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Editorial

Disclosing Pharma Payments to Oncologists: What Will We Learn?

Recent reports suggest that the Obama administration is on the cusp of approving administrative rules that will require pharmaceutical and device manufacturers to report all payments to physicians. These payments will then be posted on a Web site that is available to the public. Similar information is already available in public databases. My home state, Massachusetts, requires reporting under its Code of Conduct from all pharmaceutical and device manufacturers (available at http://www.mass.gov/dph/pharmamed), and several similar public data repositories exist. ProPublica, through its Dollars for Docs project, has made available reports from several major pharmaceutical companies (available at http://projects.propublica.org/docdollars/). Currently, the existing data tally the total payments, report the dollar value, and identify what the payment was for (e.g., consulting, travel, speakers' bureau).

Many major pharmaceutical companies in oncology, including Novartis, AstraZeneca, Pfizer, Eli Lilly, Johnson & Johnson, and GlaxoSmithKline, already make their payment information publically available, and that information is collated at ProPublica for search and review. If the proposed Federal rules come into place, then all pharmaceutical firms would be expected to report this information, including additional large companies with oncology products, such as Roche/Genentech, Bristol-Myers Squibb, Amgen, and sanofi-aventis, to name a few.

A comprehensive, detailed, national database that reports on payments by pharmaceutical companies to physicians can have great value, I believe. For one thing, it will immensely simplify the tasks of various schools and organizations seeking to collate this information on their own. NCCN, ASCO, and other cancer organizations feel an appropriate imperative to disclose potential conflicts among specialists, particularly those charged with establishing guidelines, commentary, and education. Individual hospitals and medical schools working on data registries will now be able to quickly review and summarize the activities of their faculty.

These data will also let reviewers draw their own conclusions based on the specific dollar value of the disclosure. Being listed as a "consultant" or "speaker" for a company is one kind of potential conflict, but it's one thing to be receiving $50,000 or more, year after year, from the same company, and another matter to have participated in limited consulting activity for $1500. I believe most people have a strong sense of fair play and will readily understand what passes the "sniff test" and what does not. An honest reckoning of the extent, measured in dollar values, of the relationship between the company and the doctor is a powerful antidote to the various misperceptions that can color impressions in both directions. It is certainly more appropriate than arbitrary cutoffs proposed by most groups and quasi-distinctions made among speaking, travel, consulting, and other activities.

I have occasionally searched through some of the existing databases, and I suspect those data provide a good preview of a comprehensive national registry. You can learn a few things in these registries. First, the vast majority of doctors, including many "thought leaders" and others of prominence in medicine, do not receive drug company payments. I have found no truth to the canards that "everyone does it" or that "if you have no conflict, you have no interest." Those myths are part of the dialogue to justify certain behavior. Second, a lot of doctors do receive payments, but what is declared in official disclosures and what can be found on the Web sites are frequently discordant because of the incompleteness of existing registries, the time frame of various disclosures or requests, varying definitions or understandings of reportable information, and lack of thoroughness in disclosing potential conflicts.

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Two kinds of names stand out when reviewing the list of doctors who do receive drug company money. Perhaps the most disheartening are the names of many prominent individuals with distinguished titles and significant administrative roles who accept substantial amounts of drug company money. The second, more populous, cohort is made up of rank-and-file physicians (and other health care providers), most of whom you haven't heard of. This lengthy list suggests that there cannot be much prestige in being on a drug company speakers' bureau or attending a regional advisory board.

In this discussion, though, we must acknowledge the obvious: drug companies have new drugs and many resources that are critical for both making clinical progress and disseminating the discoveries, and physicians care for patients, know the field, and interpret data. There is tremendous need for collaboration and cooperation, and physician-experts expect to be compensated for their work. Working with pharmaceutical companies to create medical progress is not evil; indeed, it is one of the important roles for clinical experts.

The concern, however, is not too much collaboration or cooperation; it is co-optation. The best way to reduce the concern is to give people the facts and let them draw reasonable conclusions. A national database of pharmaceutical payments will not address every concern over conflict of interest. For example, it does not answer questions about whether conflicts are permissible for those on expert panels, those with control of trainees or junior faculty, those who make purchasing decisions, or those who are educators. It does not determine which thresholds are appropriate and which are not. It does not consider equity holdings or involvement in start-up companies, where financial stakes are high. It does not address the challenging problem of research payments to physicians. All of which suggests that assembling and reporting a national registry is not a solution to *all* the concerns. However, it is a good step that should enable a serious dialogue and debate.