

# Medical Schools Put the Kibosh on Pharma Gifts

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SACRAMENTO — Another medical school has joined what could be a growing movement to ban faculty and residents from accepting any gifts whatsoever from drug company representatives.

The University of California, Davis, Health System decided in late November to forbid its medical staff to accept any gifts from drug salesmen, including drug samples, pens, mugs, and meals, however small they might be. Earlier, the school had banned drug company representatives from walking into the clinical areas on a preceptorship.

By taking this action, the school joins a cadre of institutions that includes Yale University, which implemented its policy in 2005, the University of Pennsylvania, which did so in July 2006, and Stanford University, which implemented its policy in October 2006. At UC Davis, the policy goes into effect in July 2007.

The new prohibition “picks off the low-lying fruit” in an attempt by the institution to create a greater distance between its clinical practice and the pharmaceutical industry, said Dr. Timothy E. Albertson, the university system’s executive director of clinical care.

The school has plans to look at the issue of conflict of interest in further detail, particularly in regard to relationships with and practices of other vendors, he said.

“We’re certainly not trying to change capitalism, but we are trying to redefine the ethics of this type of involvement,” he said.

The efforts at UC Davis and the other

academic medical centers were spurred in part by an article in the *Journal of the American Medical Association* (2006; 295:429-33).

The article noted that many authoritative bodies, including the Pharmaceutical Research and Manufacturers of America and government agencies, have made attempts to curtail practices that constitute a conflict of interest for physicians. But the article also said those actions have largely failed to change the current climate. Thus, the 11 authors of the

paper urged academic medical centers to take the lead by, among other things, banning the acceptance of gifts, samples, and payment for time spent at meetings.

Academic medical centers need to adopt such policies because the medical profession looks to them for leadership, and because academic medical centers shape the ethics of the profession, the proposal said.

The article notes that 90% of the marketing dollars spent by the pharmaceutical industry were directed at doctors, despite the increase in money spent on direct-to-consumer marketing in recent years.

According to IMS Health, a pharmaceutical information and consulting company, drug companies spent \$27 billion on product promotion in 2004, of which \$16 billion was for free drug samples and \$7.3 billion, including gifts and meals, went to sales representative contacts.

The pharmaceutical industry, which

adopted strict guidelines on gift giving in 2002, says that limiting the practices and access of their sales representatives will deprive physicians of the best expertise on their medicines.

But gifts, however insignificant, establish an unspoken quid pro quo between physi-

cians and pharmaceutical companies. If gifts did not serve this purpose, companies would not give them, the JAMA authors say. They note that the research bears this out.

According to a 2003 survey of more

than 1,000 third-year medical students, an average third-year student receives one gift or attends one company-sponsored activity a week (*JAMA* 2005;294:1034-42). That is precisely the point of the no-gift policies proposed by the JAMA article, said one of its authors, Dr. Jerome P. Kassirer, former editor-in-chief of the *New England Journal of Medicine*.

“These meals and gifts give residents and trainees the idea that pharmaceutical largesse is all right and the way things work, but it taints the profession,” Dr. Kassirer said in an interview. “They wouldn’t pass out these gifts if it didn’t matter.”

“I think the academic medical centers needed a little nudge,” he added, noting the impact the article appears to be having. “It’s a beginning.”

At the academic medical centers, free meals appear to be the biggest issue impeding acceptance of the policies among staff. The free meals allow physicians to at-

tend midday meetings they otherwise would not have time to attend, and they are a big ticket item.

At the UC Davis Cancer Center alone, it is estimated that companies spend about \$70,000 on free lunches a year. The center will now pick up those costs, and other departments may have to do the same.

At the University of Pennsylvania Health System, the adoption of its policy caused some grumbling at first, along with the loss of some legitimate educational programs that were sponsored. For the most part, however, physicians and other staff members have adjusted, said Dr. Patrick J. Brennan, the chief medical officer of the university health system.

He said there is “much less evidence” of sales representatives around the clinics and school. At one suburban clinic run by the university, sales reps turned in their identification badges in protest; but, he believes, the sales force may have adjusted. He has lately seen an increasing number of medical education programs offered to faculty and staff sponsored by a third party hired by a drug company.

At UC Davis and some of the other institutions, efforts are being made to help patients who previously might have benefited from receiving free drug samples or devices; these items have been very helpful, especially for lower-income patients, Dr. Albertson noted. The university is going to try to purchase some of the equipment that has been donated in the past, such as training inhalers for asthma patients and supplies for those with diabetes. “We’re going to make every effort to buy them” for use by lower-income patients, he added. ■

## Pennsylvania Data Reveal High Cost of Hospital Infections

BY ALICIA AULT  
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Pennsylvania has issued hospital-specific data on infections among 1.6 million patients treated at 168 facilities statewide in 2005. The report, released by the Pennsylvania Health Care Cost Containment Council, marks the first time any state has issued data on individual hospitals, and is expected to establish a baseline for future performance and quality improvement. It also overturns a lot of conventional wisdom about how infections occur.

“It’s a breakdown in processes that creates infections,” said Marc P. Volavka, executive director of the council, in an interview.

The detailed report, available at the council’s Web site ([www.phc4.org](http://www.phc4.org)), shows just how costly infections can be for patients, payers, and hospitals.

Of 1.6 million patients treated at the 168 facilities, 19,154 had a hospital-acquired infection, for a rate of 12 per 1,000 cases. The infections accounted for 394,129 hospital days and \$3.5 billion in charges.

The average length of stay was 20.6 days for those with an infection and 4.5 days for those without. Charges were higher for those with infections than for those without, averaging \$185,260 and \$31,389, respectively. Similarly, mortality was 13% and 2%, respectively.

Most cases were covered by Medicare or Medicaid. Only 276,523 of the patients had commercial insurance; among them, 1,522 acquired an infection in the hospital. Private payers covered only about \$53,000 of an in-

fection-related stay, but the total payout was \$82 million.

Even though all hospitals are reporting, it is likely that the data hugely underestimate what actually occurs, said Mr. Volavka. He noted that the council has not asked hospitals to track infections subsequent to discharge, which may be when most surgical site infections develop.

The data collection began in 2004, when hospitals were required to report on surgical site infections for circulatory, neurologic, and orthopedic procedures; indwelling catheter-associated urinary tract infections; ventilator-associated pneumonia; and central-line-associated bloodstream infections. In the third and fourth quarters of 2005, hospitals had to expand reporting to include all surgical site infections. In the fourth quarter of 2005, pneumonia, bloodstream, and urinary tract infections not related to devices were added.

Urinary tract infections (UTIs) were the most common, affecting 11,265 patients, for an infection rate of 7.2 per 1,000. Those infections were particularly common in heart failure patients, followed by those admitted for other cardiac conditions.

Surgical site infections had the second-highest incidence rate, at 5.2 per 1,000, affecting 1,615 patients. Intestinal surgery accounted for the highest percentage of surgical site infections (9%), closely followed by angioplasty and surgery for osteoarthritis and leg fractures.

These surgical infections accounted for most of the infections in each age group, except for those patients older than 60 years, in whom UTIs were most common.

Aside from UTIs, the number of infections actually declines as patients age, a fact that runs counter to prevail-

ing theories about older patients’ being more vulnerable to infection, Mr. Volavka said. He added that more UTIs occur in the over-60 group because it comprises a preponderance of people who age in state hospitals, where they are catheterized instead of helped to the bathroom.

“It’s not because the patients are by definition more at risk. It’s the behavior of the hospitals that puts them at risk,” he said.

Several recently published studies appear to support Mr. Volavka’s assertions. Researchers at Allegheny General Hospital in Pittsburgh found that severity of illness did not predict central-line bloodstream infections, and that the most common primary diagnoses among those infected—acute myocardial infarction, heart failure, respiratory failure, and deep venous thrombosis—were not usually considered risk factors (*Am. J. Med. Qual.* 2006; 21[suppl]:7S-16S). A group at a clinical research organization had similar findings, concluding that sicker patients were not necessarily at higher risk for infections (*Am. J. Med. Qual.* 2006;21[suppl]:17S-28S). Finally, a third study found that hospital practices—such as method of hair removal, hand-washing, and operating room traffic flow—played an important role in predicting which patients were at risk for surgical site infections (*Am. J. Med. Qual.* 2006;21[suppl]:29S-34S).

The studies “make it clear that it is the process of care, not the underlying clinical condition of the patient, that drives the current epidemic of hospital-acquired infection,” said Dr. David B. Nash, chairman of the department of health policy at Jefferson Medical College in Philadelphia. ■