Conflict of Interest and Implicit Bias: How It Impacts Patient Care, Research and Teaching

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HSS educational activities are carried out in a manner that serves the educational component of our Mission.

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I have the following conflicts to disclose:

Scientific Advisory Board, MIACH Orthopaedics
Educational Consultant, Smith & Nephew
Medical Publishing Board, AOSSM
Goals

- Renew awareness of conflicts we face daily
- Ponder the role of bias in our daily lives
- Begin conversation concerning individual and departmental management of conflicts
- Reflect on how these conflicts impact patient care, education and research
- Respect individual differences but be aware of our own biases
- Provoke thought and discussion regarding gender bias in orthopaedic surgery
Bias is the tendency, inclination or prejudice towards or against someone or something.

Most common examples of unfair bias relate to race, gender, ethnicity, religion or sexuality.

Whether positive or negative, these cognitive shortcuts can result in prejudgment that may lead to rash decisions or discriminatory practice.

Even those who are not deliberately prejudicial may have implicit biases which are formed by lifelong societal input that escapes conscious detection.
**Bias**

- **Confirmation bias** refers to the brain’s tendency to search for and focus on information that supports what someone already believes while ignoring facts that go against those beliefs, despite their relevance.

- **Attribution bias** occurs when someone attributes reasons or motivations to the actions of others without clear evidence to support the assumptions.
Topics To Discuss

- What drives medical and surgical care?
- Informed consent
- Patient education
- Research in clinical practice
- External conflicts
- Surgical care
  - Use of new techniques
  - Role of residents and fellows in surgical cases
  - Supervision of trainees vs “efficiency”
  - How and why we indicate cases as surgeons
Potential Drivers of Medical and Surgical Care?

- **Patient**
  - Pain and disability
  - Patient centered medical care
  - Patient satisfaction

- **Surgeon**
  - Concern for the patient
  - Desire for referrals
  - Surgical ego
  - Innovation
  - Financial benefit

- **Hospital or practice profits**

Patient driven health care

- Increased information flow
- Transparency
- Customization
- Collaboration between patient and physician
- Patient choice and responsibility
- Health social networks (physicians as collaborators)
- Quantitation of health care outcomes
Informed consent is the process of obtaining permission before conducting a healthcare intervention. Consent is collected according to ethical guidelines. An informed consent includes a clear appreciation and understanding of the facts, implications, and consequences of an action. To give informed consent, the patient must have adequate reasoning faculties and have possession of all relevant facts. A health care provider may ask a patient to consent to receive therapy before providing it. A clinical researcher will consent a research participant before enrolling that person into a clinical study.
Educating our patients

- Education is paramount to informed consent
- Patient-centered care
- Role of the internet?
- Balance between enough and too much info
- Providing an opinion based on evidence
- Providing a risk–benefit assessment
- Handouts and drawings
- Time for questions: use of physician extenders
Patient Issues

- “I don’t need that much information”
- “But the internet says …..”
- “How many of these have you done?”
- “The other doctor told me something else”
- “Why was the last surgery done?”
Enrollment in patient registry

Prospective study on a particular condition or technique
- May be easier if clear bias exists

Randomized trial – requires clinical equipoise
- Must be comfortable that two approaches may be equally effective

Inform patients of potential conflicts

Describe degree of patient involvement
Patient Issues

- “How much time will participation take?”
- “Is this experimental?”
- “If I don’t participate will you still be my doctor?”
- “What would you do?”
Conflict of Interest in Clinical Research

- Researchers have a tradition of inquiry and exchange of ideas with a shared purpose to create, critique and disseminate knowledge.

- Trust and objectivity are fundamental.

- Conflicts of interest are intrinsic to research:
  - Tangible conflicts: those involving financial relationships
  - Intangible conflicts: involve academic activities, patient care and scholarship
Conflicts on an Individual Level

- Objectivity is critical for scientific discovery
- Bias is almost impossible to eliminate
- Professional pressure can influence perceptions and actions
- Pressure to publish
  - Scientific funding
  - Faculty appointments and promotions
  - Respect of peers
- Bias can be very subtle and can creep into:
  - How research questions are selected
  - Choice of research design and participants
  - How data is collected analyzed and published
Academic Conflicts of Interest

- Peer review is benchmark of scientific process
- Academic conflict may occur if an individual interferes with peer review process
- Sources of “intellectual bias”
- David Blumenthal, MD (JAMA, 1997)
  - Has studied publication practices
  - Negative results are less likely to be published
  - Positive findings can be withheld if advantageous to authors
  - Reviewers have the potential to accelerate or delay publication
Conflict of Interest: Industry

- Professional and scientific organizations
  - Most have clear COI policies
  - Define conflicts:
    - industry relationships
    - consulting agreements
    - stock ownership
    - royalties
  - Conflicts may create ethical challenges but can be managed if appropriately disclosed
Industry–physician relationships have resulted in tremendous progress in the development of orthopaedic implants/patient care (BZ)

Surgeon/industry relationships have suffered as a result of increased regulation (BZ)

“The trust between a patient and a surgeon is critical, but the relationship is one of the most imbalanced in terms of power (DL)

“Keep in mind:
◦ Physicians are human
◦ As humans, physicians are far more vulnerable to conflicts and bias than we will admit
◦ Conflicts cannot be entirely eliminated but must be managed” (ET)
Choices as Surgeons

- Use of new techniques: balance between innovation and experimentation
  - Equivalent procedures
  - New techniques
  - New devices and costs?
  - Role of surgical reps in the OR

- Role of residents and fellows in OR
  - Balance between training and patient choice

- Supervision of trainees vs efficiency
  - How do you tread this very fine line
  - Different practices in hospital based and ambulatory surgery centers
Questions

- Do you inform patients about intent to use a new technique?
- “Will you be doing my surgery?”

- How do you prepare to do something new?
- When do you request assistance?
  - Practice partner, surgical skills course, reps
  - Do you monitor faculty members for their continued competence?

- How do you deal with complications?
  - As surgeons, we should review these with involved residents and fellows
  - Is M&M conference educational or punitive? Personal bias can impact this tremendously.
Conflict of Interest: Patient Care

What fuels our recommendations for Rx?
- Patient care
- New techniques
- Surgeon/problem solver/innovator personality
- Need to be recognized as a ‘busy surgeon”
- Financial gain

Patients appreciate innovation but disclosure is critical
- Industry relationships
- Consulting agreements
- Royalties
“Intrinsic Conflicts and Personal Bias”

- May be very difficult to define
- Surgeons and interventional physicians make money performing procedures
- Does being busy = increased status?
- Need to be vigilant about indications: *especially* critical in a teaching environment
- Team physicians have to manage patient care and athlete/coach/team expectations
Medical students are impacted by what they see and experience

Faculty members are impacted by treatment locally and nationally
  - Lack of diversity on national panels “manels”
  - Differences in introductions of male and female speakers
  - Lack of inclusion on local, regional and national committees

We are moving steadily toward diversity but does that imply inclusion?

To attract the best and brightest to orthopaedic surgery, we must remain aware of our potential intrinsic biases

"Intrinsic Conflicts and Personal Bias"

How does this impact the future of our profession?
Thoughts and Discussion

What do you struggle with?