Op-Ed

Conflicts of Interest in Medical Practice and Their Costs to the Nation's Health and Health Care System

CATHERINE D. DEANGELIS

VIRTUALLY ALL AMERICAN PHYSICIANS TAKE SOME FORM OF the Hippocratic oath when they graduate from medical school. And I would bet that all these newly minted doctors truly believe they will maintain the ethical conduct professed in that “oath” throughout their professional careers. Almost every medical school has modernized and changed the oath’s wording from its origins on the island of Kos so many centuries ago. Nevertheless, these declarations all adhere to the essence of what the original oath assured would be the foundation of the doctor-patient relationship, that the physician would always strive to act in the patient’s best interest.¹

Only the rare physician admits to having deviated from this promise and when one does, it usually is after being caught doing something illegal, immoral, or both. Sadly, the reality is that today far too many physicians have violated or ignored the true meaning of the Hippocratic oath. Specifically, many, if not most, physicians practicing today have, or have had, conflicts of interest that clearly do not result in their patients’ best interest.

The term “conflict of interest” refers to a conflict between the private interests and the official responsibilities of an individual in a position of trust. Surely physicians function in positions of trust; in fact, the very foundation of the doctor-patient relationship rests on trust. So when and where do conflicts of interest occur most often with today’s medical profession?

Let’s begin with the free black bags, instruments, or books given to medical students by a pharmaceutical company, or even the doughnuts, coffee, soft drinks, and free lunches provided at teaching conferences. Does accepting those gifts lead to acting in the best interest of patients?

Now let’s up the ante to include the free food, tickets to sporting and other events, sponsored trips to resort locales, and the shower of

other gifts given to physicians by the pharmaceutical representatives assigned to them. Some people maintain that such gifts do not influence physicians' prescribing practices. But if that were so, why would pharmaceutical companies spend billions of dollars on these items, and why would they partially reimburse their marketing representatives according to the number of prescriptions written by the physicians to whom they are assigned?

And what about the free drug samples provided to physicians for their patients? It has been argued that these free samples help patients who cannot afford them. But then why are the vast majority of these free samples for new (meaning those still under patent protection) and expensive drugs that are almost exclusively for illnesses that require the drug's frequent or continued use? Although the first prescription is free, the patient then must pay much more for future prescriptions instead of using an equally effective generic, or less expensive, drug. This manipulation works well for the direct-to-consumer advertising of drugs (look at almost any magazine), so why not use it, as Big Pharma reasons, on the men and women who control the prescription pads?

What about academic physicians who do research or write practice guidelines or review papers funded by Big Pharma? Here the association between research sponsorship by pharmaceutical and medical device companies and pro-industry conclusions is clear. Most Americans are surprised to learn that the clinical research funded by Big Pharma dwarfs the annual investment by the National Institutes of Health. Moreover, much of this industry-sponsored research is tainted by bias that is not always clearly stated.^{2,3} Of course, this unsavory practice can proceed only with the cooperation of the authors and the editors who publish the studies. The same cooperation is necessary for physicians who write and publish practice guidelines and review papers that are buttressed by industry-funded work and professional medical associations that are heavily involved in continuing medical education.⁴

And then there is the problem of physicians and biomedical and health care researchers who work for a pharmaceutical company's marketing division, rather than its scientific division. An obvious example occurs when "expert physicians" serve as industry-sponsored speakers and use the slides and data provided by the pharmaceutical company. Invariably, such "chaperoned" presentations accentuate the positive and downplay the negative (including price differentiation) aspects of the drug being

promoted. These “expert presentations” help sell the drug in question, and few in the audience may be aware that the manufacturer of the drug, medical device, or technology being extolled is also handsomely rewarding its presenter.

Finally, there is the promotion of a drug for off-label use. Imagine the following and, unfortunately, common scenario: At a major clinical or health-related lecture, a physician paid by the pharmaceutical company is “planted” in the audience. The “plant” raises his or her hand and supposedly innocently asks the presenter if he or she has ever used the drug for an illness for which the drug has not been approved by the US Food and Drug Administration (FDA). The presenter then discusses off-label uses of the drug for this or that illness or symptom. Remember that physicians in the United States can write prescriptions for any drug, whether or not it has been approved by the FDA for that illness. So why not add a few more uses, which can translate into multiple sales and millions of dollars in unexpected revenue?

As I discovered by doing a search of PubMed while I was editor-in-chief of *JAMA*, since the late 1980s the number of articles in the medical and population health literature on conflicts of interest has risen substantially. From 1975 to about 1990, there were no or very few such articles cited in PubMed. But by 2007, the number had risen to 600 and has remained at that level every year since. Not surprisingly, this rise in number corresponds all too neatly to a period when many pharmaceutical companies merged their scientific and marketing divisions.

So what does all this tell us about how physicians are maintaining their promise to act in their patients’ best interest? Don’t all these examples represent conflicts between the private, for-profit interests and the professional responsibilities of individuals (physicians) in a position of trust? And don’t such practices have huge (and frequently negative) implications for the public’s health and the cost of health care?

We can only guess what effect the Physician Payment (Open Payment Program) Sunshine Act might have on such actions. This federal act, which is part of the original Sunshine Act, requires that all manufacturers of drugs, medical devices, and biologicals participating in US federal health care programs report certain payments and items of value given to physicians and teaching hospitals. Since August 1, 2013, manufacturers also have been required to collect and track payment, transfer, and ownership information. In 2014, most of the information contained in these reports will be available on a public, searchable website.⁵

Might the embarrassment of having their name and remuneration from pharmaceutical or medical device companies exposed to the public and on the Internet persuade physicians to uphold their professional promise to act in the best interest of their patients? We can only hope.

References

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Address correspondence to: Catherine D. DeAngelis, Johns Hopkins University School of Medicine, 3704 N Charles St, Unit 105, Baltimore, MD 21218 (email: cdeange1@jhmi.edu).