The Unintended Consequences of Conflict of Interest Disclosure

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CONFLICTS OF INTEREST, BOTH FINANCIAL AND NON-
financial, are ubiquitous in medicine, and the most
commonly prescribed remedy is disclosure. The
Medicare Payment Advisory Commission and the
Accountable Care Act impose a range of disclosure require-
ments for physicians, and almost all medical journals now
require authors to disclose conflicts of interest (although
these requirements may be imperfectly heeded). Given that
some relationships between physicians and industry are fruit-
ful and some conflicts are unavoidable, can disclosure cor-
rect the problems that arise when economic interests pre-
vent physicians from putting patients’ interests first?

Disclosure has appeal across the political spectrum be-
cause it acknowledges the problem of conflicts but in-
volves minimal regulation and is less expensive to imple-
ment than more comprehensive remedies. More importantly,
even if disclosure is rarely seen as providing a complete so-
lution to the problem, it is broadly perceived to have ben-
eficial effects. There are, however, reasons that disclosure
can have adverse effects, exacerbating bias and hurting those
it is ostensibly intended to help.

Increased Bias and Insufficient Discounting
With Disclosure

Disclosure can lead physicians to offer biased advice. Two
mechanisms involved are strategic exaggeration (the tend-
ency to provide more biased advice to counteract antici-
pated discounting) and moral licensing (the often uncon-
scious feeling that biased advice is justifiable because the
advisee has been warned). In 2 sets of studies that mimic as-
pects of the patient-physician relationship, participants were
paired and divided into 2 roles: advisor and estimator.1,2 Es-
timators attempted to assess some quantity (in one study, the
value of coins in jars; in the other, recent house sale prices)
but received only imperfect information (eg, they were able
to view the coin jars briefly and from a distance). Advisors
were made into relative experts (eg, by being allowed unlim-
ited time to view the coin jars up close), and they provided
advice to less informed estimators in the form of suggested
estimates. Estimators received the advice, made estimates, and
were paid based on their accuracy. In some experimental con-
ditions, advisors were not conflicted but were paid based on
the estimator’s accuracy. In other conditions, advisors were
conflicted; they were paid to the extent that their estimators
overestimated the values in question. In some of these con-
ditions, the advisor’s conflict was disclosed to the estimator,
and in others it was not. Not surprisingly, conflicted advi-
sors gave more biased (higher) advice than those with no con-
licts. However, consistent with strategic exaggeration and
moral licensing, a key finding was that the bias was substan-
tially greater when the conflict of interest was disclosed.

The greater bias of advice with disclosure would not be a
problem if estimators (or, in the case of medicine, patients)
could use disclosure to discount the advice appropriately, but
this did not happen. With disclosure, estimators did dis-
count the advice more, but not sufficiently to counteract the
increased bias in the advice they received. In both studies, es-
timators made less money with disclosure than without it and
advisors made more, exactly the opposite of the intended ef-
fect of disclosure. This failure to properly discount biased ad-
vice is almost certainly more of a problem in medicine than it
was in those stylized experiments. Although patients are ready
to believe that physicians in general may be biased by con-
licts of interest, most are resistant to the idea that their own
physicians would be so biased.3 This may be partly due to the
common misconception that bias, to the extent it occurs, re-
sults from deliberate deception. In fact, even well-meaning pro-
essionals can find it difficult to resist the unconscious influ-
ence of the incentives that they may face for providing biased
advice. Indeed, patients may even take the disclosed fact that
their physicians have been paid by pharmaceutical compa-
ies as an indication that those physicians must be experts on
the drugs produced by those companies.4,5

Increased Pressure to Comply:
The Burden of Disclosure

Other studies specifically focusing on the patient-physician
relationship examined another potentially perverse effect of

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Disclosure: even when disclosure decreases trust in advice, it can increase the pressure on patients to comply with the advice. One mechanism of this effect is insinuation anxiety. Consider a patient who turns down her physician’s suggestion that she enroll in a clinical trial. Why did she reject the trial? One likely explanation is that she is satisfied with her current treatment. However, if disclosure has occurred (eg, if the physician has told the patient that the physician would receive a referral fee if the patient took part in the trial), the patient might worry that there would be a new interpretation of her rejection of the trial, namely, that the patient suspects that the physician is corrupt. Therefore, disclosure is likely to decrease trust in the clinician’s advice (regardless of whether the advice is biased) yet increase pressure to take the advice due to fear of signaling distrust of the physician. These effects occurred both in stylized laboratory experiments involving advisors and recipients and in scenario studies in which participants took the perspective of patients receiving advice (either with or without disclosure) from a conflicted physician.

Enhancing the Effectiveness of Disclosure

Despite its potential pitfalls, disclosure is almost certainly a good thing. It should be a patient’s right to know whether his or her physician is receiving financial benefits from prescribing a particular drug or will personally benefit if the patient accepts recommended tests or procedures. The question for policy should not be whether to disclose but how to ensure that disclosure has its intended effects.

Research has revealed ways of making disclosure more effective. For example, unconflicted second opinions are helpful in enabling patients to assess the effect of disclosed conflicts on the advice they receive. Insurers could routinely cover the cost of (and provide incentives to patients for) obtaining disinterested second opinions. Disclosure works better when it is provided by third parties and when the patient is given time to reflect dispassionately on the advice (and the disclosure) and make his or her decisions while not in the presence of the physician.

To the extent that disclosure works, it typically does so by influencing the behavior of those whom the disclosure is about more than those to whom the disclosure has been made. For example, the publication of automobile roll-over statistics led to rapid changes in automobile design, and public grading of restaurant hygiene in Los Angeles led to a decrease in food-borne illness. Applied to the patient-physician relationship, the prospect of disclosing a conflict could discourage physicians from entering into relationships that are difficult to justify.

Medical disclosure could be made more effective, less burdensome, and very likely more complete by creating a unified web-based universal online disclosure form, by storing and making available detailed explanations about payments received, and by bringing in intermediaries such as consumer watchdog groups to help patients make sense of the information. More comprehensive and uniform disclosure should make it more likely that physicians will be discouraged from entering into problematic conflicts because of the threat of having to clearly disclose them to patients and others.

When Disclosure Misses

Even if disclosure is crafted in a fashion that increases effectiveness and minimizes potentially adverse consequences, it is no panacea. Disclosure is simply not applicable to many serious conflicts of interest affecting medicine in the United States. Although payments from pharmaceutical and device companies have received most of the attention in the literature on disclosure, other conflicts, such as financial arrangements that give physicians (and their institutions) incentives for providing high-cost services of dubious value, may be more consequential. It is difficult to imagine how disclosure could even be applied to, let alone undo, those problems.

However, perhaps the most significant likely pitfall of disclosure is not its effects on the quality of advice received by individual patients or its inapplicability to many serious conflicts of interest, but the likelihood of a kind of moral licensing on the part of the profession as a whole—the rationalization that, with disclosure, the profession has dispensed with its obligation to deal with conflicts of interest. Conflicts of interest, including fee-for-service arrangements, are at the heart of the astronomical increases in health care costs in the United States, and transparency is no substitute for more substantive reform.

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