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How do we guarantee trainee professional purity?

James W. Jones, MD, PhD, MHA, and **Laurence B. McCullough, PhD,** *Houston, Tex*

In a weekly resident's meeting, the offers of several medical device companies to pay residents for completing their surveys and one endovascular company to pay for chief residents to attend a weekend conference about their products at an expensive resort are brought up. They ask for your approval. As residency director, you should:

A. Allow them to complete the surveys but not attend the conference.
B. Allow them to attend the conference but not complete the surveys.
C. Allow both activities.
D. Disallow both activities.
E. Discuss the context of the activities.

A long habit of not thinking a thing wrong gives it the superficial appearance of being right.

Thomas Paine—*Common Sense*

The subprime mortgage fiasco heralds a new era of ethical practice in our high-stakes marketplaces. The last several years have seen all sorts of traditional winners and icons become suspect. Wall Street has joined juiced athletes, high-rolling TV preachers, and business over-friendly politicians, lured by money, and more money. Now and as ever, blind trust can cloak dishonesty that harms and depreciates all of us. Can we relax, self-assured that future generations of the medical profession will continue to remain morally untouched?

There was an old Texas saying, "One cannot go back on their upbringing." If that is true, American society is in for a rocky ride. A survey of 29,760 students at 100 randomly selected high schools nationwide, both public and private, produced disturbing results. Two-thirds of respondents self-reported that they had cheated on a test in the past year, 36% had plagiarized from the Internet, and 30% had stolen from a store. These results are all the more remarkable, in that self-reporting of ethically suspect behaviors can be biased toward under-reporting. Ninety-three percent said they were satisfied with their personal ethics and character. Michael Josephson,[1] lead investigator, remarked, "What is the social cost of that—not to mention the implication for the next generation of mortgage brokers?"

From The Center for Medical Ethics and Health Policy, Baylor College of Medicine.

Competition of interest: none.

Correspondence: James W. Jones, MD, PhD, MHA, 31 La Costa Dr, Montgomery, TX 77356 (e-mail: jwjones@bcm.tmc.edu).

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In medicine, trust has been won by the selfless actions of so many over countless generations and is so important to the lives and health of society. And where else, excepting a military officer during combat, do people willingly put their life in another's hands as they do for surgeons. Trust cannot be relinquished and continues to exist because the vast majority of the public cannot imagine their doctor doing anything against their best wishes. Nozick[2] considers the "realness" ascribed to people depends on the certainty of how they will act. Jesus, Buddha, and even Hitler appear "bigger than life" because uncharacteristic courses of action are unimaginable. Physicians, ministers, and few others are "bigger than life" because society cannot imagine they could act immorally. This trust in the entire profession is in place and ascribes to the individual physician before a patient even meets them.

The surgeon's relationship with patients is understood in medical ethics to be fiduciary. This means that the surgeon makes reliable clinical judgments about the patient's health, promotes and protects the patient's health as a primary goal, and sublimates self-interest to the patient's. Physicians' continuing commitments to these components of fiduciary responsibility provide a crucial foundation for the public's trust in the medical profession. A conflict of interest can occur even when the surgeon's legitimate and necessary self-interest, including concern for personal time and an adequate income, conflicts with the fiduciary obligation to give primacy to the patient's interests.[3]

Accepting money or other gifts from medical equipment and pharmaceutical manufacturers creates conflicts of interest. In a classic discourse, Waud[4] called gifts from the medical industry "bribes to physicians" because physicians order the products; they do not pay for them. The medical industry funds an enormous amount of important basic and clinical science research and education in academic medical centers around the world. Somewhere along the way, though, the medical manufacturers' marketing depart-

ments shouldered their way into the process, and introduced the techniques of advertising and salesmanship to what medical professionals had been led to believe was a relationship built on their scientific and clinical expertise. Though told otherwise, it was no longer just the doctor's expert opinions and research programs that were sought, it was their influence as a sales broker for expensive products ordered at the patients' expense.[5]

The surgical trainee's fiduciary role, however, is insulated by the faculty surgeon's role and is largely undefined. Moreover, because residents don't have the same authority about patient care decisions, shouldn't their ethical obligations be correspondingly reduced?

Residents are more vulnerable than staff and have less understanding of the influence of marketing on their practice.[6] Residents acknowledge that medical product representatives influence others, but they regard themselves as immune.[7] One survey reported 98% had eaten a pharmaceutical company–sponsored meal within the past year, and 99% believed that pharmaceutical representatives had accurately represented their products to at least some degree. "13% of the residents responded affirmatively to the question: 'If a pharmaceutical company offered to pay you money to wear a small patch on the chest pocket of your white coat advertising their product, would you consider it?'" For these residents, the median requested reimbursement from the pharmaceutical company was $100 annually.[8]

If medical industrial contacts were not effective in altering practice patterns of physicians, the tremendous expenditures by industry would end. And surgery residents have autonomy in the daily operations of a surgical practice, making them full fiduciary partners. Conflicts of interest created by paying residents to complete surveys or to attend off-campus product-marketing conferences pose a serious threat to residents' fiduciary responsibility to their patents and to the professional formation of residents, for which they and faculty members are jointly responsible.

The remedy for undue industrial influence is responsible management of these conflicts of interest, on the basis of strict adherence to fiduciary responsibility as a matter of policy in residency training. In ethics, context is all-important. Is the purpose of the survey being taken legitimately professional? Professional legitimacy hinges on whether the data from the survey would serve a useful purpose in patient care and whether the compensation being offered is reasonable in relationship to the time and effort involved in completing the survey. Likewise, educational programs sponsored by industry should always be suspect. A conference devoted to intensely promoting a single product with availability of multiple products cannot help but be biased. What use does science have for biased data? The influence of the gift is directly proportional to its value and should be recognized as such when choosing to take gifts for educational participation.

The survey and the weekend conference both create economic conflicts of interest that threaten the formation of residents as professionals who will soon bear full fiduciary responsibility for patients. The educational value of both is deeply suspect and can be met by other means within the existing residency curriculum. Option C is ruled out. Option A is not acceptable because it underestimates the ethical threat of the survey. Option B makes little sense; if anything, the conference poses a more powerful economic conflict of interest than does the survey.

The best response is a combination of options E and D. The residency director should schedule an educational session with all of the residents to define conflicts of interest and explain the threats that they pose to fiduciary responsibility and professional formation. A very effective way to manage conflicts of interest is simply for residency programs to eliminate those that are unnecessary. The survey and the conference both create unnecessary conflicts of interest because the residency curriculum itself can, substantively and without bias, address the residents' educational needs. Some conflicts of interest cannot be eliminated, for example, in how physicians are paid (whether fee-for-service, discounted fee-for-service, or capitation) and in the self-sacrifice required to become a surgeon and engage in the practice of our demanding specialty. Unavoidable conflicts of interest should be responsibly managed by adhering to the discipline of evidence-based clinical reasoning, because it is already designed to identify and minimize bias in clinical judgment, decision making, and behavior. The educational program on conflicts of interest should address these topics in discussion with the residents. This educational activity should emphasize also the paramount importance of surgeons continuing to earn the trust of their patients and society in the profession of medicine. The importance of what is at stake cannot be overemphasized.

These interactions are global and ever-present, not unique. Global interactions require guidelines and should not be left to individual interpretation. The subject is important enough for surgery departments to establish guidelines for faculty and residents to interact with industry.

This scenario was suggested by Dr Thomas E. Brothers, who is the surgery program director at the Medical University of South Carolina and is a member of the editorial board of the *Journal of Vascular Surgery.*

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