LASKAI ANNA ESZTER

Kriminológiai Tanszék
(Doctorate in Global and Cultural Criminology doktori program)
Témavezető: dr. Fleck Zoltán tanszékvezető egyetemi tanár
(Jog és Társadalomelméleti Tanszék)

THE INSTITUTIONAL CORRUPTION OF MEDICINE: TOWARDS AN INSTITUTIONAL PERSPECTIVE

Introduction

Is it corruption if a doctor writes a prescription for medication that harms the patient if the doctor, at that moment in time, truly believed that the medication did not harm, but in fact promoted the health or recovery of the patient? At the ELTE PhD conference, after presenting under the title of "*The Institutional Corruption of Medicine*" I was asked this very question. The aim of the presentation was to describe my research subject: the institutional corruption of the medical profession through ties with the pharmaceutical industry, and as such follows the controversial idea, that when the pharmaceutical industry commits a crime, doctors may share some of the responsibility. Does this mean – as one research respondent asked in outrage – that I would wish to have a lawyer or a policeman follow every doctor around and oversee his/her practice? Would a doctor be labelled criminal if unknowingly, having the patients' best interests at heart prescribed a drug that does more harm than good? This paper will attempt to explain the framework within which institutional corruption of the medical profession ensues, and what answers this may hold for the questions above.

Towards medical culpability?

Research into the institutional corruption of medicine evolved from what in criminology is a well-documented area: the study of "*Corporate Crime in the Pharmaceutical Industry*"[1]. Braithwaite, having already executed an all-encompassing criminological documentation of the extent of criminality within the pharmaceutical industrial sector, began an important research tradition into "Big Pharma"[2] and its deviant nature giving the pharmaceutical industry the nickname, "Bad Pharma"[3] A more recent publication

[1] BRAITHWAITE 1984
[2] LAW 2006
[3] GOLDACRE 2012

has however brought to question not solely the criminality of the pharmaceutical industry, but divides the responsibility of pharmaceutical industry crimes as shared between both industry, and the medical profession. "*Many of the crimes of the pharmaceutical industry would not be possible if doctors didn't contribute to them*."[4] This is not the first time that an academic or an insider has challenged the integrity and responsibility of medical professionals in pharmaceutical criminality.[5] Gøtzche's book: "*Deadly Medicines and Organized Crime*" however, is the first piece of literature that not only criticizes the medical professional's ties with industry, but directly implicates medical practitioners in pharmaceutical industry crime.

A simplistic deduction of this sentiment results in the notion that doctors are as criminally responsible as the entire industry, and that physicians knowingly engage in pharmaceutical corporate and white collar crime, the outcome of which ultimately ends with the harm of patients. But this is a dangerously over-simplified interpretation which – if taken literally – would indeed require a policeman to be seated next to every medical professional. The responsibility of physicians in industry criminality is a much more complex argument and should be analysed not in the micro level of criminal action by a "Dr. X", but rather in the analysis of the relationships fostered by the pharmaceutical industry and the medical profession. It is through these institutional interactional platforms that we are afforded the possibility of studying the ways in which medicine is being unduly influenced by the commercial interests of Big Pharma.

Relationships between the pharmaceutical industry and the medical profession manifest within all stages and platforms in the practice of medicine. Most obvious is that medical treatment today is done through the administration of some form of pharmaceutical drug.[6] The pharmaceutical industry however is much more than just a manufacturer of pharmaceutical products, and the relationships it fosters with medical professionals takes on multiple forms. Specified are 3 types of industry-medicine interactions[7]:

(i) Communication between physicians and pharmaceutical industry sales representatives: pharmaceutical sales representatives are tasked with promoting a particular drug to physicians. This includes information about the latest studies, safety and efficacy information, as well as the added benefits of new or existing products.

(ii) Industry sponsored medical conferences, symposia, and continuing medical education: Medical professionals constantly need to update their knowledge about advances in medicine. Conference attendance and mandatory continuing medical education is a necessity. The pharmaceutical industry

[4] GØTZSCHE 2013. 3

[5] LEXCHIN 1993, WAZANA 2000, SCHAFER 2004, SCHNIER et al. 2013, LEWIS et al. 2001, JACOBS et al. 2006, GIBSON et al. 2002, MOYNIHAN 2003

[6] DREWS 2005

[7] LEXCHIN 1993

acts as a financial sponsor either in the organization and execution of these events, or by supporting attendance fees, accommodation, or travel expenses of doctors.

(iii) Pharmaceutical industry sponsored medical research and drug development (R&D): The pharmaceutical industry is a vital component in the financing of medical R&D, the majority of clinical trials being funded by industry.

Most of the interactions between pharmaceutical companies and medical professionals is reasoned by the vital role of industry in furthering advancements in medicine, and being a contributor to the education of physicians. These relationships however are criticised in that the close ties between pharmaceutical companies and the medical profession are relationships of improper dependence, whereby drug companies seek to infiltrate the medical profession, and further company interests of pushing their products to an over-medicated society. This requires that the medical profession, rather than remaining its own island of innovation, pursuing the disinterested and objective practice of medicine, become invested, to some degree, in the goals of the pharmaceutical industry. Pharmaceutical companies must make money for their shareholders, and any effort to the contrary endangers the continuity of the company. Medicine on the other hand must remain an objective, unbiased scientific endeavour that produces knowledge and maintains its authority over its practice by subordination to only the principles of its profession. "*If either abandons its fundamental mission, it ultimately fails. At times institutional imperatives are bound to conflict*".[8] It is in these diverging institutional imperatives that conflict of interest ensues, creating a situation in which one interest must be abandoned for the other to thrive. Unfortunately it is the interests of medicine that end up being put on the chopping block. Although ties with the pharmaceutical industry create conflict of interests, framing conflict of interests is restricted to the individual, seeing a deviation from institutional interests as a case of individual moral bankruptcy.[9] Doctors who engage with pharmaceutical companies, who are too chummy with sales representatives, who accept gifts, or depend on industry funding for conference attendance are viewed sceptically. Doctors whose salary is complemented by consultancy or advisory contracts with pharmaceutical companies or who seek out companies to fund medical research are too easily viewed as 'bad apples', their conflict of interest manifesting as corrupt practices due to their own incapability of maintaining professional independence. Conflict of interest in Healthcare however, is rooted within its very structure, being that the medical profession is part of a larger arena of competing institutional interests. Corruption, or crimes of corruption tend to focus on individual action and intent and this is reflected by academic inquiry as well as legal definitions.

[8] LEWIS 2001. 783
[9] COSGROVE and WHEELER 2013

A conflict of interest manifests when there is an investment in two diverging interests, or having "*a foot in two camps*."[10] Although conflict of interest does not automatically mean that corruption will ensue, it is the base for corruption itself. Corruption stems from the Latin – *corruptionem* – meaning: to break trust, illegal or dishonest behaviour especially by those in positions of power, a departure from what is good or correct. The most commonly used definition of corruption, is "*the abuse of power for private gain.*"[11] Corruption contains 4 features which set it apart from other forms of criminality.[12] Corruption is (i) an informal or illegal exchange of money, goods, or services belonging to an organization and given to benefit person/(s) not formally beneficiaries or owners of the organization, (ii) where one corrupt party is a member of the organization from which the goods, money, or services originate from, (iii) has at least 2 actors between which informal or illegal exchange happens, and (iv) manifests as a divergence or contravention of social norms, rules, or ethical principles[13]. Criminal Law reflects the elemental features of Jancsics's characteristics of corruption, manifesting in the crime of bribery. Taking the Hungarian Criminal Code, Act C. of 2012 as an example, Section XXVII defines crimes of corruption to manifest in: bribery (§290), acceptance of a bribe (§291), bribery of public officials (§293), acceptance of bribes by public officials (§294), bribery committed in judicial or public administrative procedures (§295), acceptance of a bribe in judicial or public administrative procedures (§296), buying influence (§298), and profiteering from influence(§299). The criminal code emphasizes bribery, in both the governmental as well as the market sector, defining bribery as offering or receiving financial or other material goods or services in exchange for unfair or illegal advantages usually requiring the receiver of the bribe to contravene the formal boundaries of his/her duties. Corruption is seen by criminal law as the abuse of formal power in exchange for some form of material or immaterial benefit. A criminal law approach presupposes a legal and illegal way of behaving: crimes are perpetrated by those with a guilty mind (mens rea) who fulfil – through direct action – the crime act (actus reus) defined in written law (nullum crimen sine lege).

Transparency International lists a variety of phenomena that far outnumber the criminal legal taxonomy: bribery, clientelism, collusion, conflict of interest, embezzlement, extortion, facilitation payments, fraud, illicit financial flows, lobbying, money laundering, nepotism, offshore financial centres, patronage, political contributions, revolving door phenomena, solicitation, state capture, tax evasion, and mispricing.[14] These phenomena shift about on the legal-illegal continuum, and are captured not by legal bearings but rather by a social normative of right and wrong, ethical and unethical, fair and unfair: dependent on circumstance, tradition, and norms,

[10] DREWS 2005. 26
[11] EU ANTI-CORRUPTION REPORT 2014. 2
[12] JANCSICS 2014
[13] JANCSICS 2014. 359
[14] TRANSPARENCY INTERNATIONAL GLOSSARY

differing on a scale of societal acceptance, toleration, or prohibition. Corruption is elusive, because many times it happens in grey areas of legal conduct and is not found to be situated in intent, but the fabric of interpersonal and inter-institutional relationships. Due in most part, by a continued effort to locate corruption as a singular action – static in space and time – committed by an individual of a corrupted mind, an individual-action-orientated approach limits our understanding of corruption, in that it fails to take into account the structural forces that contribute to individual behaviour. *"(…) the problem is not quid pro quo corruption involving the individual "bad apple": the problem is the "bad barrel."*[15] When researching conflicts of interest and corruption in the medical profession, the individual-action-approach dominates the discussion. Conflicts of interest in medicine however, do not simply occur within the individual decision-making process, but emerge as an intrinsic quality of the entire Health System.

Corruption in the Healthcare Sector

The European Commission published a European Union-wide analysis[16] aiming to identify where corruption manifests within the institutional interactions of key actors in the healthcare sector. Creating a typology, researchers identified forms of corruption to manifest according to interactions between patients, providers, industry, payers, and regulators. The study is important in that it takes an institutional interactional approach locating conflict of interest not in individual action, but as a result of interactions between institutions responsible for ensuring different goals in the wider Health System[17].

Main Actors	**Typology**	
Providers – Patients	Bribery in medical service delivery	Typology 1
Industry – Providers	Procurement corruption	Typology 2
Industry – Providers	Improper marketing relations	Typology 3
Industry – Regulators	Improper marketing relations	
All actors (except patients)	Misuse of (high) level positions	Typology 5
Providers – Payers	Undue reimbursement claims	Typology 6
Providers	Fraud and embezzlement of medicines and medical devices	Typology 7

Corruption in healthcare typologies[18]

[15] COSGROVE and WHEELER 2013. 648

[16] STUDY ON CORRUPTION IN THE HEALTHCARE SECTOR 2013

[17] The World Health Organization defines a Health System as "All activities whose primary purpose is to promote, restore and/or maintain health. The people institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health."
http://www.who.int/healthsystems/hss_glossary/en/index5.html

[18] Supra 16

Within Health Systems, other interests apart from providing unbiased medical care – such as affordability of healthcare, accessibility of medicines and treatments, quality assurance etc. – must be met. The different healthcare institutions work to preserve their own interests, but also have to work tightly with other institutions to achieve institutional goals. The different imperatives of each Health System institution diverge in both means and method of goal attainment, and it is in the realization of competing goals that conflict of interest emerge, and from which corruption may manifest. The institutional interactional approach is fundamental, in that there is a general tendency to see the practice of medicine to be subject only to the Hippocratic Oath and the Principles of Good Clinical Practice. This belief contributes to the authority and integrity of medicine, as well as its claim to professional dominance, but reaffirms the idea that a break from medical principles is an individual decision. Completely overlooked is that institutional principles are subject to fluidity if subject to negotiation within institutional relations. Thus what must be analysed in healthcare sector corruption, is not the corruption of the individual, but the corruption of the institutional norms that guide professional conduct.

Criminal qualities are often attached to outcomes of certain actions; they are "*secondary or collateral features, both in priority and the succession of events, of an undertaking pursued for other legitimate purposes*"[19] Drawing on an example of how legitimate practice may induce harm, Diane Vaughn's analysis of the Challenger spaceship disaster is of particular relevance.[20] Concluding that it was not corruption or evil individuals that caused the shuttle explosion but that an organizational culture of risk-taking was infiltrated by other interests to such an extent, that the boundaries of acceptable risk became distorted. It was the legitimate principles of risk being pushed to its limits: the death of 7 people a result of chipping away at engineering safety requirements until it fitted the market incentives of producing a launch on time. Corruption in medicine follows a similar path, wherein it is the principles of medicine that are distorted. The effects of industry-medicine relationships on the decision-making structures of medical professionals is fundamental to understanding how medical professionals may in fact be contributing to pharmaceutical industry criminality. This is not necessarily done by direct intent but the distortion and corruption of medical principles through undue pharmaceutical industry influence.

Distortion through industry patronage

Identified by the European Commission Study in Typology 3, an area that proved to be highly susceptible to corruption was related to the pharmaceutical industry's improper marketing to physicians. Marketing is what will get the product off the shelves and into

[19] NELKEN 2012. 639
[20] VAUGHN 1997

the consumer household and the pharmaceutical industry shells out billions on advertising. The table below shows what the world's 10 largest pharmaceutical companies spent on marketing in 2014.

Company	**Total revenue ($bn)**	**R&D spend ($bn)**	**Sales and marketing spend ($bn)**
Johnson & Johnson (US)	71.3	8.2	17.5
Novartis (Swiss)	58.8	9.9	14.6
Pfizer (US)	51.6	6.6	11.4
Hoffman-La Roche (Swiss)	50.3	9.3	9.0
Sanofi (France)	44.4	6.3	9.1
Merck (US)	44.0	7.5	9.5
GSK (UK)	41.4	5.3	9.9
AstraZeneca (UK)	25.7	4.3	7.3
Eli Lilly (US)	23.1	5.5	5.7
AbbVie (US)	18.8	2.9	4.3

Global Data: BBC Business Reporter[21]

Pharmaceutical marketing is defined in Hungary by the European Federation for Pharmaceutical Industry and Associations (EFPIA). The Code of Ethics on Pharmaceutical Marketing Communications[22] defines marketing communication, marketing practice, advertisement communication, and promotion as any activity, communication or provision of information to healthcare providers performed to influence the attitude and the conduct of the addressee to increase prescription, procurement, sale or consumption of a product, to popularize the name of a product, the image, and activity of a company, increasing the knowledge about a company's products, or even just the company logo.[23] Pharmaceutical marketing is highly successful, research showing that there is a correlation between the number of pharmaceutical sales representative interactions and the prescribing habits of physicians.[24] Increased visits see a tendency of physicians prescribing name-brand drugs over cheaper generic versions, or prefer the drugs of the advertising company over others. Marketing pharmaceutical drugs at medical conferences sees the same promotional effect, influencing the prescribing behaviour of doctors to favour the sponsor's products over others. Influence however is not only achieved by presenting a viable marketing monologue that persuades medical professionals to prescribe a drug. Doctors may not be susceptible to a well-designed marketing speech, or a colourful poster. But influence is not a one-time endeavour. For influence to be continuously successful, the loyalty of physicians and trust in a company must be achieved in other ways. The pharmaceutical industry thus aims to fulfil more than just the role of drug manufacturer and promoter, but also as a trusting contributor to education and R&D in

[21] Richard Anderson: Pharmaceutical industry gets high on fat profits, 6 November 2014
[22] EFPIA Code of Ethics for Pharmaceutical Marketing Communication 2014 Hungary
[23] Supra 22
[24] WAZANA 2000, OLDANI 2004, CHIMONAS et al. 2007, WATKINS et al. 2003

the medical sciences. Thus other relationships between pharmaceutical companies and medical professionals not exclusively categorized as marketing must also be scrutinized.

Apart from direct marketing endeavours, pharmaceutical companies interact with the medical profession through financial sponsorship. These financial contributions manifest in contractual agreements between physicians and industry or through industry funding of medical educational events and medical research.[25] Medical conferences are increasingly organized by industry, and feature information favouring the sponsoring companies' drugs. These events are not only funded by industry, but physician's attendance fees, additional hospitality costs are also covered by pharmaceutical companies. This type of financial support has the same effect on physicians prescribing habits as sales representative visits creating loyalty to a sponsor's products. Conferences will have key speakers or "*Key Opinion Leaders*"[26] i.e. physicians considered leading figures in their respective fields of medicine. Key Opinion Leaders is a term coined by pharmaceutical companies, and are physicians hired as speakers to convey information about a company's product. An obvious conflict of interest arises when physicians are paid on behalf of pharmaceutical companies to promote information on company products. Key Opinion Leaders are hired for their ability to influence other professionals in their field, and thus constitute marketing labelled as education. Similarly, these Key Opinion Leaders are regularly hired as consultants or members of advisory boards by pharmaceutical companies, ultimately having a stake in the company's profitability.[27]

Today, the costs of medical innovation are covered in majority by pharmaceutical companies. Data shows that of the $8.18 billion spent on biomedical R&D in 2012 in Europe, public funding contributed $28.1 billion, while the pharmaceutical industry spent $53.6 billion.[28] Medical research sponsored by private companies however has a much higher likelihood of reporting positive results favouring the sponsor's drug than medical research funded by public institutions.[29] Since most studies are funded by industry, the probability of biased scientific information available to physicians is particularly high. Publications on industry sponsored medical research also show a tendency to cherry-pick positive results, resulting is one-sided positive result publication, duplication of positive results, and 'hiding' results that are unfavourable to the sponsor.[30] In effect, relationships between the pharmaceutical industry and the medical profession are described as pharmaceutical marketing efforts conveniently hidden by the 'education-innovation' rhetoric, and as such are unlikely points of analysis for corruption research.

[25] BRENNAN et al 2006, MOYNIHAN 2003
[26] LIBERATI and MAGRINI 2003
[27] SISMONDO 2013
[28] CHAKMA et al. 2014
[29] SINGH 2003
[30] MELANDER et al. 2003

Conclusion

The objective of this paper has been to draw attention to the problem of corruption in the healthcare sector, and also to emphasize the limitations of an individual-orientated perspective. It is difficult to gain support for criminological research into areas that are not defined as crimes by criminal law, or where harm is the result of a series of legal actions. This is especially true for researching the legal and normal relationships between the pharmaceutical industry and the medical profession. While pharmaceutical industry marketing to influence prescribers is watched over closely, control over improper and unethical promotional tactics in other areas of industry-medicine collaboration may be weakened if the presence of industry is viewed as a normal relationship for which oversight is unnecessary. "*The Pharmaceutical Industry develops, manufactures and sells drugs. Defining illness is not its mission*."[31] To expect that the pharmaceutical industry will abandon this fundamental organizational imperative is irresponsible, but may be forgotten if close ties between industry and medicine continue to be considered a norm. "*Corruption may become institutionalized in organizations*"[32] blinding the individual from seeing the harmful outcome of an otherwise normal decision. In a relationship between two entities that pursue diverging interests, conflict of institutional imperatives is considered daily practice. By way of money, gift giving, financing of conferences, attendance fees, dinners, and trips, sponsoring research or medical equipment, and engaging in consultancy or advisory contracts with medical professionals, industry seeks to influence medical practice either directly or indirectly, ensuring promotion of their products, and tampering with information that is vital to the market authorization process of medicines as well as prescribing habits within medical practice.[33] These "*systemic and strategic***"** modes of influence are *"legal, or even currently ethical*" yet undermine the ability of the medical profession to achieve its own institutional imperatives.[34]

These processes of institutional influence, and manipulation of medical principles cannot be analysed as individual actions, but behaviours evolving from systemic disruption of medical objectivity and the distortion of medicine's impartiality. The necessity of industry-medicine relationships, as well as a blind trust in the infallibility of medical professionalism has haltered research into the risks that these relationships pose. Returning to the question posed at the ELTE PhD Conference: whether a doctor who unknowingly prescribes a drug that is harmful should be considered criminal or corrupt, is precisely the type of question that disables understanding of the institutionalization of corrupt practices, or harmful conduct. Again, we attribute criminality to the individual, rooting out the evil, psychopathic doctor who sold their soul to Big Pharma. The question that should be asked is – *why* the doctor does not

[31] KITSIS 2011. 906
[32] JANCSICS 2014. 362
[33] STUDY ON CORRUPTION IN THE HEALTHCARE SECTOR 2013. 74
[34] LESSING 2013. 2

know that a drug is harmful? *What* made the doctor believe that the drug was safe? *How* did a harmful drug make it to the consumer? *What* made the doctor choose that particular drug and not another form of treatment? Questions should strive not to identify what medical professionals *do* that constitutes corruption (although it may be an outcome of research) but what it is that that physicians have become incapable of doing. Taking on an institutional perspective may answer these questions – it is not that doctors harm their patients deliberately, but it is that the institutional imperatives of the medical profession are being undermined through ties with the pharmaceutical industry rendering them incapable of keeping patients safe.

Bibliography

BRAITHWAITE J. (1984) Corporate Crime in the Pharmaceutical Industry, Routledge and Kegan Paul,

BRENNAN A. T. et al. (2006) Health Industry Practices that Create Conflicts of Interest. A Policy Proposal for Academic Medical Centres, *Journal of the American Medical Association*, 295(4): 429-433.

CHAKMA, J. et al. (2014) Asia's Ascent — Global Trends in Biomedical R&D Expenditures, *New England Journal of Medicine*, 307(1): 3-6.

CHIMONAS, S. et al. (2007) Physicians and Drug Representatives: Exploring the Dynamic of the Relationship, *Journal of General Internal Medicine*, 22: 184-190.

COSGROVE, L., WHEELER, E. E. (2013) Drug firms, the codification of diagnostic categories, and bias in clinical research, *Journal of Law, Medicine, and Ethics*, 41(3): 644–653.

DREWS, J. In: Santoro M. A., Gorrie T. M. (2005) Ethics and the Pharmaceutical Industry, Cambridge University Press

GIBSON, E. et al. (2002) Dances with the Pharmaceutical industry, *Canadian Medical Association Journal*, 166: 448-450.

GOLDACRE, B. (2013) Bad Pharma, Fourth Estate Publishers

GØTZSCHE, P. C. (2013) Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Healthcare, Radcliff Publishing

JACOBS, J. J. et al. (2006) Relationships with Industry: Critical for new technology or an unnecessary evil? *Journal of Bone and Joint Surgery*, 88: 1650-1653.

JANCSICS, D. (2014) Interdisciplinary Perspectives on Corruption, Sociology Compass 8(4): 358–372.

KITSIS, A. E. (2011). The Pharmaceutical Industry's Role in Defining Illness, *Virtual Mentor American Medical Association Journal of Ethics*, 13(12): 906-911.

LAW, J. (2006) Big Pharma: Exposing the Global Healthcare Agenda, Carol & Graf Publishers

LESSING, L. (2013) Institutional Corruption Defined, *Journal of Law, Medicine, and Ethics* 41(3): 2-4.

LEWIS, S. et al (2001) Dancing with the porcupine: rules for governing the university-industry relationship, *Canadian Medical Association Journal*, 165: 783-785.

LEXCHIN, J. (1993) Interactions between physicians and the pharmaceutical industry: What does the literature say? *Canadian Medical Association Journal*, 149: 1401-1407.

LIBERATI, A., MAGRINI, N. (2003) Information from drug companies and opinion leaders, Double standards in information for medical journals and practitioners should go, BMJ, 326: 1156-1157.

MELANDER, H. et al. (2003) Evidence B(i)ased medicine–selective reporting from studies sponsored by pharmaceutical industry: review of studies in new applications, BMJ 326:1-5.

MOYNIHAN, R. (2003) Drug company sponsorship of education could be replaced at a fraction of its cost, BMJ, 326: 1163.

NELKEN, D. (2007) White-Collar and Corporate Crime, In: Maguire M., Morgan R., Reiner R.: The Oxford Handbook of Criminology, 4th Edition Oxford University Press

OLDANI, M. J. (2004) Thick Prescriptions: Toward an Interpretation of Pharmaceutical Sales Practices, *Medical Anthropology Quarterly*, 18(3): 336.

SCHAFER, A. (2004) Biomedical Conflicts of Interests: a defence of the sequestration thesis–learning from the cases of Dr Nancy Olivieri and David Healy, *Journal of Medical Ethics*, 30: 8-24.

SHNIER, A, et al. (2013) Too Few, Too Weak: Conflict of Interest Policies at Canadian Medical Schools. PLoS ONE: 8(7): e68633. doi:10.1371/journal.pone.0068633

SINGH, D. (2003) Drug companies advised to publish unfavourable trial results, BMJ, 326: 1163.

SISMONDO, S. (2013) Key Opinion Leaders and the Corruption of Medical Knowledge: What the Sunshine Act Will and Won't Cast Light On, *Journal of Law, Medicine and Ethics*, 41(3):635-643.

VAUGHAN, D. (1997) The Trickle-Down Effect: Policy Decisions, Risky Work, and the Challenger Disaster, California Management Review, 39: 80-102.

WATKINS, C. et al. (2003) Characteristics of General Practitioners who frequently see drug industry representatives: national cross sectional study, BMJ, 326: 1178-1179.

WAZANA, A. (2000) Physicians and the Pharmaceutical Industry: Is a gift ever just a gift? *Journal of the American Medical Associatio*n, 283: 373-380.

EU Anti-Corruption Report, European Commission, Brussels, 3.2.2014 COM(2014) 38: http://ec.europa.eu/dgs/home-affairs/e-library/documents/policies/organized-crime-and-human-trafficking/corruption/docs/acr_2014_en.pdf

Transparency International Glossary: http://www.transparency.org/glossary

Study on Corruption in the Healthcare Sector, European Commission HOME/2011/ISEC/PR/047-A2 October 2013: http://ec.europa.eu/dgs/home-affairs/what-is-new/news/news/docs/20131219_study_on_corruption_in_the_healthcare_sector_en.pdf

Richard ANDERSON: Pharmaceutical industry gets high on fat profits, 6 November 2014, BBC News: http://www.bbc.com/news/business-28212223

EFPIA Code of Ethics for Pharmaceutical Marketing Communication, Country profile: Hungary, July 2014: http://transparency.efpia.eu/countries/download/12/document/july-2014-hcp-code-final-code-of-ethics-final---with-efpia-comment[1].pdf

***

AZ ORVOSI SZAKMA INTÉZMÉNYES KORRUPCIÓJA

„*Korrupció-e ha egy orvos felír egy gyógyszert, ami a beteg egészségét veszélyezteti, ha a gyógyszer felírása idején az orvos úgy gondolta, hogy a gyógyszer ténylegesen segít a beteg egészségének javításában?*” A kérdést Budapesten intézték hozzám, miután előadást tartottam az ELTE Doktoranduszi Konferenciáján – *Az orvosi szakma intézményes korrupciója* címmel. Az előadás a kutatási témám bemutatását szolgálta, amely az orvosi szakma intézményes korrupciójának folyamatát a gyógyszeriparral fenntartott kapcsolatának tükrében elemzi. A kutatás – és így az előadás témája – azt a vitatott nézőpontot követi, hogy a gyógyszeripar által elkövetett bűncselekményekért az orvosi szakma is felelős. Jelenti-e ez azt – ahogyan kutatásom során egyik interjúalanyom felháborodottan kérdezte, – hogy „*minden orvos mellé jogászt vagy rendőrt állítanék*”? Egy orvost bűncselekmény elkövetésével vádolnánk, ha tudatlanul olyan gyógyszert ír fel betegének, ami többet árt mint használ? A következőkben ezekre a kérdésekre reflektálva kerül bemutatásra az orvosi szakma intézményes korrupciójának kutatási kerete, és keresi a választ a feltett kérdésekre.