EDITORSIAL

Doctor, Do You Have A Minute?
The Dilemma Posed by Physician Interaction with the Pharmaceutical Industry

Stuart F. Quan, M.D.

Sleep Disorders Center, University of Arizona College of Medicine, Tucson, AZ
Editor, Journal of Clinical Sleep Medicine

Several weeks ago, I awoke to a headline in my hometown newspaper announcing “UMC to loosen drug reps’ grip.” Apparenty, someone had leaked (Washington politicos are not the only leak aficionados!) to our local medical reporter a draft policy that would severely limit the interaction between sales representatives of pharmaceutical and device manufacturers, and medical school faculty, house officers and medical students. This was the first information that any of us on the faculty had of such a policy being considered. The principal reason given for development of a policy was that these interactions created an unacceptable conflict of interest between our fiduciary responsibility to the patient versus an “obligation” to the pharmaceutical and device manufacturers. Issues related to this conflict of interest have been discussed in a number of various publications and venues, and include conscious and unconscious bias in prescribing habits, perception by patients and the public that physicians were not considering the best interests of their patients when making prescribing decisions, appropriate role modeling for trainees and the cost impact of physician marketing on the price of pharmaceuticals. Although there still has not been a general distribution of the proposal to the faculty, various discussions with those responsible for drafting the policy indicate the following would be banned: unscheduled interactions between sales representatives and faculty (appointments would be required), all “gifts” (including pens, notepads, etc), unrestricted “sampling”, meals at conferences and no direct sponsorship of “speakers”. However, the current discussion at my institution is only example of similar such debates that will occur at academic medical centers throughout the country. The most important questions that need to be addressed in these discussions are whether the rationale proposed for these restrictions are sufficiently compelling to justify elimination of the benefit of these interactions and limitation of individual freedom and choice. Several universities have decided that they are, and have adopted various policies concerning these relationships which are generally more restrictive than the guidelines adopted by the American Medical Association and voluntary guidelines by the pharmaceutical companies themselves.

Unquestionably, recent years have seen increasing governmental and public scrutiny of the marketing practices of pharmaceutical and medical device manufacturers. One cannot condone intentional dissemination of erroneous and/or misleading information, or deliberate withholding of relevant information obtained in clinical trials. However, there are favorable benefits associated with relationships between pharmaceutical and device manufacturers and medical school faculty. In some training programs, commercial sponsorship is the only viable mechanism to send trainees to conferences, or to purchase books and journals. In addition, it may be the most cost-effective vehicle to bring guest faculty to an institution. Although one may argue that these are institutional responsibilities, as a training program director, I can attest that there is little interest in providing such support from medical school or hospital administrators. In addition, on a larger scale, commercial sponsorships and advertisements support the annual meeting and official journals of many medical societies including the annual meeting of the Associated Professional Sleep Societies, Sleep, and the Journal. For our members, if these latter activities were eliminated, the cost of the annual meeting and the Journal would rise substantially. This would reduce attendance and readership, thus impairing dissemination of scientific information. Similarly, there is another side of the issue regarding sampling. No doubt that use of sampling promotes use of a product. However, in a number of institutions, samples are used for indigent patients. Obviously, all of these activities need to be monitored to avoid dissemination of biased information and creation of unwritten obligations. Nevertheless, one needs to be careful that by promulgating regulations, we don’t “throw out the baby with the bath water”.

The cost of physician marketing has been cited as having a significant detrimental impact on health care costs with expenditures of $8-13,000 per year per physician. There is no doubt that advertising costs are factored into the prices of all pharmaceuticals and devices. However, in this country and worldwide, pharmaceuticals and devices are developed by private companies. In a free market economy, companies must market their products in order to survive. One should not be deluded into believing that elimination of all direct physician marketing would necessarily reduce pharmaceutical advertisement costs. It is possible that direct to consumer advertisement would increase, and even more ingenious ways of connecting with prescribers and patients would surface. One could argue that it is the responsibility of government to disseminate information regarding the relative effectiveness of pharmaceuticals and devices. However, although the National Institutes of Health spends billions of dollars on biomedical research, they do not engage in drug development and only a very small fraction is spent on testing the effectiveness of pharmaceuticals and/or devices. Similarly, the United States Food and Drug Administration provides approvals for safety and effectiveness, but does not generally compare one product versus another.
Appropriate role modeling for trainees is a legitimate concern relating to faculty interactions with pharmaceutical and device representatives. Some would suggest that exclusion of such interactions is the best role model for trainees. On the contrary, I would argue that teaching this behavior as an appropriate method of managing conflict of interest in this area is analogous to ostriches sticking their necks in the sand. After completion of training, interactions with pharmaceutical and device companies will be a fact of life, whether they be having meetings with individual representatives, seeing them at scientific meetings or explaining prescription choices to patients who have viewed direct to consumer advertisement. Moreover, it is not only interactions with pharmaceutical and device manufacturers who present conflicts of interest. Many hospitals employ clinical pharmacists who provide recommendations regarding choices of drugs. When there is a question of utilizing an expensive medication, does their fiduciary interest lie with the hospital or the patient? Thus, it is our obligation as faculty to provide our trainees with the ethical knowledge and experience concerning potential conflicts of interest at all levels and how to manage them appropriately for the benefit of our patients. In some institutions, educational programs have been developed to address these issues (reviewed in 4) and more are probably necessary.

Conflicts of interest are inherent throughout the practice of medicine and our society. For physicians, education, recognition, disclosure and individual responsibility in exercising ones fiduciary and ethical responsibilities to patients are the best mechanism for managing them. Stringent artificial controls that limit individual freedom and choice may have the unintended consequences of hampering the educational process and impairing the care for some patients.

REFERENCES