Editorial

Can sunshine cure the unhealthy entanglement of industry and health care?

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Moves are afoot around the world to increase the open disclosure of financial relationships between medical industries and clinicians, researchers and related institutions. This follows widespread concern about the potential for such ties to distort research, clinical practice and policy. In 2009, a report from the Institute of Medicine in the USA called for laws to require pharmaceutical, biotechnology and device companies to report, through a public website, the payments they make to doctors, researchers, academic health centres, professional societies, patient advocacy groups and others involved in medicine.

This recommendation has been taken up as part of the health reform agenda in the USA. The proposed Physicians Payment Sunshine Act, which has been incorporated into the healthcare reform bill passed by the House of Representatives in March 2010, requires payments to be reported. Some pharmaceutical and devices companies have endorsed this Act, and a number, including Cephalon, DePuy, Eli Lilly, GlaxoSmithKline and Merck, have begun to release details of their payments to practitioners on their corporate websites. A US company called Obsidian Healthcare Disclosure Services recently launched a searchable online database (PharmaShine) containing all of the publicly available information on such payments. PharmaShine allows users to search for health professionals receiving payments by physician specialty, city, state, and hospital affiliation. By February 2010, it had payment data for over 21 000 physicians, physician assistants, nurse practitioners and other healthcare professionals across the USA. Some institutions, including Harvard University and a related healthcare group called Partners HealthCare, are tightening regulations for doctors and scientists who consult for drug companies and medical device makers.[1]

Relationships between the pharmaceutical industry and patient groups are also coming under increasing scrutiny. Merck notes that while disclosure of grants to patient organisations has been mandatory in Europe since March 2009, it has voluntarily disclosed such payments in Europe, the Middle East and Africa since 2008. It began reporting such payments in Canada last year.[2]

Meanwhile, the Indian Medical Council recently introduced new regulations banning doctors from receiving gifts, travel and hospitality from pharmaceutical or allied healthcare companies. Doctors also must not endorse any drug or product in public. The regulations state, 'Any study conducted on the efficacy or otherwise of such products shall be presented to and/or through appropriate scientific bodies or published in appropriate scientific journals in a proper way'.[3]

In Australia, there is no systematic mechanism for ensuring full and open disclosure of financial ties, despite concern that self-regulation by the profession has been largely ineffective and that 'medicine is facing a credibility problem of unheralded proportions'.[4] The Medicines Australia Code of Conduct requires member companies to reveal some details of sponsored events, but these reporting requirements could be strengthened and extended.[5] I have established the Crikey Register of Influence (www.crikey.com.au/register-of-influence) as a mechanism for identifying some of the associations between key opinion leaders and industry marketing or disease-awareness campaigns. While this is not a systematic effort, it has helped focus some professional and public attention on the issues of industry entanglement and disclosure.

Some medical organisations and medical school deans are moving to address concerns about conflicts of interest. The National Health and Medical Research Council is investigating ways of ensuring that Australian researchers, universities, other research institutions and healthcare practitioners manage conflicts of interest more effectively. A discussion document is expected to be released in the second half of 2010. In the absence of comprehensive public reporting mechanisms, clinicians and health services could consider voluntarily making such declarations. It has also been suggested that patients should consider asking clinicians whether they receive payments or gifts from industry.[6]

Views are mixed, however, about the likely impact of increased disclosure. Some argue that transparency alone is not sufficient in every situation, and that, for example, editorials, reviews and guidelines should be written by experts without any conflicts of interest.[7] In the wake of revelations about commercial ties of experts involved in setting the World Health Organization's

pandemic influenza policies, there have been calls to exclude experts with commercial ties from major public health policy decisions.[8] Cancer Council Australia does not accept funding from the pharmaceutical industry, in part because of the organisation's role in guideline development. The Council also funds the patient group Cancer Voices, which ensures there is a patient advocacy group that is not reliant on industry funding.

Some authors argue that encouraging greater transparency is the wrong solution, and is comparable to asking doctors in the 1800s to declare whether they washed their hands between doing autopsies and delivering babies.[9] They cite the limited evidence[10] that is available, suggesting there is potential for perverse consequences, such as encouraging unwarranted trust in biased advice. A better solution, they argue, is to end the financial entanglements between industry, research and practice.

However, it is likely that such entanglements will continue into the foreseeable future. In the meantime, Australian clinicians, researchers and related organisations and institutions are likely to come under increasing pressure to provide full and open public disclosure of financial and other ties with commercial interests. It would be helpful if efforts to promote open disclosure were carefully evaluated to establish their impact on a range of areas, including the attitudes and behaviours of patients, clinicians, researchers and other relevant parties.

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Further reading

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Melissa Sweet has an honorary position as a chief investigator on a National Health and Medical Research Council-funded project 'Calling the tune? Investigating corporate influences on media reporting of health'. She maintains the Crikey Register of Influence.

Letters

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Multiresistant organisms at the front line

Editor, – I read the dental note (Aust Prescr 2010;33:71) about not using amoxycillin as the first drug of choice for oral infection to reduce the prevalence of multiresistant bacteria, for example life-threatening *Streptococcus pneumoniae*.

I am a dentist and we have always been told that amoxycillin is the best and safest antimicrobial when encountering oral infection. So what will be the next best thing?

Shahriar Sanati
Dentist, Sydney

Associate Professor Michael McCullough, Chair, Therapeutics Committee, Australian Dental Association, comments:

Dentists were once told that amoxycillin was the best and safest antibiotic for most dental infections. However, this idea has been considerably challenged over the past several decades leading to the current concept that penicillin is the best choice as first option. These concepts are clearly outlined in the Therapeutic Guidelines: Oral and Dental. Unfortunately, there is likely not going to be a 'next best thing', so we need to use our currently available antibiotics judiciously.