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Physician–Industry Financial Relationships: An Expert Interview With Allan Coukell, BScPharm

Laurie Barclay, MD

March 27, 2009 — *Editor's note: Physician–industry financial relationships and their effect on medical education were discussed at the American Medical Student Association (AMSA) 59th Annual Convention, held from March 12 to 15, in Arlington, Virginia.*

To learn more about the issues surrounding these relationships, as well as legislation generated to protect against undue influence, Medscape Med Students interviewed presenter Allan Coukell, BScPharm, director of the Pew Prescription Project of The Pew Charitable Trusts. Mr. Coukell has testified before the Senate Special Committee on Aging to promote appropriate prescribing and to address the conflicts of interest in medicine caused by pharmaceutical-industry marketing.

Medscape: Please comment on physician–industry financial relationships, as discussed in your presentation at AMSA.

Mr. Coukell: There has been a great deal of concern — both publicly and within the profession — about the extent of physician–industry financial relationships. Some such relationships are necessary and beneficial, but they nevertheless create conflicts of interest that must be managed. Other financial relationships — such as gifts from the industry to providers — are best avoided. Students can play an important role by working within the profession to encourage appropriate practices and standards. This is an activity long championed by AMSA.

Medscape: What proposed legislation is relevant to physician–industry relationships?

Mr. Coukell: The Physician Payments Sunshine Act (S.301), introduced by Senators Kohl (D-Wisconsin) and Grassley (R-Iowa), would require drug and medical-device companies to make public annual reports of their financial relationships with individual physicians, including a description of the relationship (gifts, meals, consulting payments, research funding, and so on). There have been dozens of legal settlements in recent years and numerous public investigations into the impact of physician–industry financial relationships.

The principal concern is that such relationships create a conflict of interest, in which a physician's primary responsibility — patient care — is influenced by secondary financial relationships. There are also concerns about the cost impact of industry marketing and its potential to drive adoption of technologies that might not be most consistent with the best available evidence.

Several states (Massachusetts, Minnesota, Vermont, West Virginia, and Maine) and the District of Columbia have similar transparency laws on the books — although they vary greatly in how much information becomes public. Last year, a version of the Sunshine Act was endorsed by the American Medical Association, the pharmaceutical and medical-device industry trade associations, and several major companies. We expect to see a House counterpart bill to the Sunshine Act soon, and we believe this legislation has a good chance of passing this session.

Another bill supported last year by AMSA and by the Prescription Project is the Independent Drug Education (IDEA) and Outreach Act. This would establish federal funding for so-called academic-detailing programs, in which well-trained clinicians (often pharmacists or nurses) provide unbiased drug information to physicians in their offices. Programs such as these have been used in academic settings for years and are widespread in other countries and within organizations such as Kaiser Permanente. They take the established industry model — 1-on-1 detailing — but apply it with no incentive to promote any particular product. The goal is improved care, but available evidence suggests that such programs can also produce net cost savings. We expect the IDEA Outreach Act to be re-introduced in the current Congress. Last year's Senate sponsors were Senators Kohl and Durbin (D-Illinois). In the House, Representatives Waxman (D-California) and Pallone (D-New Jersey) sponsored the bill.

Medscape: From the other material presented at the AMSA meeting, what most caught your attention, and why?

Mr. Coukell: I was struck by the sheer size of the meeting (1500-plus registrants) and by the diverse range of issues that AMSA members are engaged in.

Medscape: What do you regard as the greatest challenges facing medical students today?

Mr. Coukell: Most of today's students will practice in our fragmented health system, probably in an environment of increasing resource constraints, and with an ever-increasing level of innovation and new scientific information.

By fragmented, I mean we have multiple payers, spiraling costs, high overheads, a large uninsured population, and an even larger population moving in and out of coverage. The system is regulated and organized at local, state, national, and practice levels, but without a single coordinating authority. A fee-for-service-based system arguably does not create incentives for care coordination or preventive care. Evidence suggests that much care is unnecessary, although, clearly, many patients don't get what they need.

From electronic prescribing to portable electronic health records, the existing infrastructure does not take full advantage of available technologies, meaning that multiple providers in a single community might care for the same patient without knowing what the others are doing. None of this will change overnight, but reforms being

considered in Congress and elsewhere could help move the system toward better coordinated care.

Medscape: How can students become equipped to deal with the fragmented healthcare system?

Mr. Coukell: Students will need to develop systems and habits that let them ensure that their patients get effective, safe, and — all things being equal — cost-effective care. That will mean developing a robust approach to assessing new evidence that will inform when and how to incorporate new technologies into practice.

Medscape: What do you believe should be the future direction of medical education?

Mr. Coukell: Medical education should give students the skills to practice effectively in a data-rich environment — meaning coping with new clinical information, but also learning how to make use of outcomes and quality metrics that previous generations didn't have. As patients become more active participants in medical decision-making and care settings evolve increasingly to incorporate team-based approaches, medical education will have to prepare students for practice in this changing environment.

Finally, medical education should prepare students to work effectively on industry-funded research, but not to be influenced by marketing that isn't consistent with the best analysis of long-term outcomes and comparative-effectiveness data.

Mr. Coukell has disclosed no relevant financial relationships.