Ethics and Professionalism
Can There Be Consensus?
An Editorial Comment on the Report of the ACCF/AHA Consensus Conference on Professionalism and Ethics

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Ethics, too, are nothing but reverence for life. That is what gives me the fundamental principle of morality, namely, that good consists in maintaining, promoting, and enhancing life, and that destroying, injuring, and limiting life are evil. Albert Schweitzer

Ethical behavior is defined in terms of morality and is recognized as the mark of a good and decent person and, likewise, of a trustworthy organization. Although we value it in all aspects of life and have been dismayed by its flagrant absence in some modern examples in the business world and in government, it is, of course, most critical for those individuals and organizations whose actions touch our very lives. Professionals responsible for the health and welfare of society, whose actions can literally save or take a life, should appropriately be held to higher ethical standards. Likewise, organizations such as the American Heart Association (AHA), long trusted to provide critical information to healthcare providers, the public, patients, and policy makers, and thus with the ability to have a profoundly beneficial impact on society, must similarly follow the highest ethical standards. The foundation of all we do is based on the public’s trust. It is for this reason that the AHA, in partnership with the American College of Cardiology (ACC), sponsored the recent Bethesda Consensus Conference on Ethics and Professionalism, the proceedings of which are reported in this issue of Circulation.2 The topics covered were wide ranging, from issues of potential conflict of interest in research involving human subjects, to a discussion of the nature of academic independence, to disclosure of conflicts in presentations and in publishing.

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These topics have been the subject of much public discussion in recent years, and although one might think from the public debate that the answers to all ethical issues are self-evident, there are, in fact, many issues about which there is not complete consensus. It was the purpose of this conference to bring these issues into clear focus for open, vigorous, and constructive debate and to provide the collective counsel of the group to both organizations and their members. Both the AHA and the ACC will incorporate the issues presented at the Conference into their own internal discussions as we move forward and consider whether these recommendations should lead to any modification of our current procedures and policies.

You will see as you read the proceedings that there are areas about which there is not yet sufficient evidence to form a clear opinion, even though the principles guiding us are evident. As an example, heart hospitals, particularly those with close relationships to subspecialty practice groups, might seem to provide advantage and efficiency by grouping patients with common diseases for care; but the resultant comparative patient outcomes and the impact of these hospitals on their communities and other hospitals serving those communities are still unclear. In these instances, it seems most prudent to continue to collect data and monitor activity and outcomes before we can clarify a position that will support the best interests of the patient.

In contrast, there are many areas about which there is general consensus and support for our current policies or for new policies. The AHA has stringent policies in place to ensure that the readers of our journals are aware of any potential conflicts of interest held by authors or reviewers, and we publish those relationships with industry that are relevant to the topic under consideration in our journals, both in print and online. We do not agree with some critics who, at the extreme, feel that those who write original articles, reviews, or scientific statements or guidelines and those who advise other professionals and the public in many other ways should never have any relationship with industry. Indeed, to limit our selection of authors and reviewers to this extent would eliminate some of the most experienced scientists and investigators. By contrast, we do agree that it is ideal to include individuals without direct conflicts in all of those settings and each of those groups and to disclose any potential conflicts as discussion proceeds. This is the procedure we use in selecting the writing groups for our joint Practice Guidelines with the ACC and for the statements we publish alone or with others. The recent concern about the National Cholesterol Education Program publication, “Implications of Recent Clinical Trials for the National Cholesterol Education Program Adult Treatment Panel III Guidelines,” which was inadvertently initially published without financial disclosures, highlights the importance of these disclosures. Although few
disagreed with the content of the document, and in fact, many thought it took a rather conservative position, the issue of the potential conflicts of interest of the authors dominated the press coverage of this update, which was an unfortunate outcome for the patients and physicians for whom the science was the important public health issue. Because it was not evident in the paper, there was little coverage of the fact that endorsement of the document by the AHA was supported by independent reviewers with no conflicts who agreed with the conclusions of the paper. Clearly, we must both act ethically and ensure that the public recognizes that we have acted ethically.

Issues of conflict of interest must also be addressed in research, especially in clinical trials, the results of which have such a direct effect on practice. The conference members addressed the critical issues related to these trials and their presentation and publication. Only if transparency supports the essential trust placed in science and medicine will advances be brought to patients in an appropriate manner that benefits them most. In these trials, as in all of medicine, the interests of the patient are primary and must be the basis of all decisions. Clinician-scientists and the biomedical research industry must follow the highest ethical standards in designing clinical trials, in recruiting patients (and especially in ensuring that previously underrepresented groups, such as the elderly, women, and racial/ethnic minorities, are included in these trials), in obtaining informed consent, in making the results available to the public, and in disclosing all financial relationships that are relevant to the evaluation of these results. The AHA’s own research program assures such conduct in the research it supports, and it strongly encourages that these principles be followed in all cases. We fully support the concept espoused by the International Conference of Medical Journal Editors3 that industry should register all clinical trials in a publicly accessible place, where both positive and negative results ultimately would be available. As the results of such trials, whether industry supported or not, are presented, the AHA will continue to require at its meetings and in its publications that investigators disclose their financial relationships. Only in this way will the public continue to regard the AHA as a faithful steward of its trust and as its firm and constant advocate for better health. Just as the physician–patient relationship must be based on trust to be nurturing and effective, so, too, must we remind the public and patients by these measures that we are advocating on their behalf and that their interests are our first priority.

As you read the Consensus documents, we believe that you will be impressed by the vigorous debate and discussion that underlies the recommendations. There is consensus in most areas; in areas needing continuing discussion, we will count on you to participate in the ongoing debate as we all seek the moral high ground together.

References
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