Position statement on doctors' relationships with industry- APM

Summary

In the many ways in which doctors, and the organisations involving doctors, can interact with the commercial world a key question must be "Would I be comfortable if the details of this interaction became known to my patients?" If the answer is anything other than "Yes, entirely comfortable" then the matter is worth considering in more detail using some of the suggestions below.

The Problem-

This encompasses 2 broad areas,

1-The relationship of doctors with the pharmaceutical industry

2-The relationship of the NHS and its employees with private providers whose primary function is to make money.

Each of these areas may be subdivided further and there will be considerable overlap, but it is worth considering them at least briefly.

The ethical position of the various industries is another matter and outside the scope of this position statement which is about the doctors' position. The practices of industry will thus only be alluded to in relation to influence on doctors' behaviour. Any absence of comment here therefore does not imply either approval or disapproval.

First- The relationship of doctors with pharmaceutical companies. This operates at different levels-

A- the relationship of Individual doctors with Individual companies. This is a spectrum of importance that can vary between a free pen with the company name on it to an all expenses paid trip to an exotic location to promote a particular treatment.

B- Companies sponsoring whole events such as educational meetings of undoubted worth but which give them a platform and a credibility they would otherwise lack. Evidence exists that these events influence prescribing behaviour.

C- The relationship of pharmaceutical companies with the research that doctors use to make judgements. A range of effects here from sponsoring trials –4 times more likely to be positive than independently funded ones-,selective release or withholding of trial data to create a misleading picture (rightly much focussed on by BMJ amongst others) and also the effect of squeezing out of "Cinderella" conditions or treatments from research when there is no likely profit.

Second- The relationship of NHS and its employees to private providers whose function is to make money. All UK qualified doctors will have benefitted from state subsidy of their medical education, so even if they work wholly in private practice or do so at the time of consideration there might be considered a public good obligation. There are different levels of involvement.

A- Doctors commissioning services with NHS funds

B- Doctors working for private providers- both doing NHS work and Private work

C -Doctors referring to private providers

All citizens of the UK are bound by the law and the Bribery Act 2010 in particular is relevant. 6 principles of bribery act 2010- Proportionate procedures, top level commitment, risk assessment, due diligence, communication and training, monitoring and review.

The General Medial Council (GMC) has clear guidance on this matter too, notably GMC guidance for doctors paragraphs 77-80.

There are international agreements concerning human rights and environmental matters which may also be relevant when doctors interact with commercial organisations.

Given the complexity illustrated above it is difficult to provide watertight guidance in advance for all situations and there exists already clear guidance from both the law and the GMC. However, a useful approach might include the asking of a series of questions which can clarify matters.

In essence-<u>Who is gaining from this interaction?</u>

a)-Is there a conflict of interest , or an apparent conflict, which might unreasonably influence a decision affecting patient care or apportioning of resources which you might need to declare, ask for another opinion or withdraw from the interaction completely?

b)-How much is your clinical behaviour likely to be influenced by the interaction rather than the medical needs of the patient- such as prescribing a new drug when it is not yet an established treatment? In reality there is likely always to be some such influence- it is the degree of influence that should be the concern.

c)-Does the interaction fit in with previously agreed plans or policies-(such as Personal Development Plans or strategic plans of the NHS trust in question)?

d)-Is the arrangement transparent, recorded in the usual channels and subject to independent scrutiny?

e)-Is the interaction proportionate? This might be personally- are travel expenses what you might customarily spend on this sort of arrangement, or as an organisation- is the private provider being given too much of a particular business? What extra curricular activities are legitimately part of an "educational" event?

f)-Has there been an open tendering process subject to generally accepted procedures? Can you justify why a particular decision was taken?

h)-Has the interaction produced an impression of indebtedness, of obligation: for instance has sponsorship of an educational activity made it easier for a representative to have access to you?

i)-Has the emphasis and content of an educational event been influenced by a sponsorship arrangement or is organised by a particular company likely to benefit from the arrangement?

j)-Has the research question or the conduct of a trial been influenced by an interaction? This to include influence about both what is studied and what is not studied.

k)-Is the marketing strategy of a pharmaceutical company ethical? Points to consider will include use of "loss leaders" supplied cheaply to hospital but which cost more in the community, "me too" drugs and new formulations of questionable benefit near the end of patent life.

l)-Consider the 6 principles of the Bribery Act 2010

<u>Related considerations</u>

There are links in this area to much wider issues which are worth considering. Although addressing these here might exceed the scope of this statement it is appropriate to flag up their importance.

Ethical investment- both individual doctors and organisations, notably in the third sector, have investments in commercial organisations. There are two important ethical aspects here
1-Direct investment in pharmaceutical companies or private health providers where there may be a conflict of interest
2-Investment in companies whose profits derive from activities incompatible with our ethical principles. Examples might include- poor human rights record in workforce, environmental damage, arms manufacture and sourcing raw materials from conflict areas.
Sustainable procurement- healthcare as a whole does not have a distinguished record in this matter and consideration of sustainability is arguably an area of legitimate ethical concern when making commercial decisions. Examples include- energy efficiency, recycling, whole life cycle view of products and local sourcing of goods or services.

Ethics Committee

Further reading

1. GMC guidance 77. You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals.

   78. You must not allow any interests you have to affect the way you prescribe for, treat, refer or commission services for patients.

   79. If you are faced with a conflict of interest, you must be open about the conflict, declaring your interest formally, and you should be prepared to exclude yourself from decision making.

   80. You must not ask for or accept – from patients, colleagues or others – any inducement, gift or hospitality that may affect or be seen to affect the way you prescribe for, treat or refer patients or commission services for patients. You must not offer these inducements

2. Bribery Act 2010
3. Whopaysthisdoctor.org This is the first serious attempt, albeit embryonic, to produce a register of doctors' interests and as such an important contribution to be encouraged.

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Exeter University Sustainable procurement policy