de techniques, mais en termes d'effets souhaités, respectivement acceptés ou refusés), et que c'est lui qui sait s'il se sent en bonne santé ou malade. Hoerni : « La personne participe aux soins que lui dispensent les professionnels. Elle contribue également à la décision médicale. C'est à cette conception élargie qu'est consacré cet ouvrage ». L'auteur traite aussi, entre autres, des contributions apportées par les associations de malades.

« Être médecin de soi-même » est une vaste fresque – dont Hoerni a le secret, venant après « Les nouvelles alliances médicales » (Flammarion, 2003) et « La relation humaine en médecine » (Glyphe, 2010). Une douzaine de chapitres, allant du passé vers les contextes actuels, social et médical, puis explicitant l'émergence de l'accent sur l'autonomie du patient. On est frappé par l'érudition de l'auteur, des références historiques comme à la littérature récente parsemant chaque page. Le propos a des dimensions éthiques fortes – et philosophiques, leur application pratique dans les soins est détaillée dans les chapitres 6 et suivants, notamment quant aux manières de décider dans cette nouvelle approche. Interpellant ici de savoir que le premier Code français de déontologie (1947) disposait « Le médecin doit s'efforcer d'imposer l'exécution de sa décision ». *O tempora o mores...*

Dans son chapitre « Les difficultés et obstacles », l'auteur revient judicieusement sur les différences, voire les fossés, entre les connaissances que l'on a, les attitudes que l'on affirme et les pratiques (tabagisme, alimentation, exercice physique, etc.). Discutant aussi les nombreuses offres de soins non évaluées, alternatives, « naturelles », pour lesquelles la demande du public est forte ; citant Montesquieu « Le peuple aime les charlatans parce qu'il aime le merveilleux » (encore que la vérité oblige à noter que certains professionnels orthodoxes proposent aussi – voire vendent – du « merveilleux »).

Dans la préface, Anne Fagot-Largeault, auparavant au Comité consultatif national d'éthique, met en évidence « la réciprocité des droits et des devoirs. En acquérant le droit d'être écoutés et traités en adultes responsables, les bénéficiaires de notre système de santé acceptent aussi l'obligation de contribuer à son bon fonctionnement ». Défi important pour tous les acteurs. En effet, si le principe est acceptable par tous, il s'avère difficile, en tout cas en termes juridiques, de préciser/fixer les devoirs des patients. Ceux qu'on évoque incluent le devoir de renseigner complètement le médecin, de collaborer aux soins, d'être attentif à ne pas gaspiller les ressources – toujours rares – à disposition des patients individuels et de la collectivité, de respecter les règles de fonctionnement du système, par exemple en hôpital, d'accepter de participer à la recherche médicale, de payer ce qu'il doit. Pas toujours simple de les rendre opérationnels.

En plus d'être plein d'informations, expériences et réflexions, sur la base de la substantielle carrière clinique de l'auteur, ce livre est fort agréable à lire, par moments comme un roman.

Jean Martin

Cancer : le malade est une personne

A. Spire, M. Siri

Éditions O. Jacob ; 2010 : 261 p.

ISBN : 978-2-7381-2477-7

Le titre de l'ouvrage semble formuler une évidence, mais la réalité est toute autre. Le cancer, pour les patients, reste un combat, contre la maladie bien sûr, mais aussi contre bien des pratiques médicales et sociales, les incertitudes et les errements, les silences ou les discours inadaptés, la tyrannie des protocoles de soins, et de l'« evidence based medicine », le peu de place fait aux pratiques thérapeutiques non conventionnelles, la faible réaction sociale face aux environnements cancérogènes.

Les premières lignes du livre sont sévères : « Les oncologues d'aujourd'hui soignent trop souvent des tumeurs plus que des personnes ». Mais derrière la critique, apparaît un regard lucide sur l'évolution de la médecine, ses triomphes et ses renoncements, la perte de la clinique, le discrédit de la médecine générale, l'absence de formations des futurs médecins aux sciences humaines, et plus globalement la marginalisation de celles-ci dans les institutions sanitaires, en commençant par l'Institut national du cancer, où a été réduit considérablement le Département des sciences humaines qu'avait fait naître le Pr Khayat. Les auteurs plaident « pour une nouvelle impulsion du travail en sciences humaines articulé avec la médecine plus performante », non pas comme « un supplément humaniste à la médecine » mais comme une révolution dans la réflexion et la pratique des équipes médicales, où le malade serait pris pour ce qu'il est, « un être libre, digne et responsable susceptible de dialoguer à égalité avec les équipes médicales. En un mot, une personne ».

L'argumentaire est complet et dense évoquant la prévention et appelant à une « culture de la prévention [...] fondatrice de politiques de prévention citoyenne, responsabilisante, et pourquoi pas... joyeuse », rappelant les ambiguïtés du dépistage (en citant les travaux et les prises de positions courageuses de Bernard Junod à l'EHESP), regrettant que le « dispositif d'annonce » du diagnostic au patient, avancée incontestable, ait précipité les soignants dans une noria

organisationnelle qui a comme oublié l'essentiel, signalant dans un chapitre suivant une autre noria, la « noria des soignants » (le chirurgien, l'anesthésiste, le radiothérapeute, le psychologue, le nutritionniste...) dans laquelle le patient a du mal à trouver une cohérence.

Ce qui est prioritaire, pour Antoine Spire et Mano Siri, c'est que « si l'on soigne des personnes et non pas des tumeurs, on doit prendre en compte le fait que le malade est un individu unique, doué de parole et de jugement, quelle que soit son appartenance sociale » [...] et « non pas un bon petit soldat dont on espère qu'il jouera sa partie sans trop discuter ».

Et, citant Canguilhem, ils rappellent que « on peut se porter bien et être pourtant malade dans la mesure où on garde la maîtrise des décisions concernant son propre corps et le cours de la vie. C'est seulement si on en est dépossédé qu'on est alors mal portant ».

Le chapitre sur les traitements conventionnels et les traitements parallèles illustre cette problématique. Le recours aux médecines conventionnelles donne au patient – suivant par ailleurs son protocole thérapeutique – le sentiment d'être actif, acteur du processus thérapeutique. « Le malade qui recourt aux médecines traditionnelles n'est pas ce décrocheur thérapeutique, mystique et irrationnel [...] mais bien au contraire, il se pourrait qu'il soit ce malade acteur de sa maladie que l'organisation du système de santé appelle de ses vœux ».

Difficulté du rapport aux proches, questions sur la sexualité, les soins palliatifs, l'euthanasie, l'ouvrage est riche d'informations, de réflexions, d'interrogations, de propositions.

C'est un livre critique, engagé, mais surtout un livre de propositions. Il y a, en France, des changements à faire, rien n'est irréversible. Il y a une révolution à faire dans la formation des soignants et dans les logiques de pouvoir qui s'expriment à l'hôpital.

Jean-Pierre Deschamps

**Conflict of Interest and the Future of Medicine
The United States, France and Japan**

Marc A. Rodwin

USA, OUP, 2011 : 392 p.

ISBN : 978-0-1997-5548-6

Le livre est un document très imposant et qui survole tous les aspects des conflits d'intérêt. Le lecteur y trouvera entre autres autour de 400 références portant sur ce thème et pas loin de 600 notes de bas de pages.

Le livre est aussi une comparaison de trois pays, les USA, la France et le Japon. L'auteur a écrit seul semble-t-il l'ensemble du livre, travaillant à partir de documents et d'interviews qui sont cités dans les notes.

L'un des messages clefs est qu'il y a un continuum de conflits d'intérêts, de natures différentes et qu'il est illusoire de penser que la simple déclaration de ces conflits d'intérêts, qui est la principale solution proposée un peu partout aujourd'hui, peut résoudre tous les problèmes.

La grande qualité du livre tient à son exhaustivité pour l'abord des conflits d'intérêts :

Il parle des conflits d'intérêts de nature financière mais aussi ceux qu'on pourrait appeler de « loyauté », quand le médecin doit aussi satisfaire un tiers autre que le patient.

Le livre entre dans le détail de ces différents types de conflits d'intérêts, en listant :

- la fourniture de service par des médecins auto employés (les libéraux chez nous), où la « bonne santé de l'activité » peut entrer en conflit avec les intérêts des patients ;
- la réalisation d'actes additionnels, biologiques, radiologiques, techniques, qui entraînent aussi une meilleure rémunération ;
- les arrangements entre professionnels de santé ou même avec d'autres types de services pour organiser le marché, la circulation des patients au mieux des intérêts de tous ;
- la propriété de l'outil de travail par les médecins eux-mêmes, cliniques et hôpitaux par exemple, augmente les possibilités d'une attitude « entrepreneuriale » ;
- pour ceux qui ne sont pas auto-employés, la dépendance à une autorité qui les emploie peut créer des situations d'influence de l'employeur contraires à l'intérêt des patients et qui dépend de la « solidité » de leur contrat et de leur autorité. Ils peuvent être amenés à favoriser des jeux et intérêts institutionnels plus que l'intérêt des patients. En particulier les stratégies de réduction des coûts peuvent être contraires à l'intérêt des patients ;
- les tentatives des assureurs santé d'imposer de la capitation, du partage des risques financiers, peuvent conduire à des stratégies thérapeutiques moins optimales de la part des médecins concernés. Cela est d'autant plus vrai que ces assureurs ont un lien financier avec les médecins qui dépendent d'eux en partie ;
- les liens avec d'autres parties, sous forme de subventions, cadeaux, et autres subsides présentent un risque bien particulier, notamment quand ils viennent d'institutions fournissant des services et des produits utilisés par les mêmes médecins pour leurs patients.

Le livre raconte aussi qu'aucun des trois pays explorés n'a de système en place permettant d'éviter les conflits d'intérêts, mais qu'ils sont de nature et d'ampleur différentes, selon le pays. En particulier il insiste sur l'illusion de tout régler par la déclaration simple des conflits d'intérêts. Il suggère de les décrire et de les analyser systématiquement, en détaillant bien ce qui concerne les industries de santé, mais aussi les institutions publiques, les assurances de santé obligatoires ou non, les hôpitaux, les ONG, etc.

L'exploration de chaque pays est intéressante, mais elle est une partie plus difficile de l'exercice, car l'auteur, malgré l'importance du travail documentaire et d'interviews réalisés, n'a pas « standardisé » l'information recueillie, qui se révèle difficile à réellement comparer d'un pays à l'autre. Il manque quelques tableaux comparatifs sur des éléments « comparables ». Cela illustre le fait que la recherche comparative nécessite de bien standardiser la méthodologie en amont et de procéder de manière similaire pour chaque pays objet comparé. Du coup, on sent bien, comme professionnel de santé publique français, que la description de la France est plus « livresque » pour la France que pour les USA.

En conclusion

Les quelques « lacunes » méthodologiques n'enlèvent rien à l'intérêt du livre qui intéressera les lecteurs français, même s'ils seront parfois un peu « étonnés » de certaines descriptions trop « lapidaires ».

Et surtout, il illustre le fait que les patients ont probablement des raisons de se demander systématiquement : ce que me propose mon médecin peut-il être influencé par des intérêts autres que le mien directement ?

La société devra y répondre, probablement en définissant mieux comment organiser la pratique médicale pour minimiser l'existence de conflits d'intérêts, en promouvant largement les meilleures pratiques médicales en regard de ce problème, en clarifiant le rôle des professions de santé au sein l'économie des activités de santé, mais aussi celui de l'État, des Assurances Santé (obligatoires ou non), et des règles du marché.

Yves Charpak

Éducation à la santé, quelle formation pour les enseignants ?

D. Jourdan

Saint-Denis, INPES, Collection Santé en action, 2010 : 160 p.

ISBN : 978-2-9161-9214-7

En 2005, nous avons, avec enthousiasme, salué ici-même (Santé Publique, 2005, 17, 656) l'ouvrage paru en 2004 sous la direction de Didier Jourdan, « La formation des acteurs de l'éducation à la santé en milieu scolaire ». Ce nouveau livre est une suite logique à la démarche entreprise.

Michel O'Neill, professeur à l'Université Laval de Québec et référence incontestée dans le domaine de l'éducation à la santé et de la promotion de la santé, salue en préfaçant cet ouvrage « un exemple convaincant de ce que la France peut produire d'excellent, quand elle regarde au-delà des limites de sa capitale en se mettant au service de la planète et de ses propres régions ». Le compliment est amplement mérité.

L'éducation à la santé à l'école est « du point de vue de la santé publique un enjeu central », mais n'est-elle pas souvent, demande l'auteur, « du point de vue de l'école une problématique marginale ». Ce qui, pour D. Jourdan, est en jeu dans l'éducation à la santé à l'école n'est pas le passage d'une vision biomédicale informative à une vision globale de la santé, mais bien un déplacement du rôle de l'école ; et ce qui est valable dans le domaine de l'éducation à la santé l'est évidemment dans ceux de l'éducation à la citoyenneté, au développement durable, à la consommation, à la sécurité. « Il ne suffit pas d'obtenir la conversion d'enseignants focalisés sur un enseignement disciplinaire dépassé et rétifs à l'engagement, dans des démarches de promotion de la santé. Il est question d'une mutation fondamentale du rôle social de l'école, et donc du sens de l'activité professionnelle de ses acteurs ».

Activité professionnelle sous-entend formation, et D. Jourdan consacre de belles pages au métier d'enseignant, à la formation « qui ne se limite pas à la dimension pédagogique » mais comporte aussi des aspects politiques, éthiques, techniques

(« Ingénierie » de la formation). Il propose des moyens concrets pour la formation à l'éducation à la santé, rappelant en conclusion que la priorité n'est pas tant aujourd'hui l'acquisition de compétences spécifiques que l'inclusion, dans l'identité professionnelle des enseignants, d'une conscience de leur mission dans le domaine de la santé. « En milieu scolaire, l'éducation à la santé se réfère en premier lieu à une conception de l'éducation et non à des fléaux sanitaires et aux moyens de les prévenir [...]. La perspective est toujours celle de l'émancipation ».

La publication du livre accompagne celle du classeur PROFEBUS (*cf. infra*) dans lequel il est inséré, mais il est aussi, heureusement, diffusé isolément, non seulement pour le bénéfice des enseignants, mais aussi pour celui de tous les acteurs de l'éducation à la santé.

Jean-Pierre Deschamps

PROFEBUS, un outil au service de la formation de tous les enseignants

Clermont-Ferrand, IUFM d'Auvergne

Saint-Denis, INPES, 2010 (outil/classeur non paginé)

C'est aujourd'hui, comme une suite appliquée, un magnifique outil pédagogique que propose le Réseau des IUFM pour la formation en éducation à la santé et l'équipe de Didier Jourdan à l'Université Blaise Pascal de Clermont-Ferrand (IUFM d'Auvergne).

Édité par l'INPES, il se présente comme un volumineux classeur, incluant un nouvel ouvrage de D Jourdan « Éducation à la santé, quelle formation pour les enseignants ? » (*cf. supra*) et tout un ensemble de documents, de fiches et de matériels. Des techniques pédagogiques, des activités de classe et d'élaboration de projets de santé, concernent l'école (dès la maternelle), les collèges et les lycées. L'ensemble est complété par un DVD comportant de nombreuses annexes théoriques et techniques.

Cet ouvrage répond à un besoin fondamental. Il est diffusé aux IUFM et aux Centres régionaux et départementaux de documentation pédagogique, ainsi qu'au réseau des Comités d'éducation pour la santé (IREPS/CRES). Souhaitons qu'il en soit fait un très large usage.

Jean-Pierre Deschamps

Pratiques et éthique médicales à l'épreuve des politiques sécuritaires Actes du colloque chaire Santé/Médecins du Monde

Sous la direction des Dr O. Bertrand, J.-F. Corty, D. Tabuteau

Édition Santé, Sciences Po Les Presses, 2010 : 143 p.

Ces actes du colloque organisé en 2010 par Médecins du Monde et la Chaire Santé de Sciences-Po mêlent de façon heureuse les interventions d'acteurs de terrain et de chercheurs en histoire, en sociologie, en droit ou en économie. Didier Tabuteau s'interroge en introduction sur « l'équilibre délicat » entre sécurité et liberté. Ce sont plutôt les termes de confrontation, de face-à-face, de « couple tumultueux » qui reviennent lorsqu'il s'agit de parler de logiques sécuritaires et de logiques humanitaires, d'État-Providence et d'État-Vigile, de protection des individus – ici les plus fragiles – et de celle de la société, et dans cette alternative aux multiples faces,

c'est bien un problème éthique qui se pose et qui est ici débattu. « Être sans nation et sans citoyenneté n'en fait pas moins de l'homme un homme » écrit Ph. Bataille.

L'équilibre a toujours été difficile, depuis des siècles, entre l'aide sociale aux pauvres et le contrôle ou le maintien de l'ordre public, entre la solidarité et la police, la charité privée et l'action publique, l'universalité des droits écrite dans les textes et le particularisme fondé sur les lieux ou les origines. « L'État ne cesse jamais d'être bienfaiteur et gendarme » rappelle M. Borgetto en citant P. Legendre. Les échos du terrain montrent, à travers de multiples exemples, que c'est le gendarme qui prime aujourd'hui sur le bienfaiteur. L'État génère lui-même des crises sanitaires en étendant à l'action humanitaire une politique répressive violente, en usant du « délit de solidarité » tellement étranger aux valeurs de la République, en cherchant à réduire la visibilité des pauvres, et en entravant l'action humanitaire en éloignant, dispersant, terrorisant, en multipliant les contrôles policiers à proximité immédiate des lieux de soins... « Les publics de l'humanitaire, dit Ph. Bataille, deviennent le réservoir dans lequel l'ordre sécuritaire puise ses cibles [...]. Le propos sécuritaire abîme les acquis du travail humanitaire pour mieux alimenter les représentations sociales de la peur de l'autre, démuni, affaibli, fragile [...]. L'idéal sécuritaire ne passe plus par le sanitaire [...] pour diffuser des normes et des règles de conduite, mais il s'appuie sur ce travail pour désigner les publics et les situations qui dérangent son ordre », avec « une suractivité des forces de police en vue de chasser l'étranger jusque dans les refuges que leur ouvrent les associations solidaires qui humanisent le lien social ».

« N'est-ce pas l'inverse d'un projet démocratique que de consolider les positions de pauvreté et d'exclusion [...] pour faire valoir sa puissance et alimenter le régime des peurs et des xénophobies » interroge encore Ph. Bataille, qui plaide pour une « éthique solidaire » et pour qui « la dénonciation du contexte actuel tient à une capacité éthique et politique de mobilisation individuelle et collective des défenseurs des droits fondamentaux de la personne humaine ». En écho, P. Salignon conclut en appelant à « refuser la résignation et [à] ne pas accepter l'inacceptable [...], à persévérer au quotidien pour améliorer le bien-être de ces populations, notamment en développant des stratégies collectives de support et en étant acteurs de ce changement ».

Hommage doit être rendu à la chaire Santé de Sciences-po et à Médecins du Monde pour la qualité du débat éthique, des interventions et des conclusions de ce colloque dont les actes méritent une très large diffusion.

Jean-Pierre Deschamps

Réduire les inégalités sociales en santé

Sous la direction de L. Potvin, M.-J. Moquet, C.M. Jones

Saint-Denis, INPES, Collection Santé en action, 2010 : 380 p.

ISBN : 978-2-9161-9223-9

Ce beau livre est la suite des Journées de Prévention 2009 de l'INPES. Plus que des actes, il est le fruit d'un considérable travail éditorial mené en aval par ceux (ou plutôt celles) qui avaient organisé cette journée faisant intervenir des dizaines de chercheurs et d'équipes de terrain européens et américains. L'avant-propos avertit : « Les inégalités sociales en santé (ISS) touchent tous les pays, et les systèmes de soins sont au mieux impuissants à les réduire, mais souvent aussi

contribuent à les exacerber ». On a beaucoup écrit déjà à ce propos, de manière incantatoire, et, disent les auteures, la réduction des ISS « semble faire office de mantra pour les acteurs de promotion de la santé du monde entier ».

Pourtant ce livre rompt avec la traditionnelle et désastreuse focalisation du problème sur la seule action des systèmes de soins (et on peut regretter que cela n'apparaisse pas dès le titre). Des politiques structurées sont ici présentées, en France (les Ateliers-santé-ville, la lutte contre le saturnisme...), au Royaume-Uni, en Suède, aux Pays-Bas, qui donnent la priorité à des actions sur les déterminants de la santé qui alimentent la pauvreté : logement, revenu, emploi, éducation. Il s'agit bien de « modifier les causes des causes ». Sir Michael Marmot, qui a présidé en 2008 la Commission des déterminants de la santé de l'OMS en 2008 rappelle ses conclusions dont il faut citer au moins l'une : « Rendre plus équitable la distribution du pouvoir de l'argent et des ressources au sein des sociétés et entre elles ».

Si certains chapitres restent assez traditionnels, d'autres sont de nature à enthousiasmer le lecteur par l'avancée qu'ils réalisent, et parmi ceux-ci celui de L. Ginot et de M. de Koninck. « Les politiques publiques, disent-ils, sont le premier levier pour ne plus dissocier analyse et pratique. [...] Pour peser favorablement sur les politiques non sanitaires, les acteurs de santé publique ont d'abord à se convaincre de leur légitimité à plaider ». Il s'agit de « redonner aux facteurs dits contextuels leur dimension de déterminants sociaux de la santé en les identifiant comme éléments centraux du diagnostic sanitaire ». Un autre chapitre évoque le développement de l'Évaluation d'impact sur la santé (EIS) de toute décision de politique publique ; l'EIS est obligatoire au Québec depuis 2001, et des exemples concrets sont donnés, pris à Genève, à Montréal, au Royaume-Uni, en Nouvelle-Zélande.

Les évaluations de telles politiques sont difficiles. A. Guichard et V. Ridde présentent une intéressante grille d'analyse des actions, qu'ils ont conçue à l'INPES. Les derniers mots de l'ouvrage reviennent à M. Marmot : « Les ISS sont une des conséquences de la façon dont les êtres humains ont choisi de vivre ensemble. [Elles] ne pourront être corrigées sans actions audacieuses, délibérées et concertées. Mais ces actions exigent des ressources et une volonté politique qui entrent en concurrence avec d'autres questions pressantes, ce qui en fait un problème éminemment politique ».

Il y a encore un énorme travail à accomplir dans ce sens, à contre-courant des logiques politiques actuellement dominantes... Ce livre va dans le bon sens.

Jean-Pierre Deschamps

Comment améliorer la qualité de vos actions en promotion de la santé ? Guide d'autoévaluation construit par et pour les associations

Septembre 2009 – INPES

Un guide d'autoévaluation conçu par, pour et avec des associations... C'est une démarche exemplaire qu'a coordonnée l'INPES, et le fruit d'un groupe de travail, issu de dix grandes associations de prévention (et dont les membres sont malheureusement restés anonymes...).

Cette brochure d'à peine quarante pages est un trésor de méthodologie et de pédagogie sur la « démarche qualité », un outil de travail pratique, qui manquait en

France, alors que depuis plusieurs années, des réalisations de ce type avaient été publiées en Belgique, aux Pays-Bas et en Suisse.

Une réserve, minime : le glossaire terminal, plutôt jargonnant et technocratique, n'est pas à la hauteur du reste du document.

Jean-Pierre Deschamps

Salles de consommation contrôlée à moindres risques pour usagers de drogues Analyses et recommandations des élus locaux

Tome 1 : Auditions d'experts et visite

Tome 2 : Journée de synthèse

Actes du séminaire organisé par l'Association nationale des villes pour le développement de la santé publique « Élus, Santé Publique & Territoires »

Avril/Septembre 2010. Paris

« Un pari difficile, travailler ensemble sur un sujet complexe, confidentiel le cas échéant, et arriver à quelque chose de construit ». Le travail accompli par l'association nationale des villes pour le développement de la santé publique « Élus, Santé publique & Territoires » a la qualité que cette rubrique a déjà eu l'occasion de souligner (*Santé publique*, 2009, 21, 227). C'est la synthèse d'un travail de plusieurs mois qui est ici présentée. Un travail qui a associé des élus, des chercheurs, des associations et des équipes de terrain (psychologues, sociologues, médecins, travailleurs sociaux, policiers, juristes...) comportant des auditions d'experts, la visite de salles de consommation à Bilbao et Genève (Tome 1). Une journée de synthèse a ensuite été organisée (Tome 2).

C'était une gageure, et ça a marché. Ce processus de concentration a permis des débats nécessaires, des prises de position courageuses.

À propos d'autres thématiques

Il en ressort que les « centres de consommation – obligatoirement intégrés à la palette complète de prise en charge de la toxicomanie – constituent un outil d'amélioration de débat sanitaire et social des usagers de drogue les plus désocialisés et les plus précaires. Ces centres sont tout aussi incontestablement un vecteur de diminution des atteintes à l'ordre public et à la tranquillité de nos concitoyens ».

Les conclusions insistent sur la nécessité d'une expérimentation soigneusement évaluée. En bref, une contribution exemplaire à un débat difficile, mais aussi une classification des enjeux et des résultats possibles.

Jean-Pierre Deschamps

Santé internationale – Les enjeux de santé au Sud

Sous la direction de D. Kerouedan

Les Presses de Sciences Po. 2010

« Ce fut un immense plaisir de travailler à cet ouvrage... », écrit Dominique Kerouedan en introduction. Et c'est un immense plaisir pour nous, d'abord de le voir, car il comble manifestement un grand vide dans la littérature de santé publique francophone, et ensuite de le lire. Depuis le « Gentilini » de médecine

tropicale paru en 1993, qui faisait une large place aux approches de santé publique, aucun ouvrage général n'avait été publié.

C'est justement Marc Gentilini qui signe le préambule, rappelant que « nourrir, éduquer et soigner les populations constituent un trépied sur lequel repose le développement durable » et mentionnant que les « responsables politiques du monde ont compris, même tardivement [...] que le développement humain est aussi important, davantage sans doute, que le développement économique, et que le second ne se justifie que pour renforcer le premier ».

Optimisme ? Quelques pages plus loin, dans un texte magnifique de présentation de son livre, Dominique Kerouedan constate que « le secteur de la santé, fleuron de la coopération française [...] pendant quatre décennies, n'est désormais plus considéré comme une priorité, et n'apparaît pas comme secteur de concentration dans les documents-cadres de partenariat, signés entre la France et les pays d'Afrique de l'Ouest et Centrale ». À quelques exceptions près, elle souligne aussi « le peu d'intérêt pour la santé dans le cadre des instruments européens bilatéraux des politiques internationales ».

De fait, « en pleine mondialisation, les financements en faveur de la santé sont désormais alloués à des initiatives mondiales, et à des partenariats publics-privés mondiaux. [...] L'aide bilatérale a souffert ». Pire encore, « le poids considérable de la médecine curative hospitalière française imprègne les représentations des personnes en charge de la coopération sanitaire internationale en France [...]. Médecine et santé sont confondues. Et comme les « services de soin *stricto sensu* ont un impact de 20 % seulement sur l'état de santé de la population [...], d'autres secteurs, plus faciles à gérer, passent en priorité ».

De ce constat, Dominique Kerouedan tire une conclusion : « Donnons des armes aux non-professionnels de santé, qui leur permettent de s'emparer de ce domaine. Formons des futures politiques et administrateurs français et internationaux capables d'assumer un leadership sur ce secteur [...]. Les problématiques de santé publique dépassent largement le champ de la médecine et le champ-même de la santé. Nous avons besoin, pour mener la réflexion politique et stratégique en santé mondiale et travailler aux côtés des techniciens, de nouveaux esprits, de jeunesse, de créativité, de nouvelles idées, de dynamisme, d'enthousiasme ». Et, en 2006, elle crée un cours à Sciences-Po Paris, « Santé et politique dans les relations Nord-Sud » dans le cadre du master « Affaires internationales ».

« L'idée d'écrire un ouvrage est intrinsèquement liée à la création de cours. [...] Cet ouvrage est unique en son genre », dit-elle, associant des textes d'étudiants du cours (les deux tiers des 51 contributeurs) et ceux d'auteurs de référence participant à l'enseignement. « Nous n'avons pas cherché à uniformiser la santé [...] mais nous partageons les mêmes valeurs : la quête d'équité est au cœur de la santé publique mondiale [...]. Cette pluralité de positions reflète la teneur des débats à l'échelle mondiale. »

On aura compris qu'il s'agit effectivement d'un travail unique en son genre. Il est organisé en quatre parties : la situation sanitaire des pays en développement, l'organisation des systèmes de santé, les stratégies publiques et privées ; nationales et internationales, les enjeux de la recherche et la contribution des sciences sociales.

Cette diversité permet d'aborder des thématiques nouvelles, non traitées ailleurs, par exemple : les conséquences sanitaires des déchets électroniques liés au commerce Nord-Sud, la progression des cancers, ou du diabète de type 2 en Afrique, la migration des médecins africains vers le Nord, l'enjeu de la révision, dans un sens plus contraignant pour les États, du règlement sanitaire international...

Tout n'est pas traité, il y a des manques importants dont l'auteure principale se justifie (santé maternelle et infantile, santé reproductive, santé des adolescents et des jeunes...). C'est dommage car dans ces domaines, les compétences ne manquent pas. Cela n'altère en rien la valeur irremplaçable de cet ouvrage original, dans le paysage de la santé publique francophone et de l'aide au développement.

Jean-Pierre Deschamps