Physician-Industry Relationships: An Issue in Organizational Ethics

On July 16, 2009, *The Wall Street Journal* reported that several former employees of at least four medical-device makers alleged in lawsuits that the companies paid kickbacks to heart surgeons to use their products in surgical "ablation" procedures to treat atrial fibrillation. This is only the latest in a long list of abuses by the medical industry that have come to light of late, not to mention the numerous daily gifts and payments by industry to health care providers, particularly physicians.[1]

In recent years, several professional organizations have developed new guidelines or revised existing guidelines to better control physician-industry relationships.[2] These have ranged from fairly permissive to more restrictive.
On April 28, 2009, the Institute of Medicine issued its own report and recommendations.[3] The report notes that conflicts of interest undermine the integrity of medicine and erode public trust and calls for full disclosure in physician-industry relationships. To this end, the report offers 16 recommendations aimed at avoiding conflicts of interest in physicians' offices, biomedical research, medical education, journals, clinical guidelines, and institutions. Among the recommendations is that Congress require drug and device-makers to report on a public Web site payments they make to physicians, researchers, and academic health centers.

Senators Charles E. Grassley (R, IA) and Herb Kohl (D, WI) are co-sponsors of legislation that would do precisely that. This past May, the Vermont legislature passed a law requiring drug and device makers to publically disclose all money given to physicians and other health care providers, including names and dollar amounts. The law took effect on July 1. It also bans nearly all industry gifts, including meals, to health professionals, health plan administrators and health care facilities. Minnesota already requires drug companies to report payments to doctors. Massachusetts has new regulations limiting gifts to health care practitioners and requiring disclosure of any payment or benefit worth $50 or more.

In Vermont alone, makers of medical products spent about $2.9 million in fiscal year 2008 marketing to health care professionals. Almost half of Vermont's physicians received payments for lectures, meals or lodging from pharmaceutical companies during the course of that year. Typically, the most influential doctors were targeted. Four percent of doctors in Vermont received 60% of the payments or, put differently, $1.8 million went to only 100 physicians out of 4,573.

These long established practices that promote conflicts of interest harm the integrity of the physician-patient relationship as well as the well-being of patients and health care organizations. They weaken trust in physician decisions about medical devices and drugs, needlessly and perversely increase costs, may well detract from institutional efforts at improving quality and striving for excellence, and could contribute to patient dissatisfaction and, ultimately, harm the reputation of the organization. Justice and good stewardship would seem to require the elimination of financial conflicts of interests.

As a major provider in the American health care system, Catholic health care has an opportunity to join those who have already set tough standards concerning industry-physician relationships. Doing so follows inexorably from Catholic health care's overall mission and the values out of which it operates, especially human dignity, justice, stewardship, and the common good. Demonstrating leadership in this area is, for Catholic health care, ultimately a matter of organizational identity and integrity. There is an important opportunity here for Catholic health care to take up this issue as a critical issue of organizational ethics. In this issue's "From the Field" section, there is information about how one Catholic health care system approached the issue, along with that system's recommendations, and links to tools that were employed in the process of developing the recommendations. — *RH*

NOTES

1. For an overview of the problem, see Michael R. Panicola, Ph.D. and Ron Hamel, Ph.D., "Industry-Physician Relationships: A Call for Greater Distance," *Health Progress* 90, no. 4 (July-August 2009): 62-68.
2. For example, the Pharmaceutical Research and Manufacturers of America (PhRMA); the Association of American Medical Colleges; the American Medical Association; the American College of Obstetrics and Gynecology; and the American Board of Internal Medicine Foundation.
3. Institute of Medicine, "Conflict of Interest in Medical Research, Education, and Practice," April 28, 2009 (www.iom.edu/cms/3740/47464/65721.aspx).