Conflict of interests between physicians and pharmaceutical industry

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Resumo Neste trabalho serão sumariamente analisados os problemas éticos envolvidos na relação entre o médico e a indústria de medicamentos, suas causas e consequências, com fundamentação em amostragem geral da literatura disponível. São definidos termos e expressões necessários à compreensão do tema e ao estabelecimento dos limites para uma ampla discussão crítica que envolva representantes das escolas de medicina, das associações médicas e dos conselhos de medicina, para definição de normas que regulem as interações entre os médicos e a indústria de medicamentos. Considerações relevantes são feitas em relação às sugestões de medidas a serem implementadas visando minimizar os conflitos de interesses entre médicos e a indústria de medicamentos e tecnologias, bem como para coibir as relações ilegítimas que possam se estabelecer entre eles.

Palavras-chave: Médicos. Indústria farmacêutica. Ética.

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Physicians and the medicine industry are binded by mutual needs, as Salas, Osório and Vial state , since the first ones prescribe medicines and the industry develops and trade them[1]. They interact, sometimes, very intimately and this **interaction** is complex because there are interests involved, including financial, which can compromise physician's independence in formulating his prescriptions in detrimental of the unmistakable responsibility of *prescribing the most safe, effective and lower cost medicine and based in impartial and scientific clinical opinion*, as Balestrim[2] states.

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Relevant ethical issues pervade pharmaceutical industry and physicians relationship in clinical practice by the simple reason that prescriptions may be influenced by factors that are not related to scientific evidence due to interference, in this realm, of *secondary interest*[1,3]. It may be classified as meddling industry interest in selling its product, targeting profit, which incites it in not using persuasion techniques not based exclusively in patient's best interest. In addition, intruding may be physician's

motivation in pay back kindness from favors received with prescriptions and samples of medicines, etc. The same be stated in regard to biomedical research, also a source of great conflict of interests [4,5].

It is evident that such conflicts refer primarily to citizens in general due to possibility of been affected by ultimate consequences of these illegitimate interactions. Thus, they constitute causes of social concern and unleash heated debates and actions targeted to regulate ethics of involved actors in the relationship: physicians and the pharmaceutical industry. Physician's absolute independence is highly desirable in undertaking his prescriptions to the benefit of the object that it aims – the patient. Evidently, to him must be protected the right to receive suitable prescriptions for his disease, free of any other intromission in physician's clinical opinion who cares for him, and that may withdraw the precedence of best scientific evidence.

The conflicts of interests

According to Alpert, Furman and Smaha, in the last one hundred years, human beings life expectancy raised from 47 years to 74 years[6] . Data from the Brazilian Institute of Geography and Statistics (IBGE), of 2005, inform that this expectancy was of 77.3 years in the United States; 78.3 years in the United Kingdom; 78.6 years in Germany; 79.4 years in France; 81.9 years in Japan and of 70.3 years in Brazil[7]. According to the United Nations Development Program (Pnud) annual report, disclosed in November 2007, Brazilian life expectancy achieved already 71.7 years[8]. It is estimated that Medicine has contributed, at least, with 10% to extend life expectancy in the first half of 20th Century – while over 40% in the second half[9]. Scientific discoveries, such vaccines and antibiotics, progress in surgeries, hygienic precepts, based in microbiology, were decisive to raise the threshold of humanity's health, namely in developed countries. Atherosclerosis risk factors were discovered and provided with the development of medicine capable to control them, improving morbidity and mortality connected to the arteriosclerotic vascular disease. Clinical and laboratory advances continue to be essential components for health improvements of people[6].

Intense research activity is necessary to achieve such progress in Medicine, as well as many researchers and large investments, coming from foundations, governments, non-profit organizations and, less than it is thought, from researches coming from the industry[4,5,6]. Finance interests of corporations and of their collaborating physicians, often, have risen questioning about researchers' objectivity. The conflicts of interests threaten research activity and provoke the mistrust of people in produced outcomes[6]. Therefore, it is feared that physician-researcher interests do not coincide with what society expects and it may be paying well above of what is fair by gotten benefits, and not only in regard to treatments financial costs, but also to doubtful practices by the pharmaceutical industry[5].

In the United States, where the largest portion of medical research is done, the relationship between medical academic centers, drug industry and biotechnology have become worrisome. Although technology transfer is desireable, it has been considered as exaggerated[9]. It can be understood from Bodenheimer's[10] study that medical academic centers that previously research drugs independently now have established some kind of relationship raising suspicion concerning trustfulness of studies on drugs effectiveness.

A described example refers to authors of studies that supported security antagonists of calcium channels, and in relation to which it was checked, more commonly, finance relations with drug manufacturers than with authors who did not support the safety of these drugs. Even though, there is evidences that when study is financed by the manufacturer of a new drug, the results tend to favor it in relation to older medicine.

Studies with antineoplastics drugs that presented less favorable results when undertaken by non-profit research centers also corroborate to such evidence (39%) than undertaken under the sponsorship of the industry (5%). Evidently, this and many other facts rise questioning on the intensity of the influence of the industry over the researches and, consequently, on the credibility of information about drugs.

The industry does not use anymore researchers from academic centers as before, it contracts high level researchers to prepare and to interpret studies with drugs through *contract-research organizations* (CRO) that develop a network of sites, prepare trial protocols, send reports to sponsor company which, in turn, runs data analysis, etc [10].

About physicians' credibility on drugs effectiveness, the Allhat (*Antihypertensive and lipid lowering treatment to prevent heart attack trial)* large trial case is exemplary. This multicenter, randomized and double blind study lasted for eight years and engaged 42,000 patients with ages of 55 years or older, in more than 600 clinics. It included carriers of arterial hypertension in stages 1 and 2 and with more than one risk factor for cardiovascular disease, comparing four classes of drugs: a calcium channel blocker (amlodipine), an alpha-adrenergic blocker (doxasozine), an angiotensin-converting enzyme inhibitor (lisinopril) and a diuretic (chlorthalidone).

By this time, prescriptions of diuretics and beta-blockers were in decline in view of growing prescriptions of other mentioned drugs[11].

Despite been a class of drug much estimated in view of its effectiveness and low cost, the drop in use of diuretics was attributed to scarce commercial advertising derived from the fact of becoming generic drugs, in opposition to competitors newer and with patents still in force, disseminated with lots of advertising. According to Angel, diuretic prescriptions declined from 56% in 1982 to 27% in 1992[9]. Allhat concluded that chlorthalidone was superior to all classes of drugs used in the study in preventing cardiovascular events. The occurrence of significantly higher rate of cardiovascular disease and heart insufficiency upheld the trial with doxasozine group [11].

Allhat brought to surface the issue of lack of interest in showing the superiority of thiazide diuretics in preventing one or more forms of cardiovascular diseases,indifference probably related to the low cost of these drugs as well as the fact that patent devices did not protect them anymore. By focusing exclusively in the financial issue, company's profit, this "lack of interest" in disseminating the real findings of clinical researches must have caused by immensurable higher costs, computed in terms of human lives.

Shortage of comparative studies between drugs, with declared preference for placebo studies shows eloquently lack of interest. The shortage of trials comparing new medications with the diuretics was taken, then, as premeditated and common. Also, there are not high level comparative trials with inhibitors of gastric protons pump. It seems evident that new medications are useful in view of the common need of using more than one of them to control arterial hypertension. However, lack of comparative studies did not show the superiority of none of them. There was not interest and/or discernment by majority of physicians in relation to the fact that in absence of well prepared comparative studies it would not be possible to distinguish the superiority of any medications and, therefore, massive adhesion to new medications was not scientifically justified. In this case, advertising certainly had a decisive influence since, as shown, the choice did not correspond to patients' interests.

According to Scott[12], the industry has a large scope of possibilities to influence, direct or indirectly, the way studies are designed, analyzed, and published. The author states still that one out of five Australian physicians comprising sponsored pharmacological research noticed basic methodological gaps, such as dissimulation of relevant results and lack of data integrity, among others.

An illustrating case of reprehensible relationship between drugs industry and physicians took place in Verona, Italy, denounced in 2003 by the Police of that State, as reported by Turrone[13,14]. The conclusion of the Police pointed toward the involvement of the GlaxoSmithKline (GSK)

Italian branch, whose actions were targeted to award prizes to physicians who would prescribe drugs from the firm and would indicate them to peers if, as preferred, they were opinion formers.

As the author reports, out of the 75 accused 35 were physicians, which corresponds to 48.6% of the total. Managers and Sales representatives were accused for the practice of bribery by awarding prizes to physicians who agreed in prescribing or recommending to colleagues products of the company instead of the generic equivalent or similar produced by other companies. The company used software called *Giove* (*Jupiter*), which allowed sales representatives to monitor, in agreement with pharmacies, physicians prescriptions who had agreed to receive bribery. Telephone tapping cleared showed the close and declared relation between receipt of Money or other benefits and the expected increase in prescriptions. The 26 heads and deputies of hospitals departments, the Five university professors and four directors of hospital pharmacies were considered more valuable that physicians in general as they were awarded with trips and money [13,14].

Also, the clinical practices is affected by these relations since prescriptions of medications in promoted by intense advertising and by other efforts by the industry that, in hidden way, have the ultimate objective of getting prescriptions. Among these artifices is reported offer of gifts that may vary from simple objects, of low amount, to trips, books, etc. Evidently, this leads to the supposition that prescriptions of medications may be made without the essential and primarily consideration of its scientific effectiveness and tolerance. It seems clear that, with the objective of doing well, a physician bases his therapeutic choices in the best available scientific evidence for effectiveness and tolerance. However, when secondary interests contaminated this ideal, that is, when interference of alien elements to scientific evidence influences a prescription, there is conflict of interests[1].

Conflict of interest corresponds, according to Thompson, to a set of conditions in which the opinion of a Professional about a primary interest tends to be unduly influenced by a secondary interest [15]. In the same line, conflict of interest also is defined as (...) *the condition where an opinion or action that should be determined by a primary value, defined by professional or ethical reasons, may be or seems to be influenced by a secondary interest*[16]. According to the *American Medical Association* (AMA), there is conflict of interest when *the economic interest of a physician enters or threatens to enter in conflict with patient's best interest*[17].

Monynham lists the several ways that physicians' relationship with trade companies that may involve conflict of interests, stressing, among others, visits of laboratories sales representatives to medical offices and hospitals; acceptance of direct gifts like equipment, trips or boarding in hotels; acceptance of indirect gifts, such as support in acquisition of computerized

equipment or payment for trips to conferences, dinners, social or recreational events, participation in educational events, continued medical training, courses or seminars. In addition to participation in clinical conferences financed by the industry, undertaking of research sponsored by the industry, acquisition of pharmaceutical companies stocks; participation in clinical guidelines preparation or opinion articles financed by the industry, as well as participation in professional societies or associations financed by the industry, acceptance of payments for technical consultancy to determined companies, and member of the pharmaceutical industry advisory board. Taken as acceptable by many physicians, society may considerd these kinds of relationships with the pharmaceutical industry as inappropriated[4].

Brennan, Rothman, Blank et all[18] also presented some possibilities capable of generating conflicts of interest such gifts of any value, payment for participating in lectures and conferences, free participation in continued medical training, hourly payment to attend meetings, payment for participation in tables, supply of samples, scholarships for research projects, payment for advisory among other offers.

Still according to these authors, physicians and representatives of the pharmaceutical industry share myths related to their interactions. One of them would be that small gifts do not significantly influence physician's behavior. Another is that the simple statement of the conflict of interests would be enough to erase this type of game target to ensure economic advantage that may influence in the outcomes of a finance research. Consequentlee, institutionalization of this statement may protect sick people from these secondary interests[18]. However, still according to authors, there is no evidence that supports such impression, but rather the opposite, as attest by Dana and Loewenstein[19].

The code of interaction with health professionals of the *Pharmaceutical Research and Manufacturers of America*[20] indicates as inappropriate gift by pharmaceutical industry and direct financing of health professionals activities. The document suggests that financial support be granted directly to event organizers, who should apply them in benefit of all attendants.

In the same line, the *American College of Physicians* (ACP) manifested, in 1990, regarding the relationships between physicians and the pharmaceutical industry in article *Physicians and the pharmaceutical industry*[21], referring to ethics principles in relationships between medications industry and medical professionals. ACP report bases, exactly, in the evidence that the industry influenced physicians' clinical decisions. After its publication, evidences of this influence in medical practice continued to appear[21]. Thus, ACP pronouncing has introduced ethical standards to be observed in physicians-drugs industry relationships.

The *American Medical Association* manifested also about ethical principles in physicians-pharmaceutical industry relationship [17].

Conflict of interests expands also to several other fields of medical activity, such as surgical procedures and research. Regarding the first, Alpert, Furman and Smaha stressed that in the 1970s, when revascularization surgery was at its start, heart surgeons were generally the sole to defend it, without due rigorous criticism[6]. As they pointed out, among some American cardiologists, critic rigor missed in opinions stated about heart procedures that targeted myocardial revascularization.

These advocates of angioplasties justified the procedure even in situations lacking corroboration and even in those where controlled and random studies did not show good results. Surgeons, in their turn, saw angioplasties as procedure targeted to compete with myocardial revascularization (*coronary bypass surgery*) and, thus, enthusiasm with this technique among them was lesser than among cardiologists. Authors conclude that cardiologists and heart surgeons showed secondary interest of economic nature[6].

Steinbrook, in article published in the *New England Journal of Medicine* [22], reports an episode involving researchers and executives of the *National Institutes of Health* (NIH), major biomedical research institution of the World and its relationship with the pharmaceutical industry. In this article, the author states that people trust in relation to NIH was shaken by a report publish in the *Los Angeles Times*, in December 7, 2003 that made reference to payment for advisory made by pharmaceutical companies to executives of the institution. Although relationships of government enterprises with the industry have been well incentivized and NIH researchers were not prohibited to provide advisory, one of the reasons of the questioning relates to the possibility that this bondage could have affected scientists' decisions in setting priorities and in designing clinical trials [22].

About these interactions, recent studies by Camillere and Cortese [23] evaluated the opinion of researchers and diseased who had participated in clinical trials. One of them, undertaken by the *Department of Clinical Bioethics of the Clinical Center at the National Institutes of Health*, showed varied reactions among participant researchers who were informed about researchers' interaction with the industry. Reactions went from concern to indifference, passing by acceptance and, even, encouragement of professional and industry interaction, independently if it implied financial interest. However, few recognized that the involvement of researcher and industry might affect their decision when participating in a research[23].

According still with these authors, a recent analysis on oncological trials showed that

recruited participants (patients) were not concerned with the financial bondage between researchers and drugs companies, revealing that they would have participated in trials even if they had knowledge of such relationship. However, a significant minority would look for information to protect themselves from researchers' financial conflict of interests. Authors point out that although it is recommended that researcher clearly inform his financial interest to participants in a research, through a statement of conflict of interest, the usefulness of this document is limited in face of participants' interest in been cured for their diseases. Author stresses that these patients' safety turns to academic centers, believing that they have a system that would protect them from researchers' conflict of interests[23].

It is necessary to bear in mind that, despite the fact that Medicine is a scientific profession, adopting a scientific method of inquiring in its knowledge, many physicians lack scientific formation and exercise their profession without knowing how scientific knowledge is produced and evolves. This lacking, and not rarely, makes them believe that information received from the industry is always trustful and they do not perceive that their interaction with medications representatives, with "shrewdness and tricks" of advertising, may, to a certain extent, withdraw their absolute independence in the prescriptions that they elaborate. It may be difficult for many of them to doubt, besides that they may fear in not using a new medication, suspecting on not applying the best available knowledge to deal with their patients.

To this process concurs the fact of been scarce comparative studies about medications of the same pharmacological class, which makes choices difficult and turns physician vulnerable to advertizing. In many articles published in medical magazines, authors have links with medication producing firms as to generate mistrust about trustfulness on studies or given information. Such bonds became so common that some medical magazines began to disclose them so reader could be informed. Marcia Angell, at the time, working for the *New England Journal of Medicine*, stressed the difficulties in finding editorialist who did not have financial bonds with pharmaceutical firms [9].

Asurvey coordinated by Carneiro and Gouveia [24] shows that in Brazil 91% of physicians informed to have access to scientific magazines. Of these, only 19.4% subscribe to international magazines – monthly read by 26.2% and just 3.4% do it biweekly. The majority of Brazilian physicians who participate in the study has access to national scientific magazines and they consult them on a monthly basis (69,0%)[24]. However, despite qualification that such periodicals may have, they cover only a minimum portion of knowledge set at physicians' disponibility in English language publications, namely American. Thus, it concluded licitly that freedom of choice is not full when knowledge is missing because of

this fact. This does not relate to the fact that certain choices may be made with interference of secondary interests, but rather, in certain instances, knowledge to discern on nature of the information may be missing. In such circumstances, advertisement persuasion techniques generate greater effect.

A study by Steinman, Shlipak and Mcphee [25] showed that the majority of physicians does not believe been influenced, although they do not believe on their colleagues been equally immunes. Many do not seem been so vulnerable to commercial influences, which is attested by thousands of low cost medications prescriptions and the adhesion of the majority of Brazilian physicians to generic drugs. Authors point still, that some intern doctors believe that their clinical knowledge ensures independence to their prescriptions, and many say that they ignore pharmaceutical industry representatives when they receive gifts[25]. Coyle calls attention to the fact that patients recognize that gifts may influence medical practice, but they make distinction on inoffensive gifts (pens, books, free samples, etc.) from other more prone to influence or even corrupt (trips, luxury articles etc.) [26].

There are evidences that the impulse to pay back gifts, even the low cost ones, contrary to what is commonly proclaimed, may exercise influence people's behavior when they receive gifts. People who give or receive gifts show some expectation level of been the target of some sort of reciprocity. It is exactly this reciprocity expectation that may motivate donation.

In fact, available studies presented by Dana and Loewenstein [19] show that people, even if incited to impartiality, are not able to keep objectivity, which indicates that self-interest bias is involuntary. Secondly, the fall into partiality, even when explicitly instructed about it, suggests that self-interest is also unconscious. Lack of awareness on partiality makes them not attempting to suppress it. Many physicians, thus, are victims of these relationships and they have their autonomy reduced subliminally, but not less humiliating. Finally, the authors conclude, studies show that self-interest indirectly affects prescriptions, by changing the way that they look for and evaluate available information that they will base their choices. That is, information withdrawn selected from available literature in such manner as to corroborate with choices of prescribed medications that may not constitute the best scientific evidence or to serve other patient's peculiarities [19].

The most relevant reasons for existence of regulatory norms for theses interactions in the clinical practice is that receiving gifts is associated to a positive attitude toward medications representative, in addition that prescription rates increase after a visit of a representative to a physician, after attending symposiums sponsored by firms and after

receiving samples. Wazana[27] states, based in systematic review of literature on the topic that majority of interactions involving receipt of gifts has negative outcome in clinical practice. According to Dana and Lowenstein mentioned study, 31% of the pharmaceutical industry budgets are spent with advertisements and administration, compared to 14% targeted to clinical research and development[19].

Considering bioethics principlist methodological attitude, the interference of pharmaceutical industry interests in physician's clinical decisions would make him to disrespect the beneficence principle, as stressed previously, since the best would not have been done. Moreover, if prescription submits patient to severe adverse effects, which could have been avoided by other more suitable and effective prescription, or still when prescribed medication implies a greater risk of therapeutic failure, then, the principle of *non-mal-effecence* is equally hurt. Patient sees himself, thus, victim of the nonobservance of two bioethics principles that are based in the *Universal Declaration of Human* Rights[28]. Additionally, if treatment under issue is onerous and withdrawn from public funds, the *principle of justice* is also hurt as it subtracts funds that could have been used in benefit of other sick people.

Final considerations

Bearing in mind the high purposes of medicine, professionals who are sensible and aware of the majesty of their profession should deny in participating so intensely of a relationship that diminishes them – by taking their freedom away – and that may persuade them. Additionally, it attempts against society's most legitimate interests, by making products more expensive that withdraw exaggerated funds from public sector with their harmful consequences. As a counterpoint, it reasoned that only excesses should be inhibited since it is competitiveness for profits that fosters searching for new medications to cure illnesses and, only with an enforced legislation it would be possible to prevent such excesses and not appealing to "sanctity" of the species. Additionally, it should not be forgotten that pharmaceutical industry main duty toward their shareholders is the return for their investment. However, *enterprises should not surpassthe line that separates patient's well-being from profitability interest* [18].

It should conside that, when dealing with previously mentioned conflict of interests, there is a worrisome scale. However, where control of excesses should take place in this relationship and *who would be the gatekeeper of guards*?

It seems clear that the problem of conflict of interests in medicine is very complex and it requires a broad critical discussion, enabled only with the absence of other commitments that are not patients' well-being and the food name of the profession. However, at least in Brazil, it is necessary that this discussion to be broader, intense and involving representatives from medical schools,

medical associations and councils of medicine to define norms that regulate interactions between physicians and medications industry.

Several class associations developed, since the 1990s, guidelines to modulate this interaction, such as the *Canadian Medical Association*[29], the *Royal College of Physicians and Surgeons of Canada*[30], the *American Medical Association*[31,32] and the *American College of Physicians* [38]. Camillere and Cortese[23] stress recommendations to identify and manage conflicts of interests in medical research and education in the American academia, detailed in Federal regulations, in the *American Medical Association Colleges* reports and in the norms established by the *Accreditation Council for Continuing Medical Education*. In many academic centers, individuals presenting conflicts of interests cannot vote in purchasing decisions [23].

In Brazil, the Medical Ethics Code[34] (CfFM Resolution 1,931/09), in its Clause 104, points out to be prohibited for physician to *stop keeping professional and scientific independence in regard to medical research sponsors, satisfying commercial interest or to get personal advantages.* Within the scope of medical practice, this appreciation to patient's best interest, the mentioned code stresses still, in its Clause 109, ethics infringement that derives from lack of zeal when *relationships with the pharmaceutical, industry, orthesis, prosthesis, equipment, implants of any nature that may configures conflicts of interest, even if potential* are not declared.

Additionally, CFM Resolution 1.939/10 prohibits physician to *participate, directly or indirectly, in any kind of promotion related to providing coupons or discount cards to patients for purchasing medications,* been included in the prohibition *filling in any kind of cadastre, form, card, information card or similar documents, in regard to promotions.* Finally, the Federal government recognizes the negative influence that medication commercial advertisement done by means of donations. Clause no. 3 of Resolution RDC 96 of the National Sanitary Surveillance Agency (Anvisa), of December 17, , establishes that *as enterprises cannot award, offer, promise or to distribute gifts, benefits and advantages to prescriber or dispensing professionals, those who exercise direct sale to consumer, as well as to the public at large* [34,35].

Conflict of interest regulation is more difficult that it is supposed, holding some questionings and among them, for example, in which level, pretense ideal, advertisement should be reduced? Is it possible to pay for the research and production high costs of new medications without consumption that, in its turn, advertisement induces it? Will not advertisement restriction affect free competition among firms and research for new medications? Is it possible to know details about pharmacology of these medications without laboratory information? Which independent researchers will carry out needed investigations to set in which extent this information is correct? Who will finance these researches? Isn't it equally true that a significant portion of these

informations supplied by laboratories about medications are correct and coming from true researches and there was immeasurable progress in treatment of human illnesses? Is not the disseminated use of these medications the great scrutiny of its effectiveness and safety in face of the large sampling involved and the possibilities of uncommon effects occur? What sampling amount would be true to state on effectiveness and safety, if not the largest possible, only gotten with product liberation and its broad use? Is it not equally true that modern medications provide immense benefit were significantly responsible for increasing life expectancy, and accentuated reduction of pain from illnesses? In this realm, what is the resultant of the relation betwen losses and benefits?

Within the scope of research and development of medications, Angell suggets to *transfer focus from immitation medications to innovative medications; to srtengthen FDA as independent agency from pharmaceutical industry; to create an institute to supervise clinical trials with medications; to restrict commercial rights monopoly; to exclude from medical education the pharmaceutical industry giants; to set reasonable and uniform prices* [5].

Brennan, Rothman, Blank et all [18] believe that conflict of interest will persist and in order to remedy the situation medical school and university hospital should rigidly Regulate industry-physician interactions, Inhibiting practices that constitute conflict of interests, namely in its most profitable field: the relationship between physicians and pharmaceutical firms and medical devices producers. Preference for academic medical centers is justified in face their responsibility for medical formation, highlighting that learned or acquired habits during formation will last in practice. The necessity of scientific integrity, therefore, as recommended by the *American Medical Association* (AMA) [17]. This association suggests, still, to prohibit gifts of any kind, even those of less value, and totally forbid participation in events with free meal, payment for trips and participation in meetings or online conference. Among these prohibitions included, also, medications and medical devices offers distributed by professionals in clinics[17].

These same authors[18] forecast that free samples should have other path to reach the hand of the ill, as long as such path distances the firm and its medical products from physicians, since such proximity allows use of advertisement powerful resources. Information on new medications may be gotten by means that are more efficient and as free as possible from advertisement strategies. They recommend that physicians and other health professionals involved with standardization and purchase of medication and medical-hospital material should be definitely prohibited the establishment of any

finance relationship with medications producers, inclusively from receiving any kind of gift[18].

Relationships of academic centers with medication and technology industry, through consulting or researches, should not be inhibited as they are been replaced by the CROs, mentioned previously. However, transparent contracts and the outcomes of such interactions should be required, stated in form of research, should be exclusively limited to scientific issues, with trials publication assured, whatever are the outcomes [18].

Based in recommendations for scientific societies, Salas, Osório and Vial[1], as well as Heerlein[16], propose that financial support to scientific activities in health sector be done by scientific societies or academic institutions, both within the scope of researches and in events, since this would result in an equal distribution of sponsorship benefits. Issues discussed in sponsored scientific events should be chosen in total independence from the sponsor. They suggest, still, that an educational fund be alteranatively created with contributions, and academic institutions deciding where to target these funds and educational content. They stress that in several events – such as conferences, publications, clinical meetings and other – where physicians participate or subscribe to them should publicly state any economic bond with the pharmaceutical firm, whatever is the nature of this Bond, such as fees, trips, advisories, etc. Finally, independently of the medical institution, it is fit to publicly declare received donation and its commercial link with industry[1,16].

Medical schools should be accountable for the education about the relationship between physicians and the pharmaceutical industry, a responsibility that medical societies and councils should also have. The prevalent notion that congresses are sponsored in significant portion or that donations from industries are always lacking should be abandoned and not fostered. Finally, it is advisable, in the light of these comments, that norms and Professional codes are prepared with broad critical discussion[1].

Resumen

Conflicto de intereses entre los médicos y la industria farmacéutica

En este trabajo se discuten brevemente los problemas éticos involucrados en la relación entre el médico y la industria de las drogas, sus causas y consecuencias, con fundamento en el muestreo general de las publicaciones disponibles. Se definen los términos y las expresiones necesarias para comprender el tema y el establecimiento de los límites para un debate amplio y crítico en el que participen representantes de las escuelas de medicina, las asociaciones médicas y los consejos médicos para el establecimiento de normas que rigen las interacciones entre médicos e industria farmacéutica. Las consideraciones pertinentes se hacen en relación a las sugerencias de medidas que deben aplicarse con el fin de minimizar los conflictos de interés entre los médicos y la industria farmacéutica y de tecnología y evitar las relaciones espurias que pueden establecerse entre ellos.

Palabras-clave: Médicos. Indústria farmacéutica. Ética.

Abstract

Conflict of interest between physicians and the pharmaceutical industry

In this paper we briefly discuss the ethical problems involved in the relationship between physician and drug industry, its causes and consequences, based in general sampling of available literature. Definition of terms and expressions are necessary to understand the issue and to establish bounds for a broad and critical discussion involving representatives of medical schools, medical associations and medical councils to set standards that govern interactions between doctors and pharmaceutical industry. We made relevant considerations concerning suggested measures to implement in order to minimize conflicts of interest between doctors and drugs and technology industries, and to restrain spurious relations that could establish between them.

Key words - Physicians. Drug industry. Ethics.

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