# DANCING WITH THE PHARMACEUTICAL INDUSTRY – MEDICAL PRACTICE BETWEEN ETHICS AND BUSINESS

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***Abstract***

*The relation between physicians and the pharmaceutical companies has been increasingly discretted issue over the last several years.*

*Moreover, such relations have been proven to influence the prescribing patterns to stimulate drug supplying within hospitals, to encourage publications and research articles and even to contribute to critical article non-publication.*

*There is a complex relation between physicians, medical organizations and academic departments, on the one hand and industry on the other. Therefore, industry makes its living from the physicians prescriptions and from the devices and services they purchase.*

*Yet physicians, medical organizations, and academic departments commonly receive money and other benefits from the industry.*

*This paper reviews specialist literature and addresses the real dimension of the physician-health related industry worldwide interaction. Unfortunately, Romania has not provided any data yet, because this issue has not been officially analyzed in our country.*

**Key-words:** *health industries, relationship marketing for healthcare organizations*

**JEL Classification:** $I_{11}$, $I_{18}$, $M_{31}$

## Background

A growing body of literature continues to seriously question the correctness of most types of physician–industry relations and to suggest ways to remove them. So for, physicians have continuously and faithfully preserved their partaking of industry generosity because they consider themselves too smart to have their medical decision influenced by industry's marketing strategy (Rutledge P., 2003). This approach has survived although it is not factually supported and is highly arguable. According to an axiom that is hard to grasp when dealing with health related industries all industries have one purpose: to make money (Goldratt E., 2004). No professional ethics can obstruct this aim.

These legends and similar ones persist in spite of an extensive and broadly accepted body of literature that categorically shows that industry–physician

conflict of interest – including industry's expanding role in continuing medical education (Spingarn, Berlin, and Strom 1996) – increases the cost of healthcare to the detriment of the public, the medical profession, and the patients (Wazana, 2000). In order to face and maybe to repel the physician-industry relation concerns, the American Medical Association (AMA), the pharmaceutical industry, and medical organizations have formulated guidelines to deal with such concerns (America, 2004; Popp et al., 2004; Association, 1998). On the other hand, a closer look at these guidelines reveals their bran interpretation possibility. Conflict of interest has always been a part of medicine. With every patient treated, every physician it involved in a conflict of interests (Tonelli, 2007).

Literature provides a lot of information on industry's attempts to maneuver physicians away from their responsibility to serve the best interests of their patients. In the end, it is physicians who, as gatekeepers, control industry's success through the prescriptions they give and the devices they procure. Undoubtly, industry uses large amounts of money to persuade physicians, but by means of a technique that makes physicians consider that they are not being influenced (Chren, 1999). A 2006 report by Steinman and associates deals with the precise issue of Parke-Davis's illegal marketing of its medicine Neurontin for off-label uses (Steinman et al., 2006). More than $40 million were spent on marketing the off-label use of the drug to physicians. This activity was illegal. Prescriptions for off-label use climbed. Much of the marketing campaign involved activities with hidden marketing intention such as funding for speakers bureaus and key opinion leaders. Unexpectedly, the industry – pharmaceutical and device – acts like any other for-profit entity, seeking. The interesting part, though, is the extent in which industry hazes the distinction between marketing and education (Steinman et al., 2006) and lucrative investments the physicians naïvely facilitating the industry efforts.

**The physician perspective**

For physicians industry is a stimulating environment. It is unfair to generalize and say that every physician has the same motivations when dealing with industry, but it is important to evaluate a few persuasive ones, one or more of which may be relevant to a particular individual.

Firstly, the doctors may see themselves as being entitled to whatever industry offers them (Hayashi, 2001). This sense of entitlement could have more reasons. Sometimes, they believed they worked very hard and that those freebies were a proof of the company's appreciation. The gifts continued and increased during residency and practice – lunches brought in by medicine representatives during a seminar about a new treatment, or simply as an opportunity to eat conveniently.

Consistently, industry speakers support the physicians' prescribing behavior by affirming that it is an affront to physicians' intellect even to suggest that their honesty can be bought for a dinner or a pen. If prescribing patterns (Greene, 2007) and, perhaps, personal features are promising to a company, they may be invited to a resort for an "advisors" summit or the like – some way to raise

the ante toward further eliciting our thanks in the form of more prescriptions for the company's products and, maybe, becoming a company presenter to help persuade others to recommend more of these drugs.

A second possible reason for the physician – industry interaction is recognition. Many of them enjoy to be acknowledged as experts, and when industry turns them into experts by choosing one of them on the circuit, his name and sometimes his photo are printed in programme. When he speaks at a meeting, fellow physicians come to hear him. This can be an exciting feeling. Then, they are sometimes tapped as key opinion leader and think that this makes them special, although this acknowledgment makes it obvious that they have been converted into salespeople for industry (Network, 2004).

By responding to the acknowledgment industry arranges for physicians, they are helping industry to cover sophisticated marketing techniques under the appearance of teaching. Some of them may be so good at what industry gets them to do that they are invited to be on a company's scientific advisory board. This recognition makes them believe that they are even more allowed to expenses from industry because, after all, the statement *advice* entails that they are using their knowledge and intelligence to assist the company. Actually, they may think that they are entitled to large payments for being on this advisory board. Although industry does have physicians who provide them with essential guidance regarding drug development and marketing, many industry scientific advisory boards are simply ways to set up appreciation and enhanced allegiance among renowned physicians. Industry's business policy is to convert its "advisors" into salespeople.

The companies the advisory boards of which consist of world-wide members are even more inspired, because they are organize board conferences in remote and interesting places. The international acknowledgment for advisory board members is even puffier. Physicians may believe they are entitled to money and fancy trips, but they are not aware of the fact that by accepting the money and the trappings, they generate conflict, and contribute to expensive drug prescription, to uncertified device purchase, and to non-evidence-based tests ordering. All these increases the patients' expulses and the cost of health. Why would industry spend millions of dollars on such as honoraria, traveling, and on steak dinners for the attendees if industry did not know that such expenditures world lead to more drug prescriptions or to increased device purchase? (C., 2004).

Another reason underlying the physician-industry relation is the sense of belonging that such a relation creates. For the individual practitioner, an invitation to a fine steakhouse for dinner provides the chance to mingle with colleagues whom the company believes are worth inviting. The sense of being special is created by the company. Moreover, he has the chance to mingle with the out-of-town speakers. Physicians who do not care to partake of industry's largesse face a particularly difficult problem because attendance to meetings and interacting with colleagues is part of physicians' professional responsibilities and necessary often simply for them to do their jobs.

A fourth reason for physicians to go into and preserve relation with industry, which is, in fact, the underlying reason is money. Industry pays them for

being speakers, for participating in an advisory board, and for giving advice. Perhaps they believe that the inexorable decrease in reimbursement for our medical services is a good reason to accept some money from the industry to offset what we believe is inequitable loss of practice income. Or, they may believe that what they are doing for industry is a service to medical profession and to the colleagues who come to hear them speak. At any rate, they like money. They even like the indirect benefits that they do not receive as cash: receptions and dinners paid for by the industry, or tax-excerpt courses or courses requiring a reduced registration fee. All these benefits mean money they do not have to spend

**Industry perspective**

Their bottom-line duty is to augment value to their stockholders: to make money (Goldratt E., 2004). If a company sells soap, refrigerators, drugs, or medical devices, the stockholders want to see profit. If a company makes what seems to be an altruistic donation, it is a business-centred act. The gift may do some good in a community or in other ways, but the company's stockholders do not want the company to act like a charity entity and to spend money that has no business purpose. What is, then, industry buying with some of the $57.5 billion it spends annually on marketing to physicians – $ 61,000 per physician – or nearly twice as much as the expenditure for research and development?

Industry buys access, authority, and appreciation. These are knotted. When a company sets up a steakhouse dinner reunion, it needs a lecturer to make the meal simply incidental to a didactic activity and, therefore, tolerable under various physician–industry gifting guidelines.

Companies do much of their marketing to physicians by means of their ever-increasing influence on CME and through payments or gifts to both physician teachers and meeting attendees. In 2006, industry covered the cost of 61% of Continuous Medical Education Courses in US, spending nearly $1.45 billion, or more than three times what it spent in 1998. In the circumstance of advancing its shareholders' joint interests, this activity is simply business motivated.

Industry aims at leaders because of their reputation and the admiration held by their colleagues. In academia, there are verdicts on pharmaceutical formularies and on research projects and policies that industry has an interest in influencing and that academic institutions should have an interest in keeping free from industry's influence (Ehringhaus et al., 2008; Rothman, 2008). In professional organizations, the clinical care guidelines they create are an attractive prey for the industry; having grateful committee members on these guideline panels can yield positive results to industry's products (Steinbrook, 2007).

**Academic perspective**

Academic physicians author many of the articles published in journals and they are involved in research that may be of interest to industry. Thus, academic departments are high importance targets of industry and are lured by the same

stimulus as their faculty and community physicians – entitlement, recognition, belonging, and money – to become comfortable with industry representatives.

It may be a visiting professor agenda that industry is enthusiastic to sponsor. Finally, the department has to fight to meet its financial plan and industry's money is simply money that the department will not have to spend. Maybe the company offers money for the department to test a new device or to join in a clinical trial. These examples are ways in which industry can gain influence with the chair and faculty of the department and with its house staff.

Campbell and associates surveyed department chairs at medical schools and at US's 15 largest teaching hospitals (Campbell et al., 2007). Sixty per cent of chairs had some form of personal relation with the industry such as being a paid consultant or a scientific advisory board member or participating in a speaker's bureau. In addition, some 80% of clinical departments had one or more connections with industry, including funding for food and for CME. Most chairs did not perceive anything wrong with these personal or departmental affairs.

## Conclusions

Even though industry has brought to market many of the products that have helped improving medicine, there is major concern and strong confirmation that industry's successful marketing tactics have entailed an unreasonable increase in the cost of health. Individual physicians have proven to be sitting targets for the pharmaceutical and device industry and it is least likely to change their behavior, unless bold steps are taken in order to support and even to implement such changes.

In the end, it is essential to reiterate that this perspectives does not put an end to the physician-industry relation. On the other hand, we hope that physicians will identify their physician-industry voluntary financial relations for what they are: a conflict of interests over their responsibility to patients and to the public. The difference needs to be made, though, between interactions that have very specific aims, goals that stand to our patients' and public advantage and those that simply increase the cost of care through encouragement of needless drugs and tests or the writing of prescriptions for costly drugs when a less expensive one is just as good.

## REFERENCES


- Pharmaceutical Research and Manufacturers of America, *PhRMA code on interactions with healthcare professionals,* 2004.
- American Medical Association, *Updated clarification on opinion E-8.061: gifts to physicians from industry*, 1998.
- Elliott C., *Pharma goes to the laundry: public relations and the business of medical education*, Hastings Cent Rep 34:18-23, 2004.
- Campbell, E. G., J. S. Weissman, S. Ehringhaus, S. R. Rao, B. Moy, S. Feibelmann, and S. D. Goold, *Institutional academic industry relationships*, *JAMA* 298 (15):1779-86, 2007.

- Chren, M. M., *Interactions between physicians and drug company representatives*, Am J Med 107 (2):182-3, 1999.
- Ehringhaus, S. H., J. S. Weissman, J. L. Sears, S. D. Goold, S. Feibelmann, and E. G. Campbell, *Responses of medical schools to institutional conflicts of interest*, JAMA 299 (6):665-71, 2008.
- Goldratt E, Cox J., *The goal: a process of ongoing improvement,* Edited by N. R. Press. Great Barrington, Massachusetts, 2004.
- Greene, J. A., *Pharmaceutical marketing research and the prescribing physician,* Ann Intern Med , 146 (10):742-8, 2007.
- Hayashi, J., *Free meals from the pharmaceutical industry*. *JAMA* 285 (2):164-5; author reply 165-6, 2001.
- Network., Pharma Marketing, *Key opinion leader,* 2004.
- Popp, R. J. et al., *ACCF/AHA consensus conference report on professionalism and ethics*, Circulation 110 (16):2506-49, 2004.
- Rothman, D. J., *Academic medical centers and financial conflicts of interest*, JAMA 299 (6):695-7, 2008.
- Rutledge P., Crookes D., McKinstry B., Maxwell SR. *Do doctors rely on pharmaceutical industry funding to attend conferences and do they perceive that this creates a bias in their drug selection?* Results from a questionnaire survey, Pharmacoepidemiol Drug Safety 12:663-667, 2003.
- Spingarn, R. W., J. A. Berlin, and B. L. Strom, *When pharmaceutical manufacturers' employees present grand rounds, what do residents remember?* Acad Med 71 (1):86-8, 1996.
- Steinbrook, R., *Guidance for guidelines*, N Engl J Med 356 (4):331-3, 2007.
- Steinman, M. A., L. A. Bero, M. M. Chren, and C. S. Landefeld, *Narrative review: the promotion of gabapentin: an analysis of internal industry documents*, Ann Intern Med 145 (4):284-93, 2006.
- Tonelli, M. R., *Conflict of interest in clinical practice*, Chest 132 (2):664-70, 2007.
- Wazana, A., *Physicians and the pharmaceutical industry: is a gift ever just a gift?* JAMA 283 (3):373-80, 2000.