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EDITORIAL

Conflicts of interest and the patient–doctor covenant

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In 2003, as Editor-in-Chief of *American Journal of Respiratory and Critical Care Medicine* (AJRCCM), I introduced a policy on conflict of interest [1]. Since then, an enormous number of papers have been published on the topic. Much of this literature deals with the complexity of the topic, yet the fundamentals are simple.

If researchers receive money from industry, they have a conflict of interest. There is nothing potential about it [1]. Conflict of interest does not mean that researchers are biased or that they have inflicted harm. It simply means that there is a risk of bias, which can occur through subconscious forces. Because journals are in the business of publishing true findings, editors have an obligation of ensuring that readers are alerted about financial conflicts [1]. This part of the topic pertains to researchers, editors, and readers.

But financial conflicts are much greater than that—and affect every practicing physician. The more sacred part relates to patients.

Medications are never free. In 2015, a quarter of individuals in the USA taking prescription drugs reported that they or a family member could not afford to buy a medication within the past year [2]. In Europe, medication costs are commonly paid by governments or through insurance schemes, but the money ultimately comes from patients (in the form of taxes or insurance charges). In both continents, drug companies (and their enablers) gain from the profits.

Drug companies are investor-owned businesses. Their primary mission is to protect the interests of stockholders. The expected ethics of any business is to place sales first. It is a mistake to imagine that drug companies are bound by different economic rules than are oil companies.

Patients never receive a medication without a prescription—doctors control the golden door through which all drug sales must pass. Because doctors are the chief conduit for sales, physicians are the main target of drug-company marketing. In 2012, the pharmaceutical industry paid more than $24 billion (from their marketing budgets) to physicians in order to influence their prescribing patterns [3]. Most of this was in the form of free dinners and educational events.

Why do drug companies and medical device companies spend money on dinners, travel expenses, and medical education? Because it reaps rich dividends. Marketing of doctors achieves more than seven times the return over direct-to-consumer advertising [4]. Industry-paid doctors request the addition of a promoted drug to hospital formularies 30 times more often than non-paid doctors [5].

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More than four decades of social psychology research demonstrate that gifts—even small ones—create obligations to reciprocate [6]. Industry marketing activities are less a matter of direct manipulation than a subtle means to establish reciprocal relationships with physicians. Gift-giving creates a sense of obligation, causing physicians to give back in return [7]. Reciprocity is not a matter of conscious decision-making. It operates subconsciously [8].

Even one industry-sponsored meal (costing less than $20) combined with an educational presentation is associated with as much as fivefold greater prescribing of brand-name drugs over equally effective generics [9]. Overuse of brand-name drugs cost $73 billion between 2010 and 2012—one-third of which was borne by patients [10].

Clinical practice guidelines hold the greatest potential for influencing patient care. For some guidelines, 90% (or more) of committee members have financial links with companies whose products they are espousing [11], making the guidelines little more than a marketing tool. In critical care, we witness the progression between authors with tight links to industry and guidelines that metamorphose into a performance measure that can influence Medicare reimbursement and the accreditation of hospitals [12].

Although money is involved in the interaction between patients and physicians, the practice of medicine differs from that of other businesses. Sick people are not consumers in the mercantile sense. They cannot (freely) shop around. They are not looking for bargains. Serious illness entails much less control, higher stakes, and intense vulnerability. Trusting a finance account manager, even with one's life savings, poses much less distress than trusting a cardiac surgeon.

The relationship between a patient and physician is not a commodity transaction or contract, but a covenant. A covenant is a formal, solemn, and binding agreement, a special kind of promise—like a will or testament. Whereas a contract involves strangers, a covenant is between parties who have a close relationship with each other. Whereas a contract is based on mistrust, a covenant is based on trust. Whereas a contract is between two equal or near-equal parties (each concerned only with its own welfare), a covenant is between two unequal parties—where one is concerned about the welfare of the other. The covenant that patients expect from physicians is "to put a patient's interests first."

The physician is the final common pathway for every act done to a patient. No order can be carried out without the physician's assent. The physician cannot be a double agent: the physician serves primarily the patient or serves primarily himself (herself) or some third party.

In critical care, we all know of apologists for drug companies, who are proud of (indeed flaunt) their ties with industry and who pooh-pooh all concerns about financial conflicts. Studies in social psychology reveal that such individuals are remarkably adept at blinkering themselves to robust data that shows how their actions cheat patients [6]. Apologists may be fooling themselves, but they are not fooling the rest of us.

Compliance with ethical standards

Conflicts of interest

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