What would you be embarrassed by if someone else pointed it out first?
Margaret McCartney, p 39

Declare incentives for non-white trial participants

Mistrust may explain why non-white people are under-represented despite apparent willingness, says **Arch G Mainous III**

The National Institutes of Health in the United States and others recognise the importance of adequate representation of non-white ethnic minorities in clinical trials and require that investigators outline a recruitment plan in grant proposals.[1] Recruiting adequate numbers of ethnic minority people into trials is also important in countries such as the United Kingdom, where funding agencies do not currently require it. Such inclusion is necessary to ensure that evidence has the widest applicability, as well as for understanding healthcare delivery and quality of care among these groups.

Unfortunately, non-white people tend to be under-represented in healthcare research, even though they are reported to be as willing as white people to participate.[2 3] Mistrust is the most common barrier to participation identified in studies of non-white minority patients' participation in research, and efforts to overcome this may be key to reconciling the apparent incongruence between stated willingness to participate and low participation.[4]

Strong patient-physician relationships, and patients' trust in their physicians, are critical to the delivery of healthcare for all patients, but especially those from minority ethnic groups.[5] Patients are more likely to agree to participate in trials if they trust their physician and he or she recommends they take part.[6] Patients trust their physician to act in their best interests and assume that medical researchers also act in their interests and not just those of the investigators.[7]

Less educated and older non-white people tend to have the least trust in medical researchers

Trust in their personal physician seems to be a particularly important determinant of enrolment of non-white people,[8] partly because they tend to have less trust in medical researchers than do white people.[7] Less educated and older non-white people tend to have the least trust in medical researchers.

Physicians with large populations of non-white patients, regardless of their own ethnic group, tend to mirror their patients' attitudes and trust medical researchers less, illustrating the role of physicians acting in their patients' interests.[9] Physicians build on the trust inherent in the patient-physician relationship and become advocates for their patients as they contemplate vouching for the investigators to their patients.

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Several strategies have been suggested for recruiting people from ethnic minorities and particularly for building trust. Forming trusting relationships between physicians and ethnic communities takes respect and reciprocity, including paying attention to language or other communication barriers.[10] Another strategy is to use personal physicians as recruiters or investigators.[6]

Incentives to recruit more non-white people into clinical trials may include direct payments for each person recruited or, less directly, funding agencies may threaten to withdraw grants from trials with inadequate recruitment. So an investigator's income or career may be at risk unless he or she recruits sufficient non-white people. A recent review of UK guidelines did not endorse paying healthcare professionals to recruit patients.[11]

Mandates to include more non-white people in trials may put pressure on investigators, and in particular personal physicians as recruiters, to convince their ethnic minority patients to participate. It is unknown whether such pressure affects physicians' judgment. Might it bias the physician-investigator towards acting in his or her best interest rather than that of the patient? Given the trust and power in the patient-physician relationship, at what point does the physician's encouragement to participate become coercion?

These incentives may affect trust between patients from minority groups and physicians. One solution is for physicians to disclose information about financial incentives or other implications of them enrolling the patient.[12] A practical strategy could be for ethics committees to require physicians to declare these financial interests when obtaining informed consent from research participants.

One study found that patients who participated in trials thought that they should be given full information about payments to the physician, and they thought that physicians would be reluctant to disclose this information because their motives may be questioned.[11] Evidence suggests that trust between patients and physicians increases when financial interests in recruitment are disclosed.[13] Although it has been argued that knowledge of such incentives doesn't really affect overall recruitment, it is unclear how representative this evidence is of the attitudes among minority groups.[13] For example, in several surveys of patients' perceptions of the importance of disclosure, less than 3% of those asked were black.[14 15]

Personal physicians acting as recruiters to trials should disclose all direct and indirect financial incentives so patients can make an informed decision—and so that they know that physicians may be acting not only in the patient's best interest but also in their own. It may take a little longer to explain, and could be an awkward conversation, but it should be worth it to maintain a positive patient-physician relationship, to deliver good healthcare, and to do good science.

Arch G Mainous III is professor, Department of Health Services Research, Management and Policy and Department of Community Health and Family Medicine, University of Florida, PO Box 100195, Gainesville, FL 32610, USA
arch.mainous@ufl.edu

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NO HOLDS BARRED **Margaret McCartney**

Who pays this doctor? It's time patients knew

If my MP wanted to build a motorway, it would be reasonable for constituents to know whether he had shares in the construction company appointed, or indeed in the land that had now become valuable. And it's easy to find out: all UK MPs have to make declarations on the publicly available register of members' interests.[1]

But if I am a patient, I am unfairly ignorant. I don't know whether my doctor is a chosen key opinion leader, paid by a drug company to increase prescribing of a drug. When my doctor recommends an intervention, I don't know whether her education on my condition has come solely from a drug company representative—despite the associations between drug company education, higher prescribing costs, and lower quality.[2 3] I have no idea whether my doctor's travel to an international conference was paid for by the drug company making the product I am being recommended. Yet we know that even small gifts create changes in doctors' behaviour.[4]

What would you be embarrassed by if someone else pointed it out first?

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Such ignorance extends much further than drug companies. If a doctor recommends a food or food supplement in an interview to a newspaper, we should surely also know if that doctor is acting as a paid public relations representative of the brand. Similarly, it's only fair that readers should know if a doctor who recommends an intervention also owns its patent. If a general practitioner on a commissioning board advocates a particular supplier of services, we also need to know whether she will profit from that choice. This should not be even slightly controversial.

The House of Commons' health select committee has recently concluded that the case for the General Medical Council to hold a central register of doctors' interests is "compelling."[5] The GMC now has to work out what that means in practice. Let's hope we don't now disappear down a philosophical rabbit hole of trying to define what a declared interest should be, infecting ourselves with holier than thou declarations of attitudes towards having half a bottle of wine at dinner, membership of political parties, and how many apples we ingest daily.

At whopaysthisdoctor.org, I and a few others have set up a voluntary register of doctors' declared interests. It should be straightforward. Who is paying you to do what, and what would you be embarrassed by if someone else pointed it out first?

Margaret McCartney is a general practitioner, Glasgow
margaret@margaretmccartney.com

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BMJ BLOG OF THE WEEK **Azeem Majeed**

General practitioners should give up their independent contractor status and become NHS employees

General practitioners (GPs) have worked as independent contractors since the NHS was first established in 1948. However, we now need to review whether this model of general practice is what the NHS still needs.

GPs are currently under pressure because of rising workloads, an increased complexity of the care that they need to deliver, and a reduction in the resources allocated to primary care. Many general practitioners now find themselves struggling to cope with their day to day workload. This makes it difficult for patients to gain timely access to their general practices, and in turn increases pressure on other parts of the NHS, such as emergency departments.

How can we address these problems and make general practice a more rewarding career for doctors? We need to consider the introduction of a salaried GP service in which GPs are employed by the NHS.

A major benefit of a salaried service would be better workforce planning. GPs could be placed where they were needed, and employed in sufficient numbers to meet the local needs for primary care. They could be employed by the same NHS organisations as specialists; thus giving greater opportunities for integrated working and bridging the gap between primary and secondary care.

A salaried service would also allow junior doctors to understand the work and salary they might expect as GPs, and reduce the uncertainties that currently exist for them. Under a salaried service, GPs could be employed on similar terms to NHS consultants, with a salary based on experience and with additional payments for taking on extra duties. GPs could then have job plans, just as consultants do. As employees, GPs would also have the same employment rights as other NHS staff, such as maternity, paternity, and sick leave.

Giving up their independent contractor status is a big step and one that many GPs will find difficult to do. It may be that this is not something that is introduced nationally, but as an option in parts of the country where

workload is high, GP premises are inadequate, and the recruitment of GPs is difficult. A mandatory standard NHS contract for salaried GPs working in such areas would be a far better solution for primary care than the current alternative.

Azeem Majeed is a professor of primary care and head of the Department of Primary Care and Public Health at Imperial College London.

Competing interests: I am a GP principal at the practice of Dr Curran & Partners in Clapham, London. This article is based on a talk I gave at the Pulse Live conference in April 2014.

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