Lifelong Learning

CPD

CPD ETHICS ARTICLE

Navigating Conflicts of Interest: Waltzing With a Porcupine

In a medical context, a conflict of interest (COI) is a set of circumstances that creates a risk that a health professional's judgement or responsibility may be deflected from his primary concern (usually the patient) to a secondary party (usually him/herself). It is the 'set of circumstances' that define a COI, and these exist whether or not improper actions ensue. To use a religious analogy, a COI is the *temptation* and not the *sin*.

Hipocrates

The original Hippocratic oath was not very forceful in recognising that the patient's interests may be in conflict with the physician's interests although the modern oath taken by local medical graduates does go some way towards this recognition; "That I will exercise my profession to the best of my knowledge and ability for the safety and welfare of all persons entrusted to my care and for the health and well-being of the community".

A wide spectrum

Most COIs hinge around financial gain but they may involve other rewards and motivations such as fame, job promotion, religious beliefs or even personal relationships. COIs may be overt where the doctor is well aware that his action is, or could be unethical, but all-too-often the conflict is covert or subliminal. Most doctors would deny the possibility that the gift of a ballpoint pen or a donated pizza over journal club could influence their prescribing patterns but there is a body of research to the contrary.

Protect the patient

COIs are a normal feature of our human interactions but there are some good reasons why the relationship between a patient and a doctor should engender special consideration and protection:

- Firstly, the patient is usually vulnerable. This vulnerability may arise from a variety factors such as medical ignorance, fear or the patient's state induced by the illness per se.
- Secondly, we doctors have been substantially empowered by society. This has allowed doctors to invade the patient's homes, their minds and their bodies.

The balance between the patient and doctor is horribly skewed if compared to, say, the relationship between a prospective home owner and an estate agent.

Pharma's persuasive power

The biggest potential source of COIs arise from the doctor's relationship with the pharmaceutical industry; but this is by no means the only source of contention. In the not too distant past, local scandals arose from kickbacks by radiologists for MRIs ordered, and there are numerous examples involving perverse, favoured conditions available to specialists in private hospitals, improper relations with retail pharmacists, special arrangements with funders... The list goes on and on.

I have been wading my way through Bad Pharma by Ben Goldacre[1] and after you have read this tome you will surely be convinced that there isn't a drug that really works and that there are no honest doctors left on the planet. It makes depressing reading. Perhaps it is over-stated but it's a fact that the pharmaceutical industry is big business and they have a mandate to maximise profits for the benefit of their shareholders. They spend billions annually on marketing and a substantial part of this is spent on in-person detailing by sales representatives. Many would blame the pharmaceutical industry for the dishonest practices of doctors but this is a bit like blaming provocative clothing for rape!

Clinical practice guidelines - a new front

One of the areas where COIs have recently been brought to the attention of physicians is in the development of clinical practice guidelines (CPGs)[2]. We practice in an era where the gold standard of treatment is evidence-based medicine. No longer are we prepared to accept the recommendation of an expert in the field (eminence-based medicine) but we now are expected to understand a whole new jargon. We try to combine multiple sources of data into Cochrane-like systematic reviews and then

About the author

Keith Bolton *MBBCh, DCH (SA), FCP (Paeds)(SA), MSc Med (Bioethics & Health Law) is chief paediatrician at Rahima Moosa Mother & Child Hospital, Johannesburg and associate professor in the Department of Paediatrics & Child Health at the University of the Witwatersrand. He has been an academic paediatrian in Johannesburg for about 30 years.*
He worked in private paediatric practice between 1989-1998.

analyse this data using meta-analysis. Forest plots and Funnel plots are displayed with gay abandon. On the surface, this would appear to offer a better chance of getting closer to the truth but we should be aware that there may be hidden bias in the choice of data to be included in the review[3]. The authors of meta-analyses rarely report their funding sources and their ties to industry.

The next step after sophisticated interpretation of the data is the formation of clinical practice guidelines. These CPGs have the fundamental task of converting data into recommendations and thus have the potential to shape clinical practice worldwide. This may have great advantages to doctors and their patients, but obviously the process has huge economic relevance to drug manufacturers. This is reflected in the fact that in some instances 90% of the authors of a CPG have industry affiliations.[3]

A CPG author with industry connections may have a pro-industry bias; an author who has expertise in performing a procedure may be biased towards procedures while the recipient of research grants may be biased towards academic career advancement.[4] Some authors have used a formal tool to evaluate COIs in CPGs'[4] The domains in which they identified conflicts included: Research, Clinical practice, Personal income, Equity/stock options, Expert testimony, Fiduciary role, Advocacy role, and Patient rights. Other authors have reviewed the management strategies employed when COIs were identified in CPG panel members.[5] The best method of handling this appears to involve utilising an independent monitoring body who then either exclude or limit input from panel members with COIs.

Learning to dance

Finally, how should the practising clinician deal with the COIs in the workplace? The doctor's relationship with the pharmaceutical industry has been aptly described as 'dancing with a porcupine'.[6]

First and foremost is the ***recognition*** that a COI exists and is pervasive. All the evidence points to the fact that even apparently trivial gifts may have profound influences on behaviour. This is best countered by ***avoidance*** of compromising situations; no more pens & Benz. Where a physician is in a position of potential influence over his colleagues, it is important to publicly ***declare*** his/her conflicts of interest. This allows the audience to evaluate the message in this light. We should also be ***vigilant*** as there are perverse influences around every corner. Our patients trust us to use resources intelligently and to always act in their best interests. Our financial gains are secondary.

Recommendations

Greenberg[7] has recommended that clinicians should adopt the following principles to avoid or manage COIs:

- Disclose all relevant COIs to their patients.
- Do not accept anything of material value from 'the industry' except for legitimate work compensated at market value.
- Only act as consultants when performing defined professional services within a written contract.
- When giving presentations, the content should not be created or controlled by industry.
- Drug samples are only acceptable for use by indigent patients.
- Doctors should not accept gifts from industry sources.
- Follow ethical precepts, in the patient's best interest, when choosing treatments.
- Avoid selling healthcare products for profit in their offices.
- Recognise that the behaviour of doctors' staff should fall within the same ethical boundaries.

With regard to the development of CPGs, he also concludes that "the sponsoring organization should not accept direct funding from industry for developing, promoting or publishing guidelines".

These principles were developed for dermatologists but they seem appropriate for all of us in clinical practice.

Potential conflict of interests

Prof Bolton is in full-time academic employment. He is involved in contract research with Nestlé. He has no conflicts of interest recognised in this regard.

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