

Ensuring Accountability through Health Professional Regulatory Bodies: The Case of Conflict of Interest

Assurer l'obligation de rendre compte par l'entremise
des organismes de réglementation des professionnels
de la santé : le cas du conflit d'intérêts



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Abstract

How do self-regulated health professions' regulatory bodies address financial conflict of interest (COI) and ensure accountability to the public? Using document analysis, we examined how four Ontario regulatory colleges (physicians, nurses, physiotherapists, audiologists/speech-language pathologists) defined COI and the education, guidance and enforcement they provided for COI-related issues. These colleges are upholding the mandates to define, identify and address financial COI by providing regulations or standards and guidelines to their membership; they differed in the amount of educational materials provided to their registrants and in the possible COI scenarios they presented. Although there were few disciplinary hearings pertaining to financial COI, findings for the hearings that did occur were documented and posted on the college public registers (the listing of all registered college members along with all relevant practice information), informing the public of any limitations or restrictions placed on a member as a result of the hearing.

Résumé

Comment les organismes de réglementation des professionnels de la santé, qui sont autoréglementés, peuvent-ils faire face aux situations de conflits d'intérêts d'ordre financier tout en assurant l'obligation de rendre compte auprès de la population? À l'aide de la documentation, nous avons analysé la définition du conflit d'intérêts donnée par quatre organismes de réglementation (médecins, infirmières, physiothérapeutes, audiologistes/orthophonistes) et nous avons analysé la formation, les directives et les mesures coercitives qui touchent aux situations de conflit d'intérêts. Ces organismes sont responsables de définir le conflit d'intérêts, de détecter les situations de conflit et d'y faire face en fournissant à leurs membres la réglementation, les normes et les directives nécessaires; on note des différences dans la quantité de matériel de formation fourni aux nouveaux membres et dans les divers scénarios de conflit présentés. Bien qu'il y ait peu d'enquêtes disciplinaires en relation avec un conflit d'intérêts d'ordre financier, les résultats de ces enquêtes sont consignés et affichés sur les registres publics des organismes (la liste de tous les membres inscrits comprenant des renseignements pertinents sur leur pratique), informant ainsi la population de toute restriction qui pourrait toucher un des membres suite à une enquête.

SELF-REGULATION IS AN AUTHORITY-BASED APPROACH TO POLICY IMPLEMENTATION that may be used by the government during the implementation of health policy (Doern and Phidd 1992; Howlett et al. 2009). As clarified in the Introduction to this Special Issue (Deber 2014), self-regulation as a policy instrument allows the government to delegate responsibility for managing the creation, administration and renewal of standards governing the activities of certain groups to non-governmental regulatory bodies. It relies heavily on the concept of professionalism, which includes such factors as the existence of a

specialized body of knowledge, the recognition that good/bad practice is difficult to evaluate by those who do not have that body of knowledge, and an “agency” relationship where the professionals act on behalf of their clients, plus the potential for harm if the activities are not carried out well (Bayles 1986; Freidson 1994, 2001). Professionalism assumes that the expertise and experiences of healthcare professionals are best evaluated by similarly trained individuals who can evaluate the quality of work done and ensure that high-quality service is regarded as more important than financial gain, supporting the maintenance of professionalism in practice (Freidson 1994, 2001).

In Ontario, the *Regulated Health Professions Act* (RHPA) grants self-regulation to 26 healthcare professions (Government of Ontario 1991). Each healthcare profession has a governing regulatory body (usually called a College) that is responsible for ensuring all aspects of the RHPA are upheld. The Health Professions Procedural Code (HPPC) of the RHPA outlines the duty and objects of the colleges as well as the complaint handling process and the disciplinary process. The RHPA stipulates that in carrying out the objects, the colleges have a responsibility to “serve and protect the public interest” (p. 30). Conflict of interest (COI) is not specifically noted in the objects; however, the fifth object in the RHPA does direct the colleges to “develop, establish and maintain standards of professional ethics for the members” (p. 30).

A COI occurs when conditions exist that may unduly influence an individual’s behaviour or ability to carry out the obligations of his or her office or position (Carson 1994; Thompson 1993). These conditions are related to opportunities to advance self-interest and are often financial. COI may interfere with patient care, erode patient trust and, if not well managed, undermine the effectiveness of self-regulation (Haines and Olver 2008; Tonelli 2007). COI is influenced by how providers are paid; different payment models may incentivize undertreatment or overtreatment (Deber et al. 2008).

Another potential source of COI may arise when the pharmaceutical or medical device industry attempts to align professional interests with that of the industry instead of the patient (Brennan et al. 2006; Thompson 1993; Tonelli 2007). Influence may be exerted through gifts, continuing education sponsorship and support, guideline development or consultancy roles (Coyle 2002; Guyatt et al. 2010; Marco et al. 2006).

Various approaches can be used to address financial COI, including provincial oversight, self-regulation, policy development and full disclosure to the consumer. The RHPA specifies that the self-regulatory bodies governing the healthcare professions falling under the Act are responsible for developing, establishing and maintaining standards pertaining to ethics and conduct (Government of Ontario 1991). As part of maintaining the standards of professional ethics and conduct under the HPPC, the colleges are mandated to have an Inquiries, Complaints and Reports Committee (ICRC) and a Discipline Committee. The ICRC is mandated to investigate all complaints or reports brought forward and render a decision, which may include requiring the member to appear before a panel of the ICRC to be cautioned, refer the member to a panel of the ICRC for incapacity proceedings, or refer a specified allegation of the member’s professional misconduct to the Discipline Committee (RHPA 1991, c. 18,

shed. 2, s. 26). If the ICRC refers a case to the Discipline Committee, a panel is formed to review the evidence and determine whether an act of professional misconduct has been committed.

Disciplinary hearings are open to the public unless circumstances exist, such as issues of public security, which are outlined in the HPPC, indicating that the public should be excluded. At the disciplinary hearing, the evidence is presented to a panel of the Discipline Committee. The discipline panel is a subset of the Discipline Committee and must include at least two public members and one professional member who is also a member on the college council (RHPA 1991, c. 18, sched. 2, s. 38[2]). Public members are non-professional members of the college's council that are appointed to the council by the province's lieutenant governor. In the event that a member is found culpable, the panel can issue orders that direct the registrar to suspend or revoke the member's certificate of registration or impose specific terms, conditions and limitations on the member's certificate. Members may also be reprimanded by the panel and issued a fine not exceeding \$35,000, payable to the Minister of Finance.

The purpose of this study was to examine how financial COI was addressed by four regulatory bodies in Ontario: the College of Physicians and Surgeons of Ontario (CPSO), the College of Nurses of Ontario (CNO), the College of Physiotherapists of Ontario (CPO) and the College of Audiologists and Speech Language Pathologists of Ontario (CASLPO).

Professionalism and Self-Regulation

Professional self-regulation is an approach to accountability that places the responsibility on the professional regulatory bodies to set and enforce standards of behaviour. Owing to the nature of work performed or type of work environment within which a provider practises, standards of behaviour may be difficult to measure, and in theory may be best addressed by appealing to professionalism. For example, physicians clearly qualify as health professionals and provide a variety of services that may endanger their patients if not performed well. One complicating factor is that the complexity of the work performed, and the observability (i.e., extent to which this work is directly observed by other professionals who can judge the quality of work performed), may vary significantly across work settings. For example, physicians working in a solo practice environment, compared to those working in a hospital operating room, vary in how likely other professionals will be present and observing or collaborating on the work performed.

Methodology and Research Questions

The methodology used included a descriptive document analysis to compare each of the colleges, the results of which are reported here. CPSO, CNO, CPO and CASLPO were selected to maximize the variability among professional colleges based on number of registrants, registrants' scope of practice, types of workplace settings and the number of controlled acts bestowed upon the members of these colleges. The four colleges selected varied considerably in the number of registrants, scope of practice and authorization to perform a controlled act.

The most recent annual reports published at the time of this study indicated that CASLPO had the smallest number of registrants with 3,595 members while CPO had 7,524 registrants, CPSO had 30,227 registrants and CNO had the largest number of registrants, with 153,073 members. All the professions governed by these colleges had title protection and defined scope of practice under the RHPA. Title protection refers to restrictions that the specific health profession's act imposes in the use of the title to those who are members of the college. For example, only members of CPO can use the titles physiotherapist or physical therapist (*Physiotherapy Act*, SO 1991, c. 18, s. 8[1]). The scopes of practice are the areas that the profession's acts outline as entailing the profession's practice. For example, the *Nursing Act* outlines the following scope of practice for nursing: "The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function" (SO 1991, c. 32, s. 3).

Controlled acts are specified in the RHPA as activities that may be performed only by authorized regulated health professionals as outlined in the legislation (SO 1991, c. 18, s. 27[1]). There are 14 controlled acts outlined in the RHPA (SO 1991, c. 18, s. 27 [2]). Each of the colleges had registrants who were authorized to perform at least one controlled act. The speech-language pathology registrants at CASLPO were not authorized to perform any controlled acts, but the audiology registrants were authorized to perform one controlled act. Registrants at CPO were authorized to perform up to seven controlled acts; CNO registrants (who included nurse practitioners) were authorized to perform between five and nine controlled acts, and CPSO registrants were authorized to perform up to 13 controlled acts. A higher number of controlled acts would suggest greater autonomy and, based on the rationale behind controlled acts, greater risk of harm to the patient during the course of treatment.

Three questions guided the study:

1. How did each college define COI?
2. What steps did each college take to address potential financial COI?
3. How did each college enforce the legislation or address issues where allegations of financial COI occurred?

The documents reviewed were obtained from governing provincial legislation and regulations, including the RHPA and each profession-specific governing legislation, and college by-laws, practice standards and guidelines, policies, records, reports, training documents/modules and disciplinary outcomes. Documents were initially classified according to the type of document or publication, including government legislation, by-laws, standards, guidelines, policies, official records pertaining to disciplinary findings for the reporting year 2012, and registrant communication materials, which included newsletters, postings, educational videos and webinars. After classification, document analysis for each college examined how COI was defined; whether the college published regulations, position statements or guidelines pertaining to

financial COI; whether other educational materials were published; how COI was managed (explicit directives to the membership); and whether any disciplinary hearings conducted in the past reporting year pertained to allegations of professional misconduct related to financial COI. Evidence pertaining to the research questions was charted and the materials were compared across the four colleges. The materials consulted are listed in the supplementary Appendix (see Appendix at www.longwoods.com/content/23850).

Results and Analysis

Defining and setting standards for conflict of interest

In terms of determining how COI was defined, document analysis focused on discovering what each college had in place with respect to a code of ethics, professional misconduct regulations, COI regulations and practice standards or guidelines. Three of the four colleges, CNO, CPO and CASLPO, had a published code of ethics. CPSO did not have its own code of ethics but deferred to the national professional association, with a reference to the Canadian Medical Association's code of ethics on its website. Neither CPO nor CNO explicitly addressed COI in their codes of ethics. Only CASLPO had COI specifically noted in its code. By-law 2011-08 addressed COI in broad terms, stating in section 4.2.6 that members "shall avoid activities that could be construed as involving a conflict of interest." Professional misconduct was an important component to examine, as the regulation is used in both the definition and the enforcement of practice standards. Each college had a professional misconduct regulation in place as part of its mandated profession-specific regulations. All these regulations, as outlined in the profession-specific legislation, indicated that practising while in a COI, or in the case of CPSO, having a COI, constituted professional misconduct. However, a definition of COI was not outlined in these regulations.

The next component of the document analysis focused on COI-specific regulations and how the colleges defined COI. CPSO's COI regulation, as outlined in the *Medicine Act*, included a detailed definition of COI, including various benefits or advantages a professional might be exposed to that could lead to a COI. CASLPO had a proposed regulation for COI that was drafted in 1996, while CPO defined COI in multiple practice standards and CNO provided a definition in its Professional Conduct: Professional Misconduct reference document, which also indicated there was a proposed COI regulation for nursing, although this was not available at time of writing. All four colleges had similar definitions of COI and explicitly stated that members should take the necessary steps to avoid practising while having a COI. Each of the four colleges included additional disclosure steps. CPSO required disclosure to the patient and written notification to the college. CPO, CNO and CASLPO required disclosure to the patient in the event that COI was unavoidable. CASLPO also required members to provide patients with a list of alternative practitioners in order to offer them choices in the event of a COI.

Educational materials

A document analysis of the materials available to educate registrants of their obligations revealed similarities and differences in the types of learning materials supplied by each college (for references see Appendix at www.longwoods.com/content/23850). As noted earlier, all the colleges provided explicit definitions or directives regarding COI for registrants. CPO and CNO provided practice scenarios, self-reflection exercises or learning examples of when and why COI might occur. For example, CPO's "Guide to Advertising, Fees & Billing and Conflict of Interest" (2008) listed a number of learning scenarios, including referring patients for non-physiotherapy services at a practice where the physiotherapist would financially benefit, payment for referrals and also selling products for profit in addition to providing services. The guide included two tools to assist CPO's membership in assessing their practice scenario. The first tool included questions for professionals to ask themselves to determine whether a potential COI existed, while the second tool provided steps to follow when COI could not be avoided. CPO also had three ethics e-learning modules that included self-reflection questions and guidance.

CNO tended to focus more on maintaining professional boundaries and, in its Therapeutic Nurse–Client Relationship Practice Standard (2006), provided a decision tree to determine whether such boundaries were being maintained. In its e-learning module on maintaining boundaries, CNO suggested specific scenarios involving taking money as a gift from a patient. It also had an "Ask Practice" section of its website that provided guidance and answers to practice scenarios. The COI scenario presented was that of a nurse selling products privately and the conditions under which this might be acceptable. Both CNO and CASLPO had similar e-learning modules on social media awareness, "Pause Before You Post," which had a section pertaining to COI in the CASLPO version.

CASLPO provided specific expectations regarding the sale of products in the proposed COI regulation that involves full disclosure to the patient along with providing the patient with alternative options. CPO and CNO also provided specific expectations in their practice standards on the sale of products and included the mandate to provide patients with recommendations based on standards of the profession, along with options. All three colleges indicated that products should be sold at cost.

CPSO did not provide any practice scenarios or learning modules pertaining to COI. It did provide a summary of the COI regulation that it published in its quarterly magazine, *Dialogue* (2006), along with an electronic disclosure form. The college also provided a link to the "Good Medical Practice" learning modules of the General Medical Council, which included a module on financial COI.

Enforcement and disciplinary hearings

The colleges shared the same responsibilities under the RHPA in relation to duties and objects and addressing professional misconduct. Each college conducted mandatory investiga-

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tions when necessary and had an ICRC and a Discipline Committee. Results for the colleges' most recently published annual reports summarized each college's ICRC decisions and included the number of referrals to its Discipline Committee. Referrals included any cases where allegations of COI constituting professional misconduct might exist. CASLPO's 2012 annual report stated that three of the 25 matters decided by its ICRC for that year were referred to the Discipline Committee, and were all for the same member. No disciplinary hearings were held in 2012 (see Appendix).

CPSO's 2012 annual report noted that 67 of its 2,676 ICRC decisions were referred to the Discipline Committee. These proceedings resulted in a total of 38 members being referred to the Discipline Committee, as some had multiple ICRC referrals (see Appendix). The ICRC also reported on the types of matters that were investigated that included COI. Of the 37 hearings conducted in 2012, 13 involved allegations of disgraceful, dishonourable or unprofessional conduct, but the annual report did not elaborate on the nature of the allegations or the factual details. A review of CPSO's website postings on discipline decisions for 2012 indicated that up to four of them related to COI, although the allegations specified only professional misconduct. One case involved a member borrowing money from patients; another involved a member requiring patients to pay a "membership fee" to the member's private business in order to receive publicly funded services; and two cases involved members being reimbursed for authorizing prescription medications based on reviewing information for patients submitted online. For all these cases, the members' orders included public reprimands, a temporary suspension of registration, and terms, conditions and limitations placed on their registration. The two cases involving authorization of prescriptions included fines from other jurisdictions.

CNO reported that for 2012 its ICRC rendered decisions on 317 complaints, four of which were referred to the Discipline Committee (see Appendix). The annual report indicated there had been 41 discipline outcomes, with six revocations of registration and 35 reprimands, temporary suspensions, and terms, conditions or limitations imposed (see Appendix). The nature of the allegations and the findings were not detailed in the annual report, but were posted by member names on CNO's website. A review of the discipline decisions posted for 2012 indicated that five involved an element that might be construed as COI, as the allegations pertained to professional misconduct. One case involved a member accepting gifts from a patient; two other cases involved members taking money, gifts or credit cards from their patients or patients' families; and another case involved the member borrowing a patient's credit card to pay registration dues and also suggesting that the patient move in with the nurse. The final case involved a member borrowing money from a patient; in this case, the member resigned from the profession. In the remaining cases, all members were ordered a public reprimand, a temporary suspension of registration, and terms, conditions and limitations placed on their registration.

CPO's annual report for 2012/13 indicated that 69 decisions were rendered by its ICRC and of these, four were referred to the Discipline Committee (see Appendix). Three disciplinary hearings were completed during this reporting period, and the summaries were noted

in the report. One of the three cases involved a member submitting false claims to and being reimbursed by insurance companies for various healthcare services and products supposedly provided to her, although these products and services were never actually provided. This situation might be considered a COI because of the failure to put responsibilities as a healthcare professional ahead of personal interests, although the term COI was not used in the summary or the agreed-upon statement of facts (CPO 2013). The member was ordered a penalty that included a reprimand, a six-month suspension that could be shortened to three months upon completion of an ethics program, and practice monitoring for three years (CPO 2013).

As part of their disciplinary process, the colleges published discipline matters and outcomes and included the names of the registrants involved for the public record. CNO, CPSO and CPO summarized disciplinary outcomes on their websites. The public register of members, which each college is required by the HPPC to post, noted for each of the members the reprimands, suspensions, and terms, conditions or limitations ordered through any hearings. As previously noted, there were no discipline hearing outcomes for CASLPO, although pending hearings were noted on the website, as was the case for CPSO.

Discussion

The purpose of this study was to examine how financial COI was addressed by CASLPO, CNO, CPSO and CPO. All four colleges had the mandated committees and processes in place to meet the RHPA requirements. All four colleges had a regulation, a proposed regulation or a standard in place that addressed COI. Although all had references to COI in the profession-specific professional misconduct legislation, the colleges took different approaches in addressing COI. CPSO's COI regulation gave a detailed definition of benefit and what constituted conflict of interest. CASLPO had a proposed COI regulation posted on its website that also provided a definition of COI. Both CNO and CPO addressed COI in detailed practice standards.

All four colleges provided materials to their membership pertaining to COI, although these varied across the colleges in scope and detail. CNO and CPO provided decision tools and scenarios pertaining to possible COI, along with standards and guidelines as part of their approach. CNO and CASLPO both had online learning modules on social media that contained a section on COI, and CNO had an e-learning module that involved financial COI. CASLPO provided directives in the proposed COI regulation pertaining to the sale of products. CPO and CNO offered directives in their standards. CNO gave details on the therapeutic patient–client relationship and how crossing professional boundaries might lead to COI. CPSO had a self-reporting requirement that its membership submit notice when they were practising in circumstances where COI might be unavoidable.

The findings from the last available annual reporting period indicated that these regulatory colleges had few disciplinary hearings pertaining to allegations of professional misconduct related to COI. Specifically, four (11%) of the CPSO disciplinary hearings, five (12%) of the CNO hearings and one (33%) of the CPO hearings had elements of COI, although the term

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COI was not used in the allegations. The orders made as part of the decisions in these hearings included public reprimands, temporary suspensions of registration, and terms, conditions and limitations, all of which were posted on the public register for the college. These decisions and orders provided evidence that the ICRCs and the Discipline Committees were enforcing and upholding the HPPC mandate of ensuring accountability to the public.

What is not clear from the document analysis is how all facets of professional practice are addressed in the practice standards and educational materials in order to ensure accountability. How services are paid for, the work environment and the nature of the work being performed are practice variables that are not all specifically addressed. For example, as the payment of services and devices becomes more privatized and professionals either charge for products and services through their employer or move into an independent practice model where both services and products are sold to the public, COI may be unavoidable. As a result, these practice models may render the regulatory requirement to refrain from practising in COI situations unrealistic. Only one of these colleges required self-reporting, and only two provided learning modules outlining and addressing practice scenarios in which COI might occur. The cases that were referred to Discipline Committees that involved COI had scenarios that differed slightly by college. For example, cases unique to each college for 2012 included CPSO's cases involving member reimbursement for authorizing prescriptions through a review of online patient information, while CPO had a case involving false insurance claims and CNO had cases involving receipt of gifts. These differences may be related to the types of practice scenarios under which particular professionals may work, including type of work, work environment and how they are paid. The colleges that did provide scenarios and associated guidelines had varied scenarios, indicating that there may be differences according to a profession's practice variables.

In order to clarify how work environment, work performed and means of remuneration affect how regulatory colleges deal with COI, key informant interviews will be held in the near future with staff from each of the colleges. It is expected that the information gathered in these interviews will further inform the processes that the colleges undertake to ensure accountability to the public.

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