Physicians, finder's fees and free, informed consent

Editorial

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Résumé

LES CHERCHEURS ONT DE LA DIFFICULTÉ À RECRUTER des patients pour leurs essais cliniques et offrent souvent une prime aux médecins qui les aident à cette fin. Les médecins ont intérêt à ce que leurs patients participent à des essais cliniques, non seulement parce que ces derniers en bénéficieront directement, mais aussi parce que les résultats pourront s'appliquer à leurs autres patients dont l'état est semblable. Les lignes directrices canadiennes sur la recherche conseillent cependant aux médecins de ne pas faire participer à leur recherche leurs propres patients. L'auteur souligne que référer un patient à un autre chercheur contre prime entre en conflit avec le devoir de soin clinique. Il examine les problèmes d'éthique que suscite le versement de primes au recrutement de patients et discute des conditions qui devraient s'appliquer à ces primes.

Is it ethical for physicians to accept payment for getting a patient from their practice enrolled in a clinical research study? The term for this payment, "finder's fee," was imported from the business world, where it is used to denote the fee paid for bringing together 2 parties to a transaction, typically in order to lend money. The parties to a satisfactorily concluded agreement recognize the role played by the finder and accept that a fee is an appropriate reward. That this arrangement can be readily adopted into medical research is far from clear.

The usual business relationship between provider and purchaser is governed by the purchaser, who decides what is a fair price for what is bought. Once an agreement is reached, the buyer assumes any risk that may occur — caveat emptor. The physician and patient also function within this kind of framework, the physician providing expertise and often the intervention determined by that expertise, and the patient or a third-party payer purchasing the service.

The relationship between physician and patient is special, however, because of what economists refer to as asymmetrical information: the physician and the patient know different things. A good interview serves to diminish this difference, but only to a certain point because of the physician's expert general knowledge and ability to infer. This persistence of asymmetry introduces an element of power into the relationship that cannot be checked by other aspects such as trust or confidentiality. That power could be used to exploit.

Because of its professional nature, the physician–patient relationship has not generally succumbed to the destructive effects of exploitation. The essence of this professionalism is that the physician undertakes to advise and to act in the best interest of the patient. When, for example, there is conflict between the physician's right not to be disturbed and the patient's need for urgent help, the latter prevails. This principle was adopted by our profession centuries ago; it is most apparent in the provision of medical care to patients even when they have been unable to pay for it.

In the research setting, the power relationship between physician and patient has received special attention because the proposed project is generally not designed to meet the immediate needs of the particular patient; this exacerbates the asymmetry of the relationship. The Medical Research Council of Canada (MRC) addressed this problem in its research guidelines on informed consent: "It may be desirable to delegate the ultimate decision-seeking question to . . . another health

professional who has no direct link to the patient's future medical management."[1] The CMA, in its policy on the relationship between physicians and the pharmaceutical industry, suggests that physicians follow the MRC guidelines in structuring and obtaining consent for drug surveillance trials.[2] The draft document on the code of conduct for research involving humans of the Tri-Council Working Group (a collaboration of the MRC, the Natural Sciences and Engineering Research Council of Canada and the Social Sciences and Humanities Research Council of Canada) espouses this same principle in its section on consent.[3] In another section concerning incentives for participation, it states explicitly that the inequality in the power relationship between provider and patient produces an inappropriate incentive for the patient to agree to participate, such that "an investigator who provides health services should not ask recipients to serve in his or her research project."[4]

These guidelines on consent may startle many of us who conduct research studies involving our own patients. Of more immediate relevance, these guidelines make absolutely indefensible the prevalent practice of both obtaining consent and accepting a finder's fee for each of our patients whom we enroll in the clinical study.[5] Another example of this unacceptable custom is seen in the many drug trials for industry, which receive study support, sometimes very substantial, prorated per patient enrolled.[6] To imagine that we will refrain from coercion in these circumstances, however subtle or unconscious the persuasion, credits us with a rectitude that does not meld with the very human qualities required for effective medical practice.

The problem of recruiting research subjects concerns us all. First, our patients may benefit from a successful new treatment only available through a trial. Second, they may receive services, or even financial support, unavailable in any other way. Finally, strictness of eligibility criteria aside, the more highly selected the patients are who end up in the trial, the less likely it is that the results will apply to patients in our practices. It is, therefore, reasonable to provide some motivational measures, even financial ones, to ensure that our patients enter well-designed studies. It may be, as some have suggested,[6,7] that the situation should be judged depending on the amount of money being offered.

Can we ethically accept a finder's fee for simply referring one of our patients to another researcher? That this may be a problem is suggested by the fact that such fee arrangements are not generally disclosed to the patient, nor are they readily made public. The difficulty arises when payment of the fee is contingent upon the patient being successfully enrolled.[5–9] There is a danger that the asymmetry of knowledge, unbalanced still further by a hidden fee, creates the appearance of and potential for coercion. This situation could be immediately improved by ensuring that the arrangement be disclosed to all patients to whom the study is being offered. If a fee were paid for every eligible patient referred, regardless of whether he or she were ultimately enrolled, the ethical problem for the provider–patient relationship would be even less severe. Others have proposed solutions ranging from no material reward to placing the reward into a departmental account for potential use by all researchers.[5,7,8]

How can we ensure that our patients are enrolled into trials in an ethical manner? Canadian guidelines clearly state that investigators should not enrol their own patients into their own research studies. In my opinion, we should not accept finder's fees for referring our patients to another investigator; the finder should be someone who has no role in the particular physician–patient relationship or in the process of obtaining informed consent. Furthermore, the payment of any fee to a physician for getting his or her patient enrolled in a study should be disclosed to that patient.

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