Ann Intern Med. 2 2 13 13 - 2. www.annals.org
a h affiia i a d c e add e , ee e d f e .
See related article on pp 403-406.

In 1990, the American College of Physicians published a position statement titled •Physicians and the Pharmaceutical IndustryŽ to address ethical issues in relationships between industry and the medical profession (1). The statement, which was prompted in large part by evidence of the drug industry•s in”uence on physician behavior and concern for professional integrity and patient care, examined potential con”icts of interest in relationships with industry and provided ethical advice in certain areas. Since the statement was originally released, evidence of industry•s in”uence on medical practice, research, and education has continued to emerge, and physician…industry relationships have multiplied. Once again, the American College of Physicians…American Society of Internal Medicine reminds physicians and industry to be vigilant about potential con”icts and ethical problems. The College recognizes that while there are no easy answers to many ethical questions, guidance in certain areas can be useful.

This is part 1 of a 2-part paper on ethics and physician…industry relationships. In part 1, the College offers recommendations to individual physicians, mainly clinicians and clinician-researchers, regarding acceptance of gifts and other “nancial relationships with industry. Part 2 addresses medical education providers and medical professional societies that accept corporate funding for organizational projects or membership events, such as meetings and symposiums (see pp 403-406).

Despite the introduction in the early 1990s of ethical standards for physicians regarding physician…industry relationships, concerns persist and evidence accumulates that commercial rewards can unduly affect clinical

tries (biotechnology, pharmacogenetics, e-commerce), and potential con"icts of interest, whether real or perceived, are pervasive. Physicians meet industry representatives at the of"ce and at professional meetings, collaborate in community-based research, and develop or invest in health-related industries. In all of these spheres, partnered activities often offer important opportunities to advance medical knowledge and patient care, but they also create an opportunity for the introduction of bias.

This paper offers two positions to help guide individual physicians in making ethical decisions about interacting with industry. The positions are based on the profession•s fundamental principles of responsibility, that is, acting in a patient•s best interests (bene"cence), protecting the patient from harm (nonmale"cence), having respect for the patient and fostering informed choice (autonomy), and promoting equity in health care (justice). To uphold these principles, the primary purpose of entering relationships with industry should be the enhancement of patient care and medical knowledge. While the ethics of medicine and the ethics of business sometimes diverge, both are legitimate, and a thoughtful collaboration of physicians and industry can result in the best of patient care.

Position 1. Industry Gifts, Hospitality, Services, and Subsidies

The acceptance of individual gifts, hospitality, trips, and subsidies of all types from industry by an individual physician is strongly discouraged. Physicians should not accept gifts, hospitality, services, and subsidies from industry if acceptance might diminish, or appear to others to diminish, the objectivity of professional judgment. Helpful questions for gauging whether a gift relationship is ethically appropriate include 1) What would my patients think about this arrangement? What would the public think? How would I feel if the relationship was disclosed through the media? 2) What is the purpose of the industry offer? 3) What would my colleagues think about this arrangement? What would I think if my own physician accepted this offer?

Rationale

Physicians understand that to maintain their professional objectivity they must be mindful of potential biases in medical information (7, 11). In fact, the entire infrastructure of science and much of physician education is built on the fundamental notion of eliminating, or at least controlling for, the many and powerful biases inherent in generating and interpreting scienti"c data. Ethically and professionally, the objective evaluation of medical information is critical for deciding on best clinical practices (bene"cence) and avoiding risks to patient safety (nonmale"cence) (12…14). Thus, physicians have an obligation to themselves, their profession, and society to evaluate, correct for, and eliminate potential bias in medical information from all sources.

Recent studies and reports have examined industry in"uence on physician objectivity and behavior (15, 16), particularly prescribing practices, formulary choices, and assessment of medical information (3, 7, 17…25). Physicians frequently do not recognize that their decisions have been affected by commercial gifts and services (26) and in fact deny industry•s in"uence (3, 15, 17…22), even when such enticements as all-expenses-paid trips to luxury resorts are provided (23). Research, however, shows a strong correlation between receiving industry bene"ts and favoring their products (23, 25, 27).

What Would My Patients Think about This Arrangement?

The dictates of professionalism require the physician to decline any industry gift or service that might be perceived to bias their judgment, regardless of whether a bias actually materializes. A perception that a physician is dispensing medical advice on the basis of commercial in"uence is likely to undermine a patient•s trust not only in the physician•s competence but also in the physician•s pledge to put patients• welfare ahead of self-interest. Recent research on patient attitudes shows that patients are more likely than physicians to perceive industry gifts as inappropriate or in"uential on medical practice (19, 28, 29). More particularly, a signi"cant number of patients believe that industry gifts bias their physicians• prescription practices and ultimately drive up medical costs. Patients make a distinction, however, between acceptable and unacceptable gifts. Most think that inexpensive incentives designed for of"ce use (pens, notepads) and patient care (drug samples, medical texts) do not have a negative effect on health care. They are much more likely, however, to disapprove of items for

hospitality (such as a reception or other food and drink) that is connected with a legitimate educational program.

Understandably, even these •generally acceptableŽ examples are subject to interpretation and will frustrate some readers. Together with the fundamental questions listed in Position 1, physicians should use these recommendations as guides in making a good-faith effort to evaluate the potential for in”uence and to determine

cal education and communication company. Such companies, which are largely “nanced through the pharmaceutical industry, are for-pro“t developers and vendors of continuing medical education (47). It is important that physicians retained as lecturers in such settings control the content of the educational modules they deliver rather than allow their presentations to be scripted by the company. Lecturers should screen industry-prepared presentation aids (such as slides and reference materials) to ensure their objectivity and should accept, modify, or refuse them on that basis. Presenters using such materials should disclose their source to audience members.

Paid efforts to in”uence the profession or public opinion about speci“c medical products are particularly suspect. It is unethical, for example, for physicians to

state and federal policies regarding third-party access are not consistent and can, at times, jeopardize the con"dentiality of patient information. Cost savings are certainly encouraged, especially as a matter of justice and equity in health care. However, any agreement to change drugs should be evidence-based, not company-biased. If faced with institutional bias in drug formularies, individual physicians should be prepared to insist on waivers for unlisted drugs when it is in the best interests of their patients.

Electronic Technology

Finally, the development of •e-commerceŽ has led to ethical issues not envisioned in the 1990 position paper. Since that time, the importance of electronic commerce and Internet technology to the practice of medicine has increased dramatically. Health care systems in the 21st century will undoubtedly take advantage of electronic technology to collect and analyze clinical data, support consumer access to health information, and complement the physician•s management of patient care (13).

As valuable as consumer access is, information provided electronically can be biased by its sponsor. To mitigate this potential con"ict, physicians who have a material interest in •e-healthŽ businesses or who interact with Internet hosts to publish their own Web sites have an obligation to control the site•s medical content and regularly maintain it. Such sites should disclose all sources of industry support and clearly distinguish any commercial advertisements or sponsored content from substantive content, both in form and in placement. Physicians with commercially sponsored Web sites also need to alert users if a sponsor plans to conduct any online tracking.

CONCLUSION

The guidelines offered here identify several examples of "nancial and other material relationships between physicians and industry, but the list is not exhaustive. As opportunities for commercial ties continue to grow, physicians should be increasingly wary of threats to their professionalism and independent judgment about patient care. Providers of medical education and professional medical societies face similar problems of potential in"uence. Part 2 of this statement on industry relations will address the ethical risks and responsibilities of professional medical associations and educators.

From the American College of Physicians…American Society of Internal Medicine, Philadelphia, Pennsylvania.

Requests for Single Reprints: Susan L. Coyle, PhD, Center for Ethics and Professionalism, American College of Physician…American Society of Internal Medicine, 190 N. Independence Mall West, Philadelphia, PA 19106-1572.

References

1. Physicians and the pharmaceutical industry. American College of Physicians. Ann Intern Med. 1990;112:624-6. [PMID: 2327679]

2. . Interactions between physicians and the health care technology industry. JAMA. 2000;283:391-3. [PMID: 10647803]

3. . The gift relationship between pharmaceutical companies and physicians: an exploratory survey of physicians. J Clin Pharm Ther. 1997;22:207-15. [PMID: 9447476]

4. . Con"icts of interest, con"icting interests, and interesting con"icts, Part 3. J Clin Ethics. 1996;7:184-6. [PMID: 8889894]

5. C. Physicians and the pharmaceutical industry: an alliance with unhealthy aspects. Perspect Biol Med. 1993;36:376-94. [PMID: 8506123]

6. F. Addressing the pharmaceutical industry•s in"uence on professional behaviour [Editorial]. Can Med Assoc J. 1993;149:403-4. [PMID: 11654073]

7. BC. The accuracy of drug information from pharmaceutical sales representatives. JAMA. 1995;273:1296-8. [PMID: 7715044]

8. DE. The relationship between physicians in training and pharmaceutical companies. A time for guidelines? [Editorial] Arch Intern Med. 1992;152:920-1. [PMID: 1580715]

9. D. Pharmaceutical promotions„a free lunch? N Engl J Med. 1992;327:351-3. [PMID: 1620175]

10. Sales forces, scripts up in 1999. Pharmaceutical Representative. 2000;June:9. Accessed 21 September 2001 at www.quintiles.com/products_and_services/informatics/scott_levin/in_the_news/news/1,2226,231,00.htm.

11. D, B A. Characteristics of materials distributed by drug companies. An evaluation of appropriateness. J Gen Intern Med. 1996;11:575-83. [PMID: 8945688]

12. Ethics manual. Fourth edition. American College of Physicians. Ann Intern Med. 1998;128:576-94. [PMID: 9518406]

13. Crossing the Quality Chasm: A New Health System for the 21st Century. Committee on Quality Health Care in America, Institute of Medicine. Washington, DC: National Academy Pr; 2001.

14. . How many deaths are due to medical errors? [Letter] JAMA. 2000;284:2187-8. [PMID: 11056584]

15. A. Physicians and the pharmaceutical industry: is a gift ever just a gift? JAMA. 2000;283:373-80. [PMID: 10647801]

16. . Interactions between physicians and the pharmaceutical industry: what does the literature say? CMAJ. 1993;149:1401-7. [PMID: 8221424]

17. C EC, . Physicians, pharmaceutical sales representatives, and the cost of prescribing. Arch Fam Med. 1996;5:201-6. [PMID: 8769907]

18. [illegible]. Pharmaceutical representatives and emergency medicine residents: a national survey. Ann Emerg Med. 1993;22:1593-6. [PMID: 8214843]

19. [illegible]. A comparison of physicians• and patients• attitudes toward pharmaceutical industry gifts. J Gen Intern Med. 1998;13:151-4. [PMID: 9541370]

20. [illegible]. Interactions with the pharmaceutical industry: experiences and attitudes of psychiatry residents, interns and clerks. CMAJ. 1995;153:553-9. [PMID: 7641153]

21. [illegible]. Attitudes of medical school faculty toward gifts from the pharmaceutical industry. Acad Med. 1992;67:610-2. [PMID: 1520424]

22. [illegible] EC. Attitudes of internal medicine faculty and residents toward professional interaction with pharmaceutical sales representatives. JAMA. 1990;264:1693-7. [PMID: 2398609]

23. [illegible]. The effects of pharmaceutical "rm enticements on physician prescribing patterns. There•s no such thing as a free lunch. Chest. 1992;102:270-3. [PMID: 1623766]

24. [illegible]. Family physicians and generic drugs: a study of recognition, information sources, prescribing attitudes, and practices. J Fam Pract. 1987;24:612-6. [PMID: 3585265]

25. [illegible]. Physicians• behavior and their interactions with drug companies. A controlled study of physicians who requested additions to a hospital drug formulary. JAMA. 1994;271:684-9. [PMID: 8309031]

26. [illegible]. Scienti"c versus commercial sources of in"uence on the prescribing behavior of physicians. Am J Med. 1982;73:4-8. [PMID: 7091173]

27. [illegible]. Pharmaceutical funding and medical students. JAMA. 1991;265: 659, 662-4. [PMID: 1987423]

28. [illegible] EC. Patient perceptions of physician acceptance of gifts from the pharmaceutical industry. Arch Fam Med. 1995;4: 335-9. [PMID: 7711920]

29. [illegible]. Patients• attitudes about gifts to physicians from pharmaceutical companies. J Am Board Fam Pract. 1995;8:457-64. [PMID: 8585404]

30. [illegible]. The Gift Relationship: From Human Blood to Social Policy. New York: Vintage Books; 1971.

31. [illegible]. Doctors, drug companies, and gifts. JAMA. 1989;262:3448-51. [PMID: 2585690]

32. [illegible]. Con"icts of interests in relationships between physicians and the pharmaceutical industry. In: Spece RG Jr, Shimm DS, Buchanan AE, eds. Con"icts of Interest in Clinical Practice and Research. New York: Oxford Univ Pr; 1996:321-57.

33. [illegible]. A physician survey of the effect of drug sample availability on physicians• behavior. J Gen Intern Med. 2000;15:478-83. [PMID: 10940134]

34. [illegible]. Sample medication dispensing in a residency practice. J Fam Pract. 1992;34:42-8. [PMID: 1728653]

35. [illegible]. Closing the door on sample closets. Minn Med. 2001;84:17-20. [PMID: 11202521]

36. [illegible]. The value of pharmaceutical representative visits and medication samples in community-based family practices. J Fam Pract. 2000;49:811-6. [PMID: 11032205]

37.