

Doctors and Drug Companies — Scrutinizing Influential Relationships

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On September 6, 2007, Senators Charles Grassley (R-IA), the ranking member of the Committee on Finance, and Herb Kohl (D-WI), chairman of the Special Committee on Aging, introduced the Physician Payments Sunshine Act — so named because it aims to “shine a much needed ray of sunlight on a situation that contributes to the exorbitant cost of health care,” according to cosponsor Senator Charles Schumer (D-NY). The bill would require manufacturers of pharmaceuticals and medical devices with annual revenues of more than \$100 million to disclose the amount of money they give to physicians — whether in the form of a free dinner or vacation or a consulting fee. “This bill is about letting the sun shine in so that the public can know,” says Grassley.

The move was stimulated in part by activity in Minnesota and Vermont, which have made the reporting of such relationships mandatory — Minnesota in 1993 and Vermont in 2003. Three additional states (Maine, West Virginia, and California) and the District of Columbia have now enacted similar disclosure laws, and many other states are considering doing so. Although beliefs vary widely about the overall usefulness of the data collected under state mandates, the movement toward increased transparency is gaining steam.

Indeed, the nature, extent, and consequences of physicians' relationships with industry have become one of the most fiercely debated issues in health care today. At the simplest level, such a relationship exists whenever a physician accepts anything from a company whose products or services are related to the practice of medi-

cine. And such interactions are ubiquitous: according to a recent survey, although the frequency and intensity of the ties vary according to physicians' personal and professional characteristics, virtually all physicians (94%) have some type of relationship with industry.¹ Most commonly, physicians report receiving food and beverages in the workplace (83%) or being given drug samples by a manufacturer's representative (78%). More than one third of physicians (35%) receive reimbursement for costs associated with professional meetings or continuing medical education, and more than one quarter (28%) receive payments for consulting, speaking, or enrolling patients in trials (see graph).¹

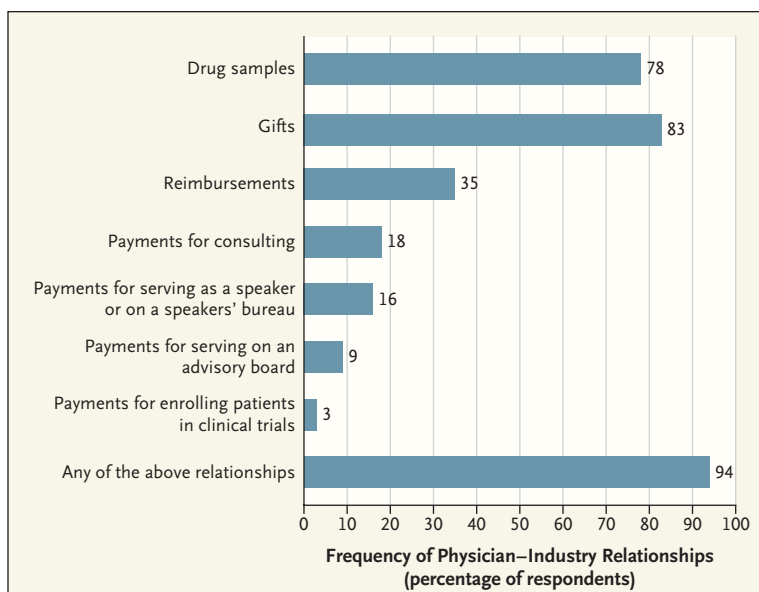
From a policy perspective, the debate centers on the overall effect of these relationships on patient care. Although most physicians deny that receiving free lunches, subsidized trips, or other gifts from pharmaceutical companies has any effect on their practices, research has shown that physician–industry relationships do influence prescribing behavior.² After all, if these relationships didn't affect physician behavior in such a way as to increase sales, companies wouldn't spend \$19 billion each year establishing and maintaining them.

Clearly, relationships between physicians and industry can have some positive effects on patient care. Many, if not all, of the drugs currently on the market simply wouldn't exist if it weren't for relationships whereby physicians enroll patients in manufacturers' clinical trials and provide companies with advice on drug development. And even a relationship in

the form of attendance at an industry-sponsored luncheon or dinner may lead physicians to recommend beneficial drugs that are being underprescribed — though there is no reason why an educational activity needs to be accompanied by an expensive meal or a trip to a tropical resort.

But physician–industry relationships can also have serious negative effects. For example, doctors with ties to industry may be more inclined than their colleagues to prescribe a brand-name drug despite the availability of a cheaper generic version. The provision of free samples may reinforce this behavior and perhaps stimulate off-label use of medications, which can pose risks for some patients. Industry relationships may stimulate the premature adoption of novel treatments, which could lead to serious health problems for patients. Industry inducements may reduce physician adherence to evidence-based practice guidelines in favor of company medications or interventions that are not recommended in independently developed guidelines. Finally, the financial rewards from industry relationships may reinforce a culture of entitlement among physicians, which could limit their ability to honestly acknowledge and manage the potential negative effects of these relationships. In general, physicians vehemently deny that their industry relationships have any of these negative effects — but they are less convinced that the same is true of their physician colleagues.³

Concern about the risks associated with physician–industry relationships has inspired action by policymakers at the federal, state,



Frequency of Various Types of Physician–Industry Relationships.

Percentages were weighted to adjust for the probability of selection within each specialty and for nonresponse. Data are from Campbell et al.¹

and institutional levels. The same day that the new Senate bill was introduced, Boston University School of Medicine and Boston Medical Center announced a new conflict-of-interest policy — prohibiting their clinicians from accepting gifts from manufacturers of pharmaceuticals and medical devices, banishing industry-funded meals from campus, and requiring physicians who serve on the hospital's drug-selection committees to be free of financial ties to companies that stand to gain from committee decisions. Similar policy changes designed to limit physician–industry relationships have been implemented at institutions such as the University of Michigan Health System, the University of Pennsylvania, the Yale University School of Medicine, the Geisinger Health System in Pennsylvania, the Stanford University School of Medicine, Affinity Health System in Wisconsin, Kaiser Permanente, and HealthPartners in Minnesota. Such organizations have taken a variety of steps to banish drug representatives from their hospitals,

reduce the use of drug samples accepted by physicians, eliminate industry-sponsored lunches, punish company representatives who break the rules (by loitering in a hospital, for instance, or giving out food), and educate doctors about pharmaceutical developments through academic physicians rather than industry representatives.

With other institutions now following suit, it seems likely that more stringent disclosure requirements and restrictions on industry relationships may soon become widespread — especially among physicians working in medical schools, teaching hospitals, and large health systems. Industry marketing practices such as sponsoring lunches at hospitals, offering free “educational” dinners at expensive restaurants, giving away trinkets such as coffee mugs and pens, and paying for questionable consultancy positions may well become much less common in the future.

Even as institutions and states exert increasing control over these

relationships, such change has seemed unlikely to be implemented at the federal level, given the strength of the pharmaceutical-industry lobby in Washington. But in light of the Sunshine Act, federal regulation is clearly not impossible. The profession of medicine may view this legislation as a further stimulus to police itself more vigilantly, to work through its professional and specialty organizations to facilitate and monitor physician adherence to current policies regarding relationships with industry and, where necessary, to develop new, more stringent policies.

Individual physicians can take some steps to maximize the benefits for patients and minimize the risks associated with their own industry relationships. They can start by recognizing that such relationships are designed to influence prescribing behavior and by carefully considering the potential effects that their own associations may have on their patients. They can familiarize themselves with and adhere to the guidelines established by the institutions in which they practice and the professional associations to which they belong. And they can bear in mind that the costs of industry dinners, trips, and other incentives are passed along to their patients in the form of higher drug prices.

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1. Campbell EG, Gruen RL, Mountford J, Miller LG, Cleary PD, Blumenthal D. A national survey of physician–industry relationships. *N Engl J Med* 2007;356:1742-50.
2. Brennan TA, Rothman DJ, Blank L, et al. Health industry practices that create conflicts of interest: a policy proposal for academic health centers. *JAMA* 2006;295:429-33.
3. Chren MM. Interactions between physicians and drug company representatives. *Am J Med* 1999;107:182-3.

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