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Clinical Cases

Drug Company Sponsorship of Clinical Conferences

Two physicians assert that pharmaceutical companies' sponsorship of clinical conferences for residents and physicians represent a conflict of interest.

Commentary by Robert Goodman, MD, and Ashley Wazana, MD

Dr. Mathews is director of the internal medicine residency program at a large teaching hospital. The department chairman asked him to seek sources of funding for the weekly noontime conferences, adding, "With all those drug companies out there wanting time with physicians, you shouldn't have a problem finding someone to buy us a sandwich and chips once a week."

Dr. Mathews asked, "That's okay with you and the department, allowing a drug company to buy lunch once a week?"

"I think so," the chairman said. "Everyone knows by now that each drug rep is going to tout his own wares. It's a wash, in the end. Most 6-year-olds know how to discriminate among fast-food ads on television; I think residents can make sound independent decisions, don't you?"

Dr. Mathews had, in fact, been talking with a rep from Melissima Inc who was trying to push Melissima's ACE inhibitor. If any product message could be neutralized by the sheer number of competing ads, an ACE inhibitor ad would be it. The rep okayed the plan. She would be there at the weekly conferences, but only in case someone had a question, she explained.

Dr. Mathews thought that, with a few words from him to the residents before the Melissima sponsorship kicked off, everything would be okay. After a while, he'd switch companies and let a Melissima competitor buy lunch. Or if it turned out that the Melissima rep was being too chatty, having too much to say to the residents, he'd switch. These things needed to be judged on a case-by-case basis, Mathews thought. All company sponsorship cannot be condemned as bad. By rough calculation, though, Melissima would be spending about $650 to $700 on the food per week. He wasn 't sure that information would pass the "how would it look in the headlines" test.

Commentary 1

by Robert Goodman, MD

There are several reasons why Dr. Matthews and his chairman ought to rethink their decision to allow a pharmaceutical representative to buy lunch for their housestaff once a week.

First, while perhaps it is true that a 6-year-old can distinguish among fast food ads (though I doubt this), there is ample evidence in the medical literature that physicians *are* influenced by promotion and that physicians who practice on the basis of promotion are more likely to prescribe inappropriate or expensive medication [1]. If all ACE inhibitors are the same, than we can hope that the housestaff will prescribe the least expensive and most convenient one, not the one made by the company that provides the best lunch.

A second reason for rejecting the offer is that *someone* is paying for this supposed free lunch, and arguably it is

patients, in the form of higher drug prices. Pharmaceutical companies spend billions of dollars every year in the US on research and development; they also spend billions of dollars each year on promotion. The industry maintains that one reason for the high cost of pharmaceuticals is the high cost of R & D that goes into each product. If this is so, then must not the high cost of promotion also go into each product? It is true that residents work hard and don't make all that much money, and perhaps their hospitals or departments should be buying them lunch; but certainly their patients —many of whom earn far less than they do—should not be buying it for them.

But the third and most important reason why the department should turn down this lunch is that the department is serving as a very bad role model for its residents if it accepts. The doctor-patient relationship is a fiduciary relationship. Fiduciaries, because of their specialized knowledge and the trust that is placed in them by the public (in this case, patients), have an obligation to avoid conflicts of interest. Gifts—whether large or small, educational or not —influence behavior, create relationships, and thus create conflicts of interest. Physicians, like judges, journalists, and basketball referees, must avoid even the appearance of conflict of interest and therefore should accept no gifts from drug companies. Residency programs, as well as faculty entrusted with the training and development of future physicians, must take the lead in role-modeling this behavior for trainees.

Last year, the Accreditation Council for Graduate Education (ACGME), which establishes the standards for the more than 7000 residency programs in the United States, produced a White Paper entitled *Principles to Guide the Relationship between Graduate Medical Education and Industry* [2]. The paper acknowledges the "proven" potential for conflict of interest resulting from pharmaceutical promotion, the "proven" influence on medical decision making, and the well-documented inability of physicians to recognize this influence. While the council found itself unable to follow its own arguments and prohibit interactions between trainees and industry representatives altogether (as it could and should have), it did state that "programs and sponsoring institutions must determine through policy, which contacts, *if any*, between residents and industry representatives may be suitable, and exclude occasions in which involvement by industry representatives or promotion of industry products is inappropriate" (italics added).

Programs must do more than this; to transmit to trainees without interference the core value (and competency) of professionalism, training programs—like individual physicians—must wean themselves entirely of pharmaceutical industry largesse and the conflicts of interest that come with it. Dr. Matthews and his chairman should, therefore, *just say no* to this free lunch

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Commentary 2

by Ashley Wazana, MD

Interactions between physicians and the pharmaceutical industry start as early as medical school, continue well into practice, and take on many forms. Residents meetings with pharmaceutical representatives (PR) occur up to 4 times per month (more in the later years) and more frequently if one also considers briefer contacts. Residents receive more

industry-paid meals and samples than faculty, while faculty receive more honoraria, conference travel, and research funding. Unfortunately, there is little available to guide most residents through many of these interactions, which impact on the behavior and practice of physicians [1].

As Dr. Matthews states in the case discussed above, the pharmaceutical industry sets aside great sums of funding for promotion. In 2000, an estimated $15.7 billion was spent by industry in promotion and marketing, more than the amount they spend on research and development [2]. Of that, $5 billion goes to pharmaceutical representatives (PRs), whose workforce numbers more than 60,000. These numbers amount to 1 PR and at least $100,000 for every 11 practicing physicians in the US. Industry-sponsored events in 2000 numbered 314,000 [2].

Such numbers and scale have a tendency to drown the critical issue of physician conflict of interest. Medicine's relationship with industry is often considered as a free market exchange where physicians interact with pharmaceutical representatives who bear gifts. In this free enterprise light, physicians' relationship with the industry is normal, if not expected, and simply reflects various stakeholders' attempts to capture a greater portion of the market share. Pens, books, educational materials, samples, meals, and conference travel funding become legitimate means to establish confidence and comfort between the promoter and the promotee [3].

This comparison with marketplace interactions is not appropriate, however, because the practitioner of medicine has a very different relationship with his or her patient. Doctors have fiduciary duties to their patients. As caregivers, they make decisions about treatments for their patients, and their relationship with the patient is their primary interest. The one who will be the ultimate recipient of the promoter's influence, in this case, is the patient, not the physician, hence the interaction is not a standard market exchange [4].

The conflict of interest in the industry-physician relationship differs from other forms of ethical dilemmas. The common form of ethical dilemma (eg confidentiality, consent to treatment issues), assumes that 2 or more "competing interests have a presumptive claim to priority, and the problem is in deciding which to choose" [5]. A conflict of interest, however, is "a set of conditions in which professional judgment concerning a primary interest (such as patients' welfare or the validity of research) tends to be unduly influenced by a secondary interest (such as financial gain)" [6]. In the relationship between physicians and the pharmaceutical industry, the physician's responsibility to the patient has priority over his or her responsibility to any industry "partners," so industry influence creates a conflict of interest. A number of other circumstances expose physicians to similar conflicts: research on patients, physician risk sharing in health maintenance organizations and hospitals, and self-referrals.

A conflict of interest, however, is a condition and not necessarily a behavior. One can *be in* conflict of interest and not *act* a way that conflicts with one's primary interest [7]. In the case of industry-physician conflicts, the physician must give priority to patient welfare and care and prevent the secondary interest from influencing that priority.

The outcomes of industry-physician interactions, the secondary interest, have been studied. One study found a positive outcome (improved ability to identify the treatment for complicated illnesses); 21 studies found negative influence associated with the secondary interest [3]. The outcomes of industry–physician interactions include an impact on knowledge (inability to identify wrong claims about medication), attitude (positive attitude toward pharmaceutical representatives; awareness, preference, and rapid prescription of a new drug), and behavior (making formulary requests for medications that rarely held important advantages over existing ones; non-rational prescribing behavior; increasing prescription rate; prescribing fewer generic but more expensive, newer medications at no demonstrated advantage.)

In the case of Dr. Matthews and the noon conferences for residents, there is good evidence to support the belief that drug company sponsorship of continuing medical education (CME) affects presentation content in that the sponsor's drug is preferentially highlighted and changes in prescribing practice have been shown to favor the sponsor's drug [8,9]. Resident exposure to pharmaceutical representative speakers at lunch rounds is likewise associated with dissemination and learning of inaccurate information about the sponsor's and competitor's drug [10].

It is a mistake on Dr. Matthew's part to believe that the sheer number of ads will neutralize the effect of any single ad. The case of ACE inhibitors is a case in point; we now know that, although Beta blockers and a diuretic are first line treatment for hypertension, clinical practice does not reflect that knowledge [11,12,13,14,15]. Exposing oneself to

promotion of a medication from "saturated" markets exposes one to class-specific, not drug-specific marketing techniques. This does not necessarily provide prescribing information or an antidote to marketing influence.

Finally, the "headline test" Dr. Matthew mentions alludes to the American College of Physicians' suggestion that physicians should be guided in making decisions about their activities by whether they would be willing to have their interactions widely known [16]. Of concern, though, is that, according to one study, patients believed gifts to be less appropriate and more influential than did their physicians [17]. Equally relevant is the evidence that physicians are often not aware of how interactions affect them [18]. The guidelines by the AMA have been one such attempt to acknowledge this limitation for all physicians [19].

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