

THE RELATIONSHIP BETWEEN PHYSICIANS AND THE
PHARMACEUTICAL INDUSTRY:

ETHICAL PROBLEMS WITH THE EVERY-DAY CONFLICT OF
INTEREST

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Marketing activities by the pharmaceutical industry directed at physicians are estimated in the range of \$13 billion annually. Others have estimated that the costs are approximately \$13000 per physician per year (1). Despite policy recommendations by the Food and Drug Administration, the American College of Physicians-American Society of Internal Medicine, the American Medical Association, and the Royal College of Physicians, these expenditures and the relationships they create seem entrenched (2;3;4;5). Orłowski and Wateska document a three to four fold increase in prescriptions written for products which are aggressively marketed to doctors; they further note that the products are disproportionately prescribed in institutions where physicians receive lavish gifts and entertainment from the industry (6). Dependence on financial support for Continuing Medical Education (CME) and drug samples further encourage these entanglements.

From the industry's viewpoint, the relationship is effective, at least in small studies, which show changes in prescribing behavior and requests for formulary inclusions, despite physicians' claims of ambivalence on the subject (7;8). Goldfinger expresses concern about physicians being manipulated and the expected common courtesy for acceptance of gifts (9). Reeder et al., in a survey of chief residents in emergency medicine programs note that residents believe modest gifts of nominal value are acceptable (10). The acceptable ceiling value of gifts cited by the residents is \$100. Lexchin notes the frequency with which Canadian doctors accept corporate hospitality and "education" but they simultaneously express concern about the scientific rigor and quality of company sponsored research (11). The

absence of hard data about how the promotional money is spent and precisely how much those expenditures alter physician behavior has been cited appropriately as reason for caution in overdrawing conclusions. Recognizing the scarcity of objective data, Wazana has recently documented the extent of interactions of pharmaceutical representatives with medical students, residents, and attending physicians (12). Reviewing methodologically sound articles, she provides data which quantifies the extent of such contacts, and the degree to which they influence prescribing practices, formulary inclusions, and continuing medical education.

Kessler has commented on the contribution to journals of articles from corporately sponsored symposia whose proceedings include claims of superiority for the sponsored product based on unblinded studies and also which include criticism of generic equivalents (13). Relman notes that economic incentives can introduce subtle biases into the conduct, analysis, or reporting of research results that may escape even careful peer review (14).

Parenthetically, physicians have a negative perception of the influence of direct-to-consumer advertising of drugs. They believe that such advertising distorts patients' expectations and perceptions of the motivation of physicians in medication prescription writing, wherein the best or latest product may differ from that which is prescribed. Ironically, these same physicians seem less concerned about any distorted prescribing practices arising from aggressive marketing to physicians. Physicians seem to trust themselves more than their patients to be impervious to marketing (15).

I will argue that this relationship 1) is grounded in self-interest and is thus contrary to the physician's proper suppression of self-interest, a violation of the act of profession, 2) is contrary to the patient's interest, and 3) is destructive of the scholarly and pedagogical obligations of the good physician. I will also examine the counter-arguments employed to justify the relationship and why those justifications fail. Finally, some modest but specific reforms will be suggested. Not to be considered, but worthy of attention are ethical problems pertaining to physician ownership of pharmaceutical stocks and problems in industry-sponsored research, a practice described as lacking oversight and fraught with conflict of interest (16).

Self-interest

Suppression of self-interest is an essential activity for the physician, repeated in historic codes, oaths, and more contemporary writings about a proper ethic of medical practice (17). It is a central element of the act of profession

described by Pellegrino and Thomasma, wherein the physician offers to help the patient, promises to be competent, to act in the patient's interest, to restrain his self-interest, and not to violate the patient's trust (18). Those physicians who conduct their professional lives in a mode of predominant self-interest properly receive society's and the profession's opprobrium.

Jonsen describes a dynamic tension between self-interest and altruism in the moral life of the physician (19). The relationship considered here is one in which this tension dissolves in favor of self-interest. Emoluments which the physician receives solely because he is a physician, apart from any fair fee or compensation to which the physician is entitled, are ethically problematic. By a spectrum of actions, the self-interested physician takes more than his due from the industry, and ultimately from the patient who buys the product. These activities include the widely tolerated "modest" meals, elsewhere described as the "pizza parade", work-related pens, flashlights, pocket references, and note pads. Ostensibly cheap favors are given by friendly representatives, usually with a pitch for the product *du jour*, with a narrative about its superiority and warnings about the drawbacks of competing products, even products of the same drug class. Acceptance of these modest gifts might seem inconsequential; experience suggests otherwise. The energy exhibited when such trinkets are available indicates how valued they are by recipients. How much they really cost is unclear; that they are given at such expense to the pharmaceutical manufacturer suggests that they alter physician behavior.

The appeal to self-interest escalates with invitations to lectures presented at lavish restaurants, often with the often forgettable lecture as mere prelude to the main event, a sporting event or theatrical production to which the physician and family members are invited. Such behavior at the patient's expense and without the patient's consent represents the physician's surrender to self-interest. Another manifestation of self-interest occurs when the physician either submits to a telephone interview or participates in a focus group, for which he receives an envelope with cash or a cash equivalent gift. More than a decade ago, Bricker wrote that "...a physician who is paid for nothing more than sitting through a promotional exercise is behaving unethically"(20). The amount of the gift, seemingly generous for the physician's time, is large enough, typically \$100 to \$250, to entice the doctor but small enough to elude detection by the IRS. In such cases, the physician has become an agent of the industry in bolstering its market share. He *de facto* extracts more from the patient; the price of the drug increases to pay for these blandishments. The physician is complicit in a scheme to develop corporate marketing strategies while simultaneously evading taxation for compensation for that complicity. This is part of a two pronged

strategy by the industry to influence physician-prescribing behavior while simultaneously engaging in direct marketing of prescription drugs to patients in newspapers, magazines, and television. The absence of data on the magnitude and consequences of such activities is acknowledged. The impropriety of these activities is suggested by the lengths to which physicians and the industry go to conceal them. This concealment is manifested by the sponsorship of cash-paid focus groups by corporations whose direct relationship to the pharmaceutical industry is difficult to trace.

The receipt of such emoluments serves only the physician's interest and may be counter to that of the patient, and thus violates the act of profession. Justification for such behavior rests on an unstated, inescapable, but fragile assumption that being a physician confers entitlement. The industry would have no interest in providing such indulgences were not the physician *as physician* able to enhance its profitability by writing prescriptions. This occurs at that time when the patient most trusts the doctor, during the writing of the prescription, an act that promises "Here is how I will help you." If the prescribed product is that which is best for the patient, influences brought to bear have been paid for by the patient who had no knowledge that he or she would subsidize such expenditures. More disturbing, the product marketed by the physician's benefactor may not be that which is best for the patient.

Offering a counterpoint Peppin claims that customers are similarly dependent on right and good actions of automobile repairmen for brake service jobs and subcontractors for potentially dangerous home repairs, both of whom have probably been influenced by suppliers (21;22). While not endorsing such activities Peppin sees no inherent ethical problem in the relationship of doctors and pharmaceutical manufacturers. He outright rejects the idea that these activities are wrong because patients pay, but do not give consent. He maintains the patients need only have enough information to make an informed choice about their continued relations with such doctors. He grounds his arguments in Engelhardt's view of a community of moral strangers lacking a shared common ethic. What is missing from Peppin's argument is any consideration of the concealment of the lucrative aspects of the relationships and whether patients thereby can be truly informed. Also worthy of consideration is that physicians are trained in publicly supported institutions, are permitted to learn by taking care of patients, and publicly promise to live their professional lives in a particular way and thereby hold their skills and knowledge in trust.¹⁷ This trust and public promise defines medicine not as a community of moral strangers but rather as a moral community.

This idea of comparability with other occupations draws an unwarranted comparison. The physician is not a tradesman, broker or general contractor;

he is entrusted with a particular obligation that he has publicly professed to fulfill, to persons with unique vulnerabilities. Apart from that trust, that patient cannot evaluate the motivation for or quality of that act of prescription. Indeed, Peppin draws back from his arguments when trust is endangered. Tradespeople must confront their own ethical issues. Self-interested behavior by non-medical craftsmen and tradespeople is qualitatively different from the ethical consequences of a physician's acting from self-interest. In a free market, tradespeople must live with the consequences of their good or shoddy workmanship. That is not the concern of medicine; indeed, the obverse may apply. Many depend upon the specialized knowledge and skills of those who service computers or do home or automobile repairs. Arguably, more self-effacing professionalism is required on their part, not less on medicine's part. Examples abound wherein physicians prescribe heavily detailed products for entities such as hypertension, acute sinusitis, community-acquired pneumonia, and urinary tract infections when less costly but seldom-detailed agents have proven safety, efficacy and low cost (23;24). When such flawed clinical decisions are driven by self-interest, the practice is not only medically but also ethically indefensible.

The medical and the philosophy literature richly document the transformative nature of the gift relationship. Persons who accept gifts and hospitality and exchange camaraderie are willingly part of an altered and expanding relationship (25). Camenisch notes the obligations that gifts engender and the norms that gifts create (26). Not knowing what is owed, one tends to return more than enough: in the case of the doctor, access for promotions and prescription writing. That doctor who perceives that his receipt of gifts and hospitality conveys no reciprocal obligation relates to the industry and to patients in a stance of unbridled self-interest.

The physician is not the drug manufacturer's "customer" and, therefore, has no entitlement to privileges rooted in the client-provider relationship. The manufacturer's client is the patient who purchases the product and who alone benefits or suffers the consequences. The doctor's obligation is to prescribe the safest, most efficacious, least expensive drug, based on scientifically sound, unbiased clinical judgment. Any motive on the part of the physician other than the patient's good is indefensible and is the ethical descendent of the properly discredited practices of kickbacks and fee splitting for referrals.

Contrary to the Patient's Interest

The physician influenced by favors from the industry undermines patient interest by prescribing more expensive or less efficacious products for the patient's problem. This occurs in a relationship of trust, without the patient's knowledge or consent. Trust is further undermined when the physician is less competent because he has been influenced by clever promotion in the guise of scientific data. Not coincidentally, outspoken advocates for evidence-based medicine have been most vocal in their concerns about the relationship of physicians, especially resident physicians, with the pharmaceutical industry. This is not offered as an *ad hominem* argument; Guyatt notes that the requirement for high quality evidence is inconsistent with data provided with lunches, gifts and advertising materials that intrude on the agenda (27).

Other threats to the patient's interest occur. When residents present cases in noon conferences for which pharmaceutical representatives have provided lunches, the presence of the representative undermines the confidential nature of the doctor-patient relationship. Some intrusion into confidential space is tolerated by society because medicine is trusted not to abuse that special relationship in medical education. The presence of students and allied health professionals is consistent with the obligation to teach one's colleagues and more junior trainees. Pharmaceutical representatives have not been so entrusted and have no claim for intruding into such confidential disclosures. Their mere presence violates the patient's interest and society's trust. The only rationale for their presence is the chance to promote their products at an opportune moment.

Patient confidentiality and privacy are further violated by tutorial bedside clinical rounds for pharmaceutical representatives in teaching hospitals. The stated purpose is to make representatives more knowledgeable about the diseases for which their products are indicated. Physicians, nurses, and other allied health professionals have been entrusted by the public with the privilege of learning from the direct study and supervised care of patients, so that society will have a continuous supply of qualified health personnel. Society has no such covenant to assure a supply of knowledgeable pharmaceutical representatives, trained effectively to market to physicians but at the unacceptable expense of patient privacy and confidentiality.

Undermining the Pedagogical and Scholarly Role

The public should understand that professional fees pay for doctors' overhead including professional dues, subscriptions, and continuing medical

education. They further should know that teaching hospitals incur educational expenses. They probably should know that part of the cost of prescriptions is for marketing. When these educational and marketing costs become so intermingled, the patient has no way of knowing where education ends and marketing begins. He knows his need for a competent physician who discerns the difference between education and marketing. The physician who yields to direct or subtle pressure from advertising, company-sponsored CME, or who follows the practice of previously enticed role model colleagues in prescribing more expensive or less efficacious pharmaceuticals has participated in a perverse form of covert bedside resource allocation. Rather than trusting in the doctor's beneficence, all that protects the patient is *caveat emptor*.

One of the stated benefits of the physician-industry entanglement is support for educational activities. Patient interest is threatened when that which is presented to the physician as objective, scientifically rigorous, unbiased information is commercially slanted to the benefit of a particular manufacturer. The obligation of competence, related to the prudent conduct expected of the physician is endangered by a too-close relationship with the pharmaceutical industry. The physician who is the mere sum of mind-dulling marketing agendas is less than the beneficent and competent agent of the patient's good. All that his patients can anticipate is that he will be an honest broker of the various products about which he has been detailed, a meager model of a physician. When that image of the doctor is further contaminated by simultaneous self-interested solicitation of favors and gifts from the industry, the obligation to the patient further suffers.

The pedagogical and mentoring role of physicians is integrally enmeshed in the duty to the patient. The effect of demonstrated behavior on impressionable trainees is enormous. Wright et al. document that residents are influenced by role model attending physicians, including those who stress the importance of physician-patient relations (28). Residents who observe a proper distancing of teachers from the pharmaceutical industry learn something different from those who observe respected role models soliciting favors, invitations, and honoraria. The physician educator who by word or example demonstrates such behavior to his trainees has betrayed his trust to his patients, his students, and to the patients of those he is teaching. He has given a benediction of legitimacy to a practice worthy of condemnation. No amount of savvy with clinical diagnosis, technical procedural skill or biomedical knowledge can undo the harm done in undermining the patterning of that which is involved in being a physician.

Support for Continuing Medical Education

Industry support for hospital based Continuing Medical Education seems morally praiseworthy. The industry has ample resources, hospitals and academic departments are financially threatened, and hospitals need CME programs, particularly hospitals with a strong teaching mission. What institutions need and what they get may be very different. Physicians need exposure to the full range of pathology, pathophysiology, diagnosis, and management, only a part of which is pharmacotherapy, possibly slanted to the sponsoring company's products. Where biased information is presented, the hospital's educational mission is distorted. Patient management strategies involving other than the sponsoring company's product are not stressed. The good of the patient is ill served by educating trusted professionals in other than an evidence-based manner. The costs, while subsidized by the industry, are passed on to the patient in prescription costs. A hired speaker willing to promote a product for a stipend has benefited at the patient's expense. This is not to condemn all speakers who go on the lecture circuit and who receive honoraria for their efforts. The intent is to demonstrate how such activities might endanger the pedagogical duty of physician educators, particularly where educational duty clashes with obligations to the firm which has paid for the presentation of the sponsoring company. More data are needed about the degree to which hired speakers feel compelled to endorse and promote the products to speak the company line. The fact of such coercion is documented (29). Bickell describes her experience, corroborated by others, as a speaker who was admonished by company representatives not to say anything unflattering about the sponsor's product (30).

By ceding the financing of continuing medical education to the drug industry, the profession and hospitals endorse a view that education is no longer their own responsibility, but is instead the responsibility of business. That industry, even an "ethical drug house", like all businesses, has ethical obligations markedly different from medicine. Converting medical education into a hybrid educational and promotional activity is inconsistent with a proper ethic of medicine and the duty of competence. Departments are absolved of their didactic responsibilities and then transfer that responsibility to those whose intent is something additional to dissemination of scientifically rigorous information. Departments unwilling to provide for educational needs at some collective sacrifice should examine the validity of their educational mission. Sensitive to this concern, some departments have attempted to find other means to sponsor CME activities in a way, which prevents commercial bias. Guyatt et al. have advocated ending drug lunches, banning representatives from formal residency educational events, and

refusal of funding by any company if the grant is contingent on inclusion of materials specified by the companies (31). They are confident that responsible companies would not want the negative public and professional perception that such withdrawal of educational support would create.

Pharmaceutical Samples

The need for and availability of pharmaceutical samples is cited as a justification for a collaborative relationship with the pharmaceutical industry. Advocacy for sick, needy patients is a proper role for the physician, as is providing some free care. Predictably, physicians are favorably disposed toward those pharmaceutical representatives who liberally furnish samples. Physicians use samples for the medically indigent as starters for patients, and also for themselves, their staffs, and their families. Some representatives are generous in providing samples for indigent patients.

On closer examination, this rationalization cannot carry the weight of their problematic relationship. Samples have costs and when physicians distribute them for personal, family or staff use, those costs are borne by patients who subsequently pay more for the products (32).

Many indigent patients have some degree of coverage for medications through Medicaid. Those most likely to benefit from dispensing of samples are the uninsured working poor, who being uninsured, are denied access to the clinic system. Further, even if for reasons of charity or justice one dispenses samples to such patients, can they afford the monitoring required for many drugs? Since availability of samples is unpredictable, will the patient be switched from one product to another, without the development of a coherent plan of medical management?

Rather than depending on samples, we might accomplish more by advocating for fairness, and by declining gifts and promotions which inflate drug prices and undermine the ethic of medicine. Further, as in the previously cited instances of hypertension and community acquired pneumonia, by prescribing suitable generics and older, safe and efficacious drugs, one can serve the patient's interest in an efficient and effective manner. Finally, that the availability of samples does not exonerate the doctor of concern for an improper relationship with the industry is attested by the concerns of both British and Canadian writers (33;34). Those nations have universal access to health care and prescription drugs. Their professional societies and academic departments nonetheless decry the closeness of doctors and manufacturers.

The episodic availability of samples cannot right a system that denies care to so many. This access is currently undermined by denial of coverage

for entire classes of drugs (statins, proton pump inhibitors, calcium channel blockers, disease modifying agents for rheumatoid arthritis) by less robust insurance plans. Company philanthropy alone cannot excuse societal obstacles to fair access. A medical community that settles for less is ethically impoverished.

Everyone Does It

The relationship of physicians with the pharmaceutical industry is widespread and accepted by many physicians as so commonplace as to be unobjectionable. But as is clear, common practice and social convention do not per se constitute ethical justification. The fact that doctors are enmeshed in a relationship so inimical to the ethics of medicine is worthy of condemnation, not approval because of its ubiquitousness. The claim that the multiplicity of enticements from many manufacturers protects the physician from the influence of any one company is specious. Any benefits flowing from the seller-buyer relationship properly belong to the patient and not to the doctor, whose single-minded concern is the good of the patient. His only relationship with the manufacturer is as prescriber of that which is demonstrated to be best for the patient at the least risk and cost.

In a thoughtful article questioning the premises of critics of the relationships of physicians with pharmaceutical representatives, Peppin has criticized the intemperate language of “bribery”, “shill”, and “corrupting” that makes its way into articles on this subject, including this one (21). He properly states that hospitals market themselves to patients and that hospital residency programs market themselves to applicants. Hospital marketing to patients is an issue that merits consideration. Some residency recruiting is crass and excessive. The intent of that recruiting is arguably patient-centered as a strategy to recruit those who will render the best care. This differs from hospital or pharmaceutical promotions where the intent is merely to build market share. Generous gifts, lavish hospitality, the accumulation of seemingly cheap trinkets, envelopes with one hundred dollar bills, and self serving advertisements in no way assure that the prescribed product is best for this patient. Collectively they assure that even if it is the best, because of the indulgence of the physician’s self-interest, it will cost more. Peppin admits to concerns about undermining trust. When medicine stands accused of acting contrary to the interests of patients by questionable practices of gatekeeping and covert rationing decisions, and “double agency”, i.e., divided loyalty to patients, but also to insurance plans and health care institutions, self-interested grasping for favors from a highly profitable industry further jeopardizes patient trust (36). To ask that if patients and the

public voice no objections, why then should physicians object is irrelevant, given the lengths to which both doctors and the industry go to conceal the unseemly aspects of the relationship, with cash payments for assistance in building market share.

One further anecdotal reason cited as justification is that at a time of shrinking practice revenues, physicians are compelled to get what they can where they can. This includes subsidized travel, entertainment, meals, and cash.

Proposals for Reform

For medicine to protect its proper patient-centered ethic, several suggestions are offered for an ethically defensible relationship between medicine and the pharmaceutical industry. Although both medicine and business are ethical activities, they are not the same ethical activities. Business has multiple obligations to multiple others that are dependent on its ethical conduct: shareholders, employees, customers, suppliers, distributors, and the community in which it operates (37). Irrespective of calls for more nuanced loyalties to patients and divided loyalty, medicine has no such divided loyalty; it is singularly focused on the patient's need; in ethical dilemmas, the patient's need must be the tie breaker.

Physicians should avoid those entanglements which threaten objectivity, even if entered into pursuant of a good end such as an ethical business practice.

They should refrain from those activities which are self serving indulgences offered by a wealthy, powerful industry, whose intent is to find its way into a seller-customer relationship with patients, using the physician as deal broker, and in effect, paying him a commission or finder's fee.

Physicians should be aware of the consequences of receiving gifts and hospitality, however lavish or modest, whose intent is to change physician behavior in a way that first benefits the industry.

Training programs should document how they educate trainees about the ethical consequences of their entanglement with the pharmaceutical industry.

Residents who violate institutional ethical standards should be counseled and if necessary disciplined.

Faculty should disavow and refuse any participation in programs which are purely promotional and must shape their teaching to conform to evidence-based medicine.

Those practices whose purpose is merely to avoid exposure or embarrassment, such as cash payments, pseudo-educational events, and events sponsored by fronts for the industry should be scrupulously avoided.

The American College of Physicians-American Society of Internal Medicine has suggested to its members that they avoid those practices such as compensated travel, “honoraria” for listening to lectures of questionable merit whose purpose is solely to achieve greater market share, expensive gifts and entertainment, and involvement in non-educational or minimally educational events (4). Self-questioning about what would patients think, what would colleagues think, and what is the industry’s intention are important considerations. While laudable questions, a proper ethic is one in which physicians are disposed to avoid improper relationships irrespective of disclosure. Physicians do not avoid sexual encounters with patients because of fear of disclosure; they refuse them because they are wrong. The same applies to improper relationships with the pharmaceutical industry; they should be avoided because they are wrong. ACP-ASIM also recommends that financial relationships with industry be disclosed and not be permitted to compromise objective judgment, including physician participation in corporate-sponsored research. This implies that such arrangements be disclosed to patients who are subjects in such research. ACP-ASIM has recommended similar cautions for health care institutions and CME sponsors who accept corporate support for educational programs.

Residents require exposure to behaviors by faculty that affirm rather than undermine the ethical nature of medicine. Rather than witnessing faculty requesting perks, gifts, and honoraria, residents and students are better served if what they observe is firm but polite declining of such emoluments.

They should learn how critically to receive information and how to obtain unbiased sources of pharmacological data. Use of consensus practice guidelines would seem to be a useful strategy for avoiding conflicts of interest that arise from relationships of doctors and the drug industry. Avoidance of drug manufacturers’ influence is more complicated than would seem at first appearance. Choudry et al. have observed that 87% of guideline authors and panel members have financial linkages to drug companies whose products are included in the guidelines. Once again, physicians, including here guideline authors, perceive themselves more impervious to corporate influence than are their colleagues. Only 7% admitted that these relationships might influence their judgement in writing guidelines, whereas 19% felt that such relationships influence their panel colleagues (14).

Residents and other physicians can be encouraged to buy their own pens and their own lunch.

Norms should be established whereby inappropriate comments to friendly, seemingly flirtatious representatives which could be construed as sexual harassment will not be tolerated, even if the representatives subject to such comments voice no objection.

Departmental educational directors, with the oversight of accrediting bodies, must assure that scientific programs are free from commercial bias.

Programs that fail to meet that standard should be scrutinized by the Accreditation Council of Graduate Medical Education.

Collectively, teaching programs should approach the industry and invite its participation in blended educational trusts over which the department heads shall maintain control of the choice of topics and speakers. This will assure balanced, unbiased information and sever the ties of speakers to the industry while empowering the companies to be philanthropic.

Policy should be developed wherein distribution of drug samples is targeted at those who are most genuinely needy and otherwise without access.

Hospitals and health care institutions, through their institutional ethics committees should make this issue an agenda item; they should provide some oversight and ethical direction about professional and institutional relationships with the pharmaceutical industry. The ethics committee should advocate for avoidance of improper relationships involving physicians, and disclosure of potential conflicts of interest including honoraria, consultants' fees, pharmaceutical and medical device stock ownership, research support, and underwriting of continuing medical education.

In the meantime, the further entanglement with the pharmaceutical industry continues to undermine medicine as a moral activity. The relationship violates patient autonomy inasmuch as it causes therapeutic and economic consequences to the patient without the patient's knowledge or consent. It violates justice-based medical practice to the extent that it unfairly distributes patient goods to physicians in a way other than by commonly agreed upon practices of physician compensation. Most importantly, it violates the beneficence model of medicine by abusing the trust of patients in a self-interested manner. It has brought medicine at least part way down a slippery slope (see table 1).

It nurtures a transactional sort of medicine based on mere prescription writing, to the detriment of William May's transformative model of practice, which should simultaneously provide counseling on such issues of healthy life style as diet, exercise, and stress management (39). A more careful, appropriate relationship with the industry will redirect the focus from mere prescription to the care of the patient (40). Medicine and industry are not adversaries. They have different ethics; therefore, a too-close relationship makes them an incongruous fit with each other. What is needed is a medicine grounded in the universal human need of the sick and the sworn obligation of a particular group of trained professional to help, to be

competent, to serve the patients, to restrain self-interest, and to honor the patient's trust.

Table 1. Physician Relationship with the Pharmaceutical Industry: Slippery Slope

<i>Top (?)</i>	<i>Bottom</i>
1. Physician as beneficent agent of patient	1. Broker of products in proportion to enticements.
2. Restraint of self-interest	2. Pure self-interest.
3. Trust in physician	3. Caveat emptor.
4. Education as scientific exercise in diagnosis, pathology, pathophysiology, and comprehensive management	4. Education as pharmacotherapy and product marketing.
5. Educational programs with corporate financial support	5. Clinical scientists as hucksters for products with company supplied graphics.
6. Modest gifts – pens, lights, notepads.	6. Theatrical and sporting tickets.
7. Modest food and drink	7. Four star meals in lavish settings.
8. Marketing as public activity via journal ads, mass mailings, and detail cards	8. Marketing as surreptitious with envelopes of cash.

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