

Conflict of interest and corruption in healthcare

A paper by a working group of the Global Committee of the Christian Medical Fellowship

Payments by pharmaceutical and infant formula companies to doctors, sponsorship of meetings and the expectation that bribes are sometimes key to passing exams, professional promotion and everyday life are just some of the challenges facing doctors globally. While all doctors worldwide need to practice with skill and integrity – they also need discernment. The issues of conflict of interest and corruption and their potential impact on a doctor's practice and the availability of healthcare, especially for poor people, may not be sufficiently appreciated. Such terms, together with any bases for response, need clarification.

What is conflict of interest?

NHS England defines conflict of interest¹ as 'A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold.' A Wikipedia definition of direct challenge for doctors² describes 'conflict of interest in healthcare' when the 'primary goal of protecting and increasing the health of patients comes into conflict with any other secondary goal, especially personal gain to healthcare professionals'.

The public and private sectors of the medical-industrial complex have a range of conflicts of interest which may impact in several ways. Some companies provide or pay for high quality continuing medical education (CME); this is especially appreciated when national governments fail to provide adequate training. A 2017 systematic review by the Cochrane Collaboration found that research sponsored by the pharmaceutical and medical device industries tends to provide favourable results about the sponsor's product compared with studies supported by other sources of sponsorship.³ It is unknown how widespread the practice is of

failing to publish results of studies which show no benefit of the drug/technology in question. The Physician Payments Sunshine Act of 2010, as part of the Affordable Care Act (USA)⁴ requires that financial relationships of physicians and teaching hospitals with pharmaceutical and medical device industries are reported and made publicly available via the Open Payments Programme website.⁵ In 2017 – this system described 10.7 million payments totalling \$2.8 billion. 64 per cent of US-based physician-editors of highly-cited medical journals received industry-associated payments.⁶ Few other countries have such a culture of openness. The UK does not and recently the Scottish Parliament formally rejected a petition to introduce legislation that could have created a searchable record of all payments to healthcare professionals.⁷ Examples of conflict of interest include:

- (a) Payments or inducements to prescribe certain types of treatment.
- (b) Provision of 'hospitality' by pharmaceutical and other companies and
- (c) Support for CME by pharmaceutical and other companies. All of these may result in greater prescribing of particular treatments, possibly more expensive treatments, with the result that, overall, supplies for government provided healthcare may be reduced.
- (d) Payment for attendance at and travel to professional meetings by pharmaceutical and infant formula companies and those selling equipment.
- (e) Favouritism - giving more time to those who are relatives/friends/members of the same faith group/people of influence in professional or personal life or those who have 'given gifts' to a preferred charity previously.⁸
- (f) Accepting 'gifts' of equipment for improving clinical care in return for ordering specific drugs or equipment.

What is corruption?

Transparency International – an international NGO with wide experience of tracking corruption globally⁹ - defines corruption as ‘the abuse of entrusted power for private gain’ and classifies corruption as ‘*grand*’, ‘*political*’ and ‘*petty*’ depending on the amount of money and the sector where it occurs. **Grand corruption** occurs at a high level of government, enabling leaders to steal funds at the expense of the public good. **Political corruption** occurs when senior officials (including doctors) distort processes and divert resources for their own personal benefit. **Petty corruption** involves everyday abuse of entrusted power by public officials (including doctors) in their interactions with citizens who seek access to basic healthcare services, which are supposed to be provided by government, without charge, in communities, clinics and hospitals.

Many doctors work in environments where *political* corruption and petty corruption are endemic. Individually, doctors may have high standards of integrity, but they struggle when all around them compromise theirs. It is especially hard when, even for doctors, salaries are low and there is a long-established tradition of giving ‘gifts’ when ‘doing business’. Corruption also occurs in environments where poverty is not so prevalent. There are helpful reviews of the nature of corruption and its prevalence worldwide.¹⁰ Notwithstanding the variation in emphases on types of healthcare provided between different faith groups, their contribution to healthcare globally is massive.¹¹ However, all have to face up to the challenges of conflict of interest and corruption in their professional and personal lives. A review of problems faced by the Church¹² and support by faith groups in promoting public integrity¹³ are helpful. There are analyses of corruption in a number of societies, reviewing the vicarious contributions of different faith teachings, attitudes, greed and ‘honour’.¹⁴

Examples of corruption could include:

Grand corruption:

- (a) Senior officials re-arranging allocation of government funds destined for healthcare so that they benefit personally or politically. Indeed, senior officials (including doctors) in Romania have been prosecuted for diverting funds for their own use.¹⁵ As elsewhere, this Corruption resulted in reduced access to and provision of government-provided services and supplies.

Political corruption:

- (a) Demands for bribes by officials in order to obtain permission to set up a new healthcare programme.
- (b) Fraud and embezzlement within healthcare systems, including decisions on which services/drugs to procure so that officials (including doctors) gain financially.
- (c) Senior officials (including doctors) making it clear that

applications to ethics committees can be ‘fast tracked’ on payment of an extra fee to committee members.

Petty corruption:

- (a) Asking nurses to inform patients that a ‘gift for the doctor’ is necessary before the doctor will see them in a ‘free’ government clinic.
- (b) Payment to community leaders who request money/gifts in order to ‘facilitate’ a new community healthcare programme.
- (c) Accepting money from companies which sell supplies or equipment in return for assisting with the award of successful contracts.
- (d) Persuading patients to ‘be seen privately’ or accepting ‘commission’ for referring patients to a private clinic.
- (e) Prescribing treatment (eg. intravenous fluids) for all illnesses and recommending complex investigations in private clinics for simple, treatable conditions.
- (f) Paying bribes to assist in passing professional exams and promotion.
- (g) Paying bribes to officials/powerful people to facilitate visas/work permits.
- (h) Paying bribes to police, customs officials and security guards.
- (i) Paying bribes ‘by proxy’ – asking somebody else to do the bribing on your behalf by paying extra fees to ‘clearing agents’ at customs.

These are just some of the many situations, faced by many doctors worldwide. Those working in poverty-stricken environments face extremely difficult, often agonising, situations daily. The impact of culture on what is perceived as ‘normal accepted practice’ as opposed to ‘corrupt practices’ has received rather little discussion or guidance. However, UK specific examples of conflict of interest and corruption in research have been reported at a 2019 meeting of the Royal College of Physicians, UK.¹⁶

What is the scale?

This is very difficult to assess but the Global Corruption Report of 2006 by Transparency International describes a large series of detailed country case studies of conflict of interest and corruption globally, including Europe.¹⁷ A survey of 17 countries in 2013, showed that over 70 per cent of the public believe that medical and healthcare services are corrupt or extremely corrupt in Serbia; Albania; Tanzania; Bulgaria; Kyrgyzstan; Morocco; Ukraine; Bosnia and Herzegovina; Russia; Egypt; Greece; Lithuania; Mongolia; Kosovo; Malawi; Moldova; Mozambique.¹⁸ Transparency International also reviewed Corruption in the UK, suggesting that Corruption is a greater problem than is currently recognised.¹⁹ Complacency and a lack of knowledge of the nature and extent of corruption in key sectors and institutions were identified as well as

incoherent, uncoordinated and inadequately applied policy responses. Their review outlined particular concerns about corruption in national institutions, highlighting six key themes and making fourteen general recommendations, in addition to sector-specific recommendations and recommendations for future research.

What are the effects of conflict of interest on healthcare?

Inappropriate marketing relations between doctors and pharmaceutical companies may drive prescribing practices such that patients are prevented from receiving the best, evidence-based treatment available. At the lowest level of conflict of interest – doctors may alter their prescribing patterns to be in-line with the interests of those who give them money. At the highest level, doctors may prevent the adoption of policies for best ‘value for money’ in community, clinical and public health services. Disagreements between doctors who ‘will’ and those who ‘will not’ take money for providing healthcare services that should be provided free by government, are likely to damage teamwork and working relationships between colleagues as well as reducing levels of healthcare provision.

What are the effects of corruption on healthcare?

The World Bank ‘considers corruption as a major challenge to its twin goals of ending extreme poverty by 2030 and boosting shared prosperity for the poorest 40 per cent of people in developing countries. In addition, reducing corruption is at the heart of the Sustainable Development Goals and achieving the ambitious targets set for Financing for Development. Corruption has a disproportionate impact on the poor and most vulnerable, increasing costs and reducing access to services, including health, education and justice. Think, for example, of the effect of counterfeit drugs or vaccinations on the health outcomes of children and the life-long impacts that they may have on them. Empirical studies have shown that the poor pay the highest percentage of their income in bribes. For example, in Paraguay, the poor pay 12.6 per cent of their income to bribes while high-income households pay 6.4 per cent. The comparable numbers in Sierra Leone are 13 per cent and 3.8 per cent respectively’.²⁰

David Cameron, Prime Minister of the UK in 2015, described corruption as ‘the cancer at the heart of so many of the problems we face around the world today.... Efforts to address global poverty are too often undermined by corrupt governments preventing people getting the revenues and benefits of growth that are rightfully theirs. The World Economic Forum estimates that corruption adds 10% to business costs globally, while the World Bank believes some \$1trillion is paid in bribes every year. Corruption doesn’t just threaten our prosperity; it also undermines our security...World leaders simply cannot dodge this issue any longer’.²¹

Bribery within healthcare services (including those in communities,

clinics and hospitals) is likely to contribute significantly to limited access to healthcare, especially by the poorest and most vulnerable populations who cannot afford to pay bribes. Medical fraud and embezzlement divert essential finances that could be used to support inadequately funded government provided healthcare programmes.

Are there any guidelines for doctors?

The UK Committee on Standards in Public Life, founded in 1995 under the chairmanship of Lord Nolan, has vitally important principles, unknown by many doctors.²² These standards require that ‘holders of public office should exhibit these principles in their own behaviour and should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs. Holders of public office should act solely in terms of the public interest’.

The standards required include:

- (a) **Selflessness** (working solely for the public interest).
- (b) **Integrity** (not gaining financial or other material benefits for themselves, their family or friends).
- (c) **Objectivity** (taking decisions impartially, fairly and on merit using the best evidence and without discrimination and bias).
- (d) **Accountability** (accountable to the public for their decisions and must submit themselves to scrutiny to ensure this).
- (e) **Openness** (taking decisions in an open and transparent manner, not withholding information from the public)
- (f) **Honesty** (being truthful by declaring any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest).
- (g) **Leadership** (actively promoting and robustly supporting the above principles and being willing to challenge poor behaviour wherever it occurs).

The General Medical Council UK Code of Practice for Doctors states that if doctors are faced with a conflict of interest – they should be open about the conflict and declare the interest formally. Further, doctors should not accept inducements, gifts or hospitality which may affect or be seen to affect the way that doctors prescribe. NHS England recognises that fraud and corruption may occur within the UK health service and provides examples and analyses, together with recommendations, in their 2016 Report. NHS England also recognises the importance of managing conflict of interest – providing statutory guidance for Clinical Commissioning Groups in their 2017 report.²³ Indeed, as from 2017, the NHS UK requires Clinical Commissioning Groups (CCGs) to have:

- (a) Registers of interest which are publicly available.
- (b) Records of offers of gifts from suppliers or contractors. Such gifts should always be declined.

- (c) Hospitality (meals and refreshments) under £25 can be accepted and does not need to be declared. Hospitality between £25 and £75 can be accepted but must be declared. If the value of the hospitality is over £75, it must be declared and should be refused unless senior approval is given.
- (d) Offers of business class travel/foreign travel and accommodation, outside employment and shares in health-related companies all need to be declared.

The World Medical Association (WMA) (2009) describes specific guidelines on what is acceptable and what is not in relation to funds for attendance at medical conferences, accepting gifts, funds for research and paid/unpaid affiliations. The WMA goes further in its report of 2015 to describe a 'Moral Duty', referring to the importance of the Declaration of Helsinki in relation to research, with guidance on how research should be regulated, especially if paid for by pharmaceutical companies.²⁴

Despite all these guidelines, an investigation by Channel 4's Dispatches programme (UK TV) found that 59 of 195 Clinical Commissioning Groups in the UK had recorded a breach of the WHO code of practice designed to support breastfeeding.²⁵ *The Telegraph* reported that, in 2016, pharmaceutical companies paid £116.5 million to doctors in consultancy fees, travel, hospitality and other costs. Only a third of doctors receiving such funds declared it.²⁶ Furthermore, an investigation by the *BMJ* in 2018 showed that an important number of Clinical Commissioning Groups failed to declare financial support from the pharmaceutical industry.²⁷

It is not clear how much conflict of interest and corruption is included within the curricula of medical schools. Neither is it clear on how many doctors, at all levels in their careers, are aware of agreed policies and guidelines for recognising and managing these issues or their need to abide by them. There is little information on the rate of reporting of these issues in regular professional appraisals.

Some examples of conflict of interest and corruption experienced by CMF members

The CMF is privileged to have an extensive global network of around 250 members, working in over 50 countries worldwide, who are contactable by email. As part of the preparatory work for this document, CMF members overseas were asked to describe examples of conflict of interest and corruption that they have faced in their professional and personal lives. Their replies resulted in at least 25 case studies of 'real life' situations experienced by Christian doctors working in a range of environments. For obvious reasons – the replies have been anonymised but they provide invaluable descriptions of challenges. **(Appendix 1 is provided separately with Case Studies of Conflict of Interest and Corruption in Healthcare Worldwide)**

What does the Bible say about corruption?

The Bible is rich in its teachings, providing standards for public life and service and personal behaviours. Some verses focus on the *unjust social and cultural systems* which foster and sustain a *culture of corruption* in which many poor people live, often desperate for access to healthcare. Other verses focus on *personal behaviour, integrity* and *consistency*. One without the others is insufficient. Doctors need to be consistent in their personal and professional lives. There are key Bible verses on:

- (a) Working for justice – (Isaiah 10:1-3) '*Woe to those who make unjust laws, to those who issue oppressive decrees to deprive the poor of their rights.*'
- (b) Not accepting bribes – (Deuteronomy 10:17) '*For the Lord your God... shows no partiality and accepts no bribes.*'
- (c) Making wise decisions – (2 Chronicles 19:7) '*Judge carefully for with the Lord there is no injustice or partiality or bribery.*'
- (d) Awareness of the damage that bribery causes to individuals – (Ecclesiastes 7:7) '*Extortion turns a wise man into a fool, and a bribe corrupts the heart.*' Doctors need to be discerning, wise and impartial. Bribery damages individuals. – (Exodus 23:8) '*Do not accept a bribe, for a bribe blinds those who see and twists the words of the righteous.*'
- (e) Aware that good leadership by doctors is vital? (Exodus 18:21) '*Select capable men from all the people – men who fear God, trustworthy men who hate dishonest gain and appoint them as officials.*' *Integrity in medicine means intact, functional or healthy.* So, having 'moral integrity' implies a consistent link between internal convictions, intentions and external actions. Conversely, when doctors act against these moral principles, they become damaged internally, morally impaired and weakened. Speaking out, and working with high standards is essential in order to create more *just societies* in which healthcare is given *honourably*. All doctors should work and live in ways that are consistent with God's character.

How can doctors ensure that they do not act corruptly?

Doctors need to be aware of the possible ways that they can behave corruptly in their work. While doctors are increasingly required to record their clinical work and submit it for review by their seniors/mentors, including reporting of issues of probity, doctors may not receive adequate guidance on what 'corrupt practices' are and how to ensure that these are avoided. It is vital that clear policies and procedures are in place for identifying corruption, together with professional, experienced mentoring on how to abide by such policies and procedures. Working towards greater knowledge and 'openness' is key, requiring a rigorous but caring and supportive environment for colleagues as 'potential corrupt practices' are discussed. They need to be aware of the way

that any doctor can 'collude with corruption' in their personal life. This is particularly difficult for doctors working in communities where corruption is endemic – where 'gifts' of money and favours are continually expected, including being asked for bribes by police and other officials. This also requires a rigorous and analytical, but highly supportive, review of the nature of corruption in individual situations. In some situations, the issues and appropriate responses are obvious but for many doctors facing daily requests for 'special payments' in their professional and personal lives – it is not always easy to know what to do. There is a vital need for more careful, supportive reflection on what 'is permissible' and what is 'not permissible'.

How can doctors respond to conflicts of interest?

While doctors are trained to work in clinical or public health posts, their training is mostly technical, often providing little guidance on how to negotiate the complexities of real-life situations where different options are often available. There are suggestions for change in healthcare systems to reduce conflict and confusion²⁸ This is a particular challenge when resources are limited, either for their own professional training and development or healthcare for patients. While many professions use 'risk analysis' to identify pitfalls of accepting support or inducements to work in a certain way – this may not be adequately practised in medicine. There are evidently many opportunities for improvement in recognition of conflict of interest and its management. Greater awareness of the benefits of 'risk management' in all areas of payment and support is likely to be helpful. While risks and pitfalls may be greater among doctors working in resource-poor settings, there is clearly a need to consider 'risk' in any culture and environment. Decision-making by professional groups is a challenge. The *BMJ*²⁹ and the Royal College of Paediatrics and Child Health (UK)³⁰ have both recently decided not to take money from the infant formula industry for advertising and support of conferences respectively. *Managing conflicts of interest in the NHS: Q&A for medical staff*³¹ gives useful advice. It is published by NHS England, primarily for CCGs, but it is a useful advisory for any doctor. The document advises on Conflicts of Interest as they may arise in doing private practice (even in 'own time'), receiving sponsorship for organising conferences or financial support for attending them, receiving money for research from companies and being a shareholder in or an adviser to a medical products company. There is also useful advice on *Fostering professionalism and integrity in research*, produced by the Erasmus University, Rotterdam and widely used in training of PhD students and other researchers.³²

Protection of whistle-blowers

Speaking out about an issue of 'malpractice' – whether clinically, legally, morally or ethically – can be highly risky, professionally, financially and personally. The *BMJ* (2019) reports that 'Pledges to

protect whistle-blowers are repeatedly broken'.³³ The authors of a *BMJ* (1997) paper describing the scale of violation of the WHO code on marketing of infant formula in four countries³⁴ were described as 'zealots and not to be trusted' and the study design was immediately condemned by the International Association of Infant Food Manufacturers as 'biased in design and execution'.³⁵ Protective mechanisms for those who report malpractice in relation to corruption or conflict of Interest appear inadequate in many environments.³⁶ Unsurprisingly, there are very few accounts of how 'whistle-blowers' have highlighted particular malpractices, how these have been tackled and whether the 'whistle-blower' has been able to continue, undamaged, in their own professional career.

Behaving honourably

The combination of societal poverty, the strain to support one's family adequately, social and fiscal inequity, commercial pressures, powerlessness and greed are key underlying factors which create a 'climate of injustice'. It is difficult for doctors in better-off societies to understand the pressures which colleagues in poor communities are under. But, however poor or affected by injustice, all doctors have to make decisions in their professional and personal lives. The rule of law, professional codes of practice, status, culture and Scripture may all drive conscience and behaviour. However, it is not always easy to know what to do in specific situations. It is suggested that biblical principles, which strongly underpin the Nolan Principles in the UK, are adhered to by all doctors. In particular, it is suggested that small groups of doctors could find it valuable to meet up to identify issues of conflict of interest and corruption that they face on a daily basis in their own environment and discuss. It is likely that confidentiality, respect, support and prayer are vital as such groups discuss their challenges and responses, seeking to work with integrity in a professional and supportive way.

Appendix 1 – provided separately – includes 25 case studies of 'real-life' situations that have been experienced by CMF members. These might be useful as discussion starters such as 'What should I do when I am faced with such a situation?' when groups of doctors meet to discuss how to behave honourably in difficult situations.

Conclusion

Tackling injustice and behaving honourably are required behaviours for all doctors, worldwide, whether serving in communities, clinics or hospitals, and in whatever environment, however difficult. The difficulties in knowing how to respond when faced with issues of 'conflict of interest' and 'corruption' are considerable and appear to be inadequately recognised by doctors. It can be difficult to discern the right 'course of action'. It is hoped that the principles outlined in this document, including those from

Scripture as well as from professional bodies and good practice guidelines will be helpful to groups of doctors as they discuss the ‘real-life’ challenges they face. It is suggested that using these guidelines, together with appreciating, praying for and supporting colleagues, as they seek to work honourably in a range of environments, is essential for improving healthcare worldwide.

Acknowledgements

This review has been assembled by a working group of the Global Committee of the CMF (Martin Allaby, Ibrat Djabbarov, Jonathan Fisher, Steve Fouch, Fi McLachlan, Huw Morgan, Andrew Tomkins, Marius Ungureanu, Catriona Waitt and John Wyatt). They have been assisted by a large number of individuals and organisations, including Transparency International, for which the working group is extremely grateful. The views expressed in this document do not necessarily represent the views of CMF or the authors’ employing organisations.

References

1. Managing Conflict of Interest in the NHS - Guidance for Staff and Organisations. *NHS England*. 7 February 2017. [bit.ly/2z1znhc](https://www.nhs.uk/2017/02/07/managing-conflict-of-interest-in-the-nhs/)
2. Conflict of Interest in the healthcare industry. *Wikipedia*. [bit.ly/2NqB5H7](https://en.wikipedia.org/wiki/Conflict_of_interest_in_the_healthcare_industry)
3. Lundh A, Lexcin J, Mintzes B, Schroll JB, Bero L. Industry sponsorship and research outcome. *Cochrane Database Syst Rev* February 2017. [bit.ly/2L6Hwvm](https://doi.org/10.1002/14692702.cd011329)
4. Physician Payments Sunshine Act (USA). *Wikipedia* 2010. [bit.ly/2PcgUOD](https://en.wikipedia.org/wiki/Physician_Payments_Sunshine_Act)
5. Open Payments Program website (USA). [openpaymentsdata.cms.gov](https://www.cms.gov/medicare/physician-and-clinician-remuneration/2013openpayments)
6. Wong VSS, Avalos L N, Callaham M L. Industry payments to physician journal editors. *PLoS One* 7 February 2019. [bit.ly/2ZuH9DZ](https://doi.org/10.1371/journal.pone.0199922)
7. Ross JS. Scotland rejects ‘sunshine’ legislation. *BMJ* 2019;364:11379. [bit.ly/2Pr110y](https://doi.org/10.1136/bmj.n11379)
8. Ozieranski P, Rickard E, Mulinari S. Exposing drug industry funding of UK patient organisations. *BMJ* 2019; 365:11806. [bit.ly/2ZnzbsB](https://doi.org/10.1136/bmj.n11806)
9. Transparency International. [transparency.org](https://www.transparency.org/).
10. Measuring Corruption. *Transparency International*. [bit.ly/2MwOoVR](https://www.transparency.org/en/measuring-corruption)
11. Tomkins A, Duff J, Fitzgibbon A, Karam A, Mills EJ, Munnings K et al. Controversies in faith and health care. *The Lancet* 2015; 386(10005):1776-85. [bit.ly/2ZkoBqF](https://doi.org/10.1016/S0140-6736(15)00000-0)
12. Allaby M. *Inequality, Corruption and the Church: Challenges & Opportunities in the Global Church*. Oxford:Regnum Books International 2013
13. Faith and Public Integrity Network. fpinetwork.wordpress.com
14. Schaeffer F, Mangalwadi V. *Corruption vs True Spirituality*. Minneapolis: MacLaurin Institute. 1998
15. Ungureanu M, George A, Voinea S. Patients are denied care because of corruption in Romania. *The Lancet* 2017; 390 (10108):2121-2214. [bit.ly/2zmeSAL](https://doi.org/10.1016/S0140-6736(17)32214-1)
16. Wilmshurst P. *Research Misconduct*. Presentation at Royal College of Physicians UK Meeting, Manchester 25-26 April 2019. [youtu.be/FAr9XD5xnBs](https://www.youtube.com/watch?v=FAr9XD5xnBs)
17. Global Corruption Report 2006:Corruption and Health. *Transparency International*, 2007. [bit.ly/2ZIZzmu](https://www.transparency.org/pdfs/gcr2006/gcr2006.pdf)
18. Global Corruption Barometer 2017. *Transparency International* 2018. [bit.ly/2BJaDBF](https://www.transparency.org/en/global-corruption-barometer-2017)
19. Corruption in the UK: overview and policy recommendations 2012. *Transparency International* 2007. [bit.ly/2L5PR2i](https://www.transparency.org/pdfs/corruption-in-the-uk/corruption-in-the-uk.pdf)
20. Combatting Corruption. *The World Bank*. 2018. [bit.ly/30uoeXb](https://www.worldbank.org/en/topic/anti-corruption)
21. Cameron D. Corruption: More than a cancer. (Speech) 13 December 2017 *Transparency International*. 2017. [bit.ly/2NsH2Cu](https://www.transparency.org/en/speeches/cameron-david)
22. The 7 Principles for Public Life (The Nolan Principles). *Gov UK*. [bit.ly/2rmNcFu](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281122/nolan-principles.pdf)
23. Managing Conflicts of Interest: Revised Statutory Guidance for Clinical Commissioning Groups. *NHS England* 2017. [bit.ly/2Zx4qFD](https://www.nhs.uk/2017/02/22/managing-conflicts-of-interest-revised-statutory-guidance-for-clinical-commissioning-groups/)
24. WMA Statement on Conflict of Interest. *World Medical Association*. October 2015. [bit.ly/2ZlaxBG](https://www.wma.net/doc/default-source/ethics/20151021-statement-on-conflict-of-interest.pdf)
25. Channel 4. Breastfeeding uncovered. *Dispatches* 18 March 2019. [bit.ly/2PrmwEO](https://www.channel4.com/programmes/dispatches)
26. Bodkin H. Big pharma cash and hospitality to doctors rises as one in three refuses to reveal earnings. *The Telegraph* 30 June 2017. [bit.ly/30sfJMt](https://www.telegraph.co.uk/health/2017/06/30/big-pharma-cash-and-hospitality-to-doctors-rises-as-one-in-three-refuses-to-reveal-earnings/)
27. Moberly T. CCGs fail to declare pharma funding. *BMJ* 16 January 2018 [bit.ly/2NBnLyl](https://doi.org/10.1136/bmj.n1136)
28. McCartney M, Heneghan C, Finnikin S. Healthcare: Conflicted, Confused and in Need of Change. *The Lancet* 2019;393:10188:2281-2283. [bit.ly/2Hmx5mm](https://doi.org/10.1016/S0140-6736(19)31018-8)
29. Godlee F, Cook S, Coombes R, El-Omar E, Brown N. Calling time on formula milk adverts. *BMJ* 2019;364:11200. [bit.ly/346Z7My](https://doi.org/10.1136/bmj.n1200)
30. RCPCH Statement on Relationship with Infant Formula Companies. *RCPCH* 13 February 2019. [bit.ly/2zfwmyQ](https://www.rcpch.co.uk/2019/02/13/rcpch-statement-on-relationship-with-infant-formula-companies/)
31. Managing conflicts of interest in the NHS: Q&A for medical staff. What does this mean for me? A guide for medical staff across the health system. *NHS England*. 2017. [bit.ly/2zoBy3x](https://www.nhs.uk/2017/02/22/managing-conflicts-of-interest-in-the-nhs-q-a-for-medical-staff-what-does-this-mean-for-me-a-guide-for-medical-staff-across-the-health-system/)
32. van Donzel M, Dijkstra D, Wynstra F. *Fostering professionalism and integrity in research*. Final report of the Taskforce Scientific Integrity Erasmus University Rotterdam. October 2013 [bit.ly/2Zks2Om](https://www.erasmus.nl/2013/10/22/taskforce-scientific-integrity-erasmus-university-rotterdam/)
33. Dyer C. Whistleblowers ‘Promises of Protection are repeatedly broken. *BMJ* 2019;364:11482. [bit.ly/322j0m3](https://doi.org/10.1136/bmj.n11482)
34. Taylor A. Violations of the International Code of Marketing of Breast Milk Substitutes: Prevalence in 4 countries. *BMJ* 1998;316:1117. [bit.ly/2Pafm7O](https://doi.org/10.1136/bmj.316.7147.1117)
35. Wise J. Baby Milk Companies accused of Breaching Marketing Code. *BMJ* 1997;314:165 [bit.ly/2MxCmvF](https://doi.org/10.1136/bmj.314.7083.165)
36. Deborah Cohen D, Mulinari S, Ozieranski P. The Whistleblowing drama behind Astella’s suspension from pharma’s trade body. *BMJ* 2019;366:14353. [bit.ly/2znGcPf](https://doi.org/10.1136/bmj.n14353)

