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Correction
Re: Doctors behaving badly?, by Martin H N Tattersall and Ian H Kerridge, in the 18 September issue of the Journal (Med J Aust 2006; 185: 299-300). The first reference was attributed to the wrong newspaper. The reference should read: " 1 Stop the gravy train [editorial]. The Sydney Morning Herald 2006; 7 Aug: 8

Doctors behaving badly?

Martin H N Tattersall and Ian H Kerridge

It is in doctors' and the drug industry's best interests that their interactions be openly declared

> There is no such thing as a free lunch. Pharmaceutical companies lavish meals, five-star travel, cash and gifts on doctors for one reason: to encourage them to prescribe their drugs. The standard retort from the medical profession is that doctors have sufficient clinical objectivity — and personal integrity — not to be so crudely swayed. Perhaps so.[1]

The interaction between doctors and the pharmaceutical industry was recently catapulted into the public domain by a piece of investigative journalism published in *The Australian*, detailing the wining and dining of doctors by the pharmaceutical giant, Roche, at an educational meeting in Sydney.[2] What surprised many observers was not the revelations regarding the extent of hospitality provided by pharmaceutical companies to doctors, but the response of the Australian Medical Association (AMA). The AMA's public stance was that pharmaceutical industry sponsorship of accommodation and restaurant meals is perfectly acceptable, that drug company sponsorship serves to "oil the wheels" of medical education, and that industry-sponsored events provide valuable opportunities for doctors "to critically question the companies' products" and that "no patient harm comes from this practice".[2] A review of the literature, however, suggests that this is not true.[3,4]

The Australian Competition and Consumer Commission (ACCC) had a differing view. Following the recent release of the ACCC's revised guidelines for disclosure of industry support, the Chairman of the ACCC noted that "Consumers should be able to have confidence that decisions made by their doctors are made solely having regard to their best interest without any potential for influence by benefits or perks".[5] Stated in these terms, the issue is not so much the pharmaceutical industry itself, but the prevention, assessment and management of conflict of interest and, more fundamentally, the importance of public trust in doctors.

The moral core of medicine and the therapeutic relationship has always been expressed in terms of the possession and expression of values such as honesty, integrity, benevolence, respect, compassion, courage and trustworthiness. Trust, which in relation to health care may denote faith, commitment, respect, belief and confidence, has been the focus of extensive academic exploration by a broad range of writers.[6-10] All have pointed to the centrality of trust in therapeutic relationships, the "non-legal" expression of trust, the specific and contextual nature of trust and the manner in which trust can be threatened, diminished or destroyed by actions or behaviour including professional incompetence, abuses of power, boundary violations, experience of harm or the lack of care or respect, deception and manifest conflicts of interest.[11] Of those things that may damage trust in doctors, much of the attention in recent years has been on recognising and managing conflict of interest.

What then constitutes a conflict of interest and how may we avoid it occurring?

Although medical codes of ethics and statements of medical professionalism often give the impression that doctors have a single higher duty to care for the sick, in reality, the relationships that doctors have with their patients are determined by multiple interests, many of which may influence care or decision making. Doctors may hold patient care as their highest professional ideal, but they may also be concerned with community welfare, participation in research, career advancement, student teaching, continued employment, public or professional recognition, and the obligations they have to their care for themselves and their families. While it is inevitable that doctors will have multiple interests, true conflicts of interest (a set of conditions in which professional judgement concerning a primary interest, such as a patient's welfare, is unduly influenced by a secondary interest, such as financial gain) are neither inevitable nor common.[12] But distinguishing where there are no conflicts between these interests from where there is a genuine conflict of interest is sometimes difficult, as any assessment of behaviour must take into account the ethical standards of the profession, the nature of the relationship in question, and the values of the community within which it occurs. What makes this assessment even more difficult is that standards of doctors' behaviour may change as a consequence of deeper sociocultural changes, and according to changes in professional interests, and changes in public or patient needs and expectations. This means that the only way to establish that a conflict of interest exists is to have all the relevant facts available for scrutiny by the participants in the relationship, and by the community or an independent third party. This is only possible if there is a genuine commitment to disclosure and transparency in all areas of medical practice.

Unfortunately, a review of the history of medicine suggests that the medical profession has, until recently, generally been reluctant to be exposed to public scrutiny, either out of fear of legal or social repercussions that may result from such disclosure, or on the grounds that that there is no need for it or no public desire for it. Although such concerns may be understandable, for the most part they are unfounded. Transparency and honest disclosure may actually reduce loss of trust, formal and informal complaints and litigation, and it is the culture of secrecy and sense of moral superiority that sometimes runs through the health professions, rather than "unnecessary" exposure to a disinterested public, that threatens public trust and undermines the doctor–patient or researcher–patient relationship. In this regard, it is of note that a recent randomised trial in the United States of disclosing doctors' financial incentives to patients found that patients' trust in their doctors was unharmed, and their loyalty to their doctor's practice was strengthened.[13]

Therefore, it is hard to disagree with the ACCC that there is merit in increasing the degree to which the relationships between doctors and the pharmaceutical industry are transparent. It may, as has been claimed, ultimately prove to be the case that these relationships do not give rise to conflicts of interest and that the ACCC's new reporting requirements are excessive or unreasonable, but at this stage we do not know that this is true, and we have ample evidence that interaction with industry can create complex and

dependent relationships and influence decision making, prescribing, formulary requests, attitudes and knowledge regarding pharmaceuticals and therapeutics, and the design and interpretation of research.[14] In light of this, it is in doctors' and the industry's best interests that their interactions be openly declared in the relevant context. This will enable informed public and professional consideration of the legitimacy of each group's interest and determination of whether a conflict of interest exists and what measures should be taken to deal with it.

There are many means for encouraging transparency, responsibility and accountability in health care, including the incorporation of ethics in medical education; support for inquiries into professionalism and trust; introduction of templates for disclosure of secondary interests in the research and clinical setting;[15] development and compliance with codes of ethics by the major medical colleges and industry groups; incorporation of patients' representatives and conflict of interest committees into hospitals; and establishment of health care complaints commissions by government. All are deserving of support, even though currently there are insufficient data to evaluate the effect of most such interventions.

Given what we know about the fragility of trust in medicine and the interaction between doctors and the pharmaceutical industry, the profession should support moves to increase disclosure. Even though disclosure may not, in itself, reduce the frequency of unethical behaviour or relationships, and may have no effect on public awareness, it is impossible to adequately identify, manage or prevent conflicts of interest if doctors, the peak bodies that represent them, and the industry groups with which they deal are not completely open about their interactions. Claims that the medical profession is not subject to influence, that the possibility of conflicts of interest arising in relationships between doctors and the pharmaceutical industry does not exist, and that disclosure requirements will lead to the collapse of continuing medical education are naïve, unfounded, inappropriate, and counterproductive.

> Doctors occupy a unique position of trust in society. They should act solely in the best interests of the patient — as many do. But drug companies spend billions of dollars on promotions because they work. The medical profession cannot have it both ways. If doctors want to be seen to be beyond influence, the remedy is simple. Be willing to say thanks, but no.[1]

Competing interests

None identified.

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