Policies Regulating the Activities of Pharmaceutical Representatives in Residency Programs

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Background. Residents frequently interact with pharmaceutical representatives during their training. The purpose of this study was to determine the prevalence of policies restricting or regulating the interactions of pharmaceutical representatives with family medicine residents.
Methods. A descriptive, cross-sectional survey was sent to all 386 accredited family practice residency programs. Programs were surveyed for the presence of restrictions or policies regarding the following circumstances and activities through which pharmaceutical representative–resident interactions could occur: (1) contact during working hours, (2) clinic drug samples, (3) personal samples for residents, (4) displays, (5) distribution of literature, (6) gifts and outings, and (7) group presentations.
Results. Overall, residency programs tended to allow most of these activities and had only informal guidelines regarding pharmaceutical representative interaction. Written policies were present in 58% of the programs. Prohibitions of some type were present in 41% of the programs. A higher prevalence of written policies was noted in military programs, larger programs, and programs located in hospitals with only family practice residents.
Conclusions. There are wide variations among family practice residency programs regarding the regulation of pharmaceutical representative–resident interactions. In view of the educational mission of residency training programs and the recent concern over the ethics of the relationship between the medical profession and the pharmaceutical industry, it would be prudent for all residencies to develop written policies addressing the activities of pharmaceutical representatives in training sites.
Key words. Pharmaceutical representatives; ethics, medical; family practice; internship and residency. *J Fam Pract 1992; 34:54-57.*

The influence of pharmaceutical marketing practices on medicine is multifaceted and has become the subject of ongoing controversy, viewed as beneficial by some and detrimental by others.[1–5] Medical professional groups, such as the American Medical Association (AMA), have recently developed guidelines regarding appropriate pharmaceutical industry interactions with the medical community.[6–8] The pharmaceutical industry spends an estimated $5000 to $6000 per physician per year on product promotion, through both print advertising and the extensive use of pharmaceutical representatives.[9–12] Of concern to some is what effect pharmaceutical industry influence has on residency education. Lurie et al[8] showed that interactions between pharmaceutical representatives and residents were frequent, and that these interactions could influence prescribing habits.

Because of the high concentration of faculty and residents at academic training centers, these programs may serve as targets for the pharmaceutical industry.[9] Residents may be ill prepared to deal objectively with the barrage of industry-produced literature, "detailing," and enticements that they will encounter in training.[8,9,13,14] If training programs were to develop clearly delineated policies to regulate interactions between residents and pharmaceutical representatives, the outcome should be sound ethical behavior and an increased ability to objectively evaluate information.

Currently, little is known about regulatory policies in residency training programs. This study was to determine whether formal policies exist in family practice training programs and what aspects of the interactions between residents and pharmaceutical representatives they attempt to control.

Methods

In January 1991, we surveyed directors of all 386 programs listed in the reprint of Accredited Graduate Resi-

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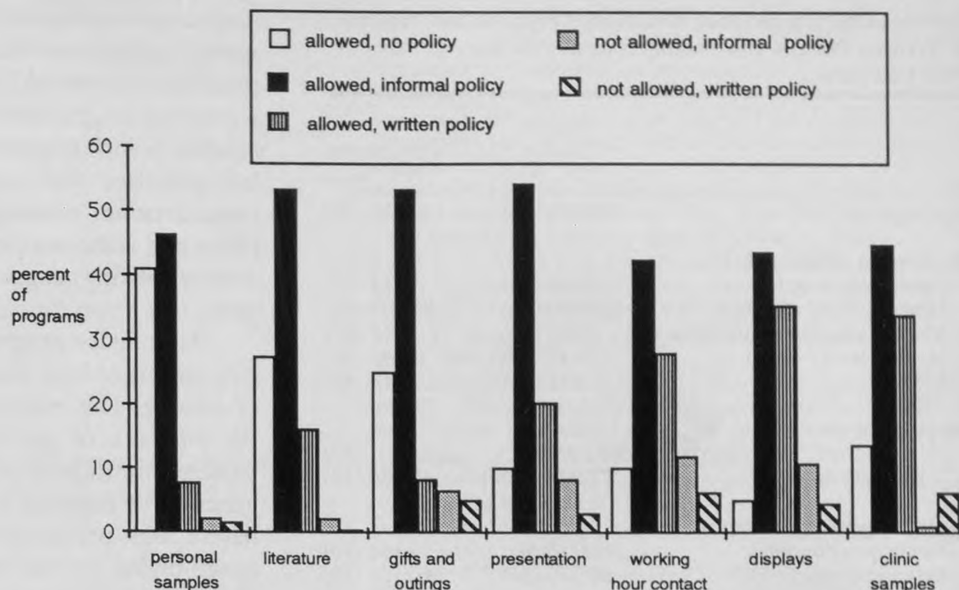

Figure 1. Prevalence and formality of policies of family practice residency programs regulating seven specific activities of pharmaceutical representatives.

dency Programs in Family Practice of the American Academy of Family Physicians (AAFP). We inquired about seven types of common interactions between residents and pharmaceutical representatives: (1) contact during working hours, (2) complimentary clinic drug samples, (3) drug samples for residents' personal use, (4) displays at residency activities or clinic sites, (5) distribution of literature, (6) gifts and social events, and (7) group presentations. The survey asked whether such activities were or were not allowed, and whether the policy was informal (not written down) or formal (written down).

To assess program characteristics that may be associated with the policies, programs were classified by program administration, size, and teaching status, ie, family practice residents only or presence of other residents in the hospital. Program administration was defined by the categories assigned by the AAFP as (1) community-based, no medical school affiliation, (2) community-based, medical school affiliated, (3) community-based, medical school administered, (4) medical school–based, and (5) military. A program size of 18 residents was the cutoff used to classify programs as small or large, with small being ≤18 residents, and large being >18 residents.

Since we surveyed our complete target population, significance testing was not performed. Three hundred thirty-two surveys were returned. Four were excluded because the programs currently had no residents. This resulted in a total of 328 usable surveys for an 86% response rate after two mailings.

Results

Figure 1 shows the overall results for all programs. For all survey categories, the most common practice was to allow an activity with informal guidelines. For personal samples, literature distribution, and gifts and outings, the next most common practice was to allow the activities with no formal or informal policy. For the remainder of the categories, the most common practice was to allow an activity, but with written guidelines. The least reported practice in all categories was to prohibit an activity with either informal or written policies.

For the subsequent analyses, we were interested in whether programs had any kind of written policy or prohibition in place. A program was considered to have a written policy if it reported having at least one written policy either allowing or prohibiting one of the activities. A program was considered to have a prohibition if it had either an informal or written policy forbidding an activity.

Overall, 190 (58%) programs have a written policy, and 133 (41%) have prohibitions. Of the programs with prohibitions, only a small number (6%) prohibited more than two activities. By contrast, written policies tended to be more comprehensive, with 58% covering more than two areas. Table 1 shows the distribution percentages of written policies and prohibitions by types of program administration. All 13 military programs had a written policy, and 11 of the 13 (85%) had prohibitions. There were no striking differences noted with the other program types. Because the military programs were so