EDITOR'S CHOICE

Doctors should tell patients who is paying them and why

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How much should your patients and colleagues know about who is paying you and why? Pretty much everything, argue two articles published this week.

In an open letter to the UK General Medical Council, Margaret McCartney and colleagues say that patients should be able easily to find out what drug companies and others are paying their doctors (doi:10.1136/bmj.g236). At the moment there is no formal mechanism for doing this, despite evidence that such payments influence clinical decisions.

Leana Wen agrees (doi:10.1136/bmj.g167). As a physician in Washington, DC, she has become increasingly troubled by conflicts of interest that are apparent to doctors but hidden from patients. She sees full transparency as part of "a renewed professionalism." This should extend beyond payments from industry, she says; doctors should also make clear to patients how they are reimbursed. Payment structures such as fees for services (or, in the UK, the Quality and Outcomes Framework) incentivise doctors to order tests or to provide specific treatments. Patients need to be able to ask whether tests and treatments are being prescribed because they are in their best interests or because they benefit the doctor, she says.

The sums of money paid to individual doctors can be substantial, especially in the United States. In high profile cases uncovered by Senator Chuck Grassley, undeclared payments amounted to several million dollars (doi:10.1136/bmj.b3139). In the UK the stakes are lower, but a senior academic physician, John Bell, regius professor of physic at Oxford University, is recorded to have been paid around £260 000 in 2011 by the drug company Roche (doi:10.1136/bmj.e8351). This was found only after digging in the company's accounts.

For most doctors the sums will be much smaller, and many will be receiving money only from their employer. But payments to key opinion leaders for speaking or writing on a company's

behalf, and benefits in kind such as industry funded education, are widespread.

Attitudes do seem to be changing. When GlaxoSmithKline recently announced that it will stop paying doctors to market its drugs (doi:10.1136/bmj.f7579), the president of the Royal College of Physicians welcomed the move (<http://bit.ly/1aBGLDm>). However, to me GSK's announcement simply served to highlight how bad the current situation is. Why did we ever think it was right for doctors to be involved in marketing drugs? And if the college really thought that doctors should not accept payments for this kind of activity, why has it not done more to change the situation? Why not, for example, ask members and fellows to minimise such conflicts and require that they declare them?

The authors of both *BMJ* articles this week have set up websites where doctors can declare their sources of income: whosmydoctor.com and whopaysthisdoctor.org. But such voluntary declaration is just the first step to restoring trust in the profession. Wen says that declaration should be mandatory as part of informed consent. McCartney and colleagues ask the General Medical Council to consider maintaining annually updated declarations of interest alongside details of each doctor's qualifications and registration status.

Not everyone will welcome such moves with open arms. Wen reports extreme hostility to her initiative from some doctors, and McCartney and colleagues acknowledge that being required to declare sources of income will concern some. But declarations of interest are now standard practice for publication in medical journals. The same should be true for our dealings with patients.

Cite this as: *BMJ* 2014;348:g259

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