In his commentary “The Role of the Pharmaceutical Industry in Medical Education in Psychiatry,” Dr. Lazurus summarizes several documents published by national and government organizations (1) and focuses his discussion on pharmaceutical industry funding of medical education, educational content, and the qualifications and expertise of medical educators, along with potential conflicts of interest. He seems to suggest that the guidelines presented in his commentary may initiate the process of resolving the conflictual relationship between academia and industry. I will expand on Dr. Lazurus’ commentary by 1) examining the underlying conflict between academia and the pharmaceutical industry; 2) reporting on the role of professionalism and other core competencies to address the conflict; 3) elaborating additional concerns about the promotional activities of industry in medical education; and 4) commenting on our social contract as physicians.

Central Conflict

While both the medical profession and the pharmaceutical industry have a goal of improving patient health, there is one major difference: altruism lies at the core of medicine’s professionalism. As partners in a fiduciary relationship, physicians are expected to protect the patients’ best interests. The social contract that medicine holds with society requires doctors to place the patients’ needs first. In contrast, like all corporations, the first obligation of the pharmaceutical industry is to maximize shareholders’ return on investment. Industry can act in a beneficent manner. Their contributions of medications and support during the aftermath of Hurricane Katrina is an example. However, industry’s bottom line remains their bottom line, and industry uses evidence-based promotional activities to improve sales of their products. It is this promotional activity that often conflicts with the best interest of patient care, as it may encourage expensive medications over lower cost alternatives.

While promotional activities should have no place in educational settings, the medical/industrial complex remains intertwined. For example, in academic settings, industry routinely provides meals, funding for retreats, and grants for speakers and clinical drug trials.

Role of Professionalism and Additional Competencies

Believing that their doctors will always act in their best interest, patients continue to place their trust in their doctors. Physicians are accorded status, autonomy, control over knowledge and training, and financial rewards in return for their trusted expertise and dedication. As stated in the Charter on Medical Professionalism (2), “Professionalism is the basis of medicine’s contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity. . . .” The Charter goes on to say, “Essential to this contract is public trust in physicians, which depends on the integrity of individual physicians and the whole profession.”

These tenets are elaborated in the Accreditation Council for Graduate Medical Education (ACGME) Principles to Guide the Relationship Between Graduate Medical Education and Industry (3), which should be on the reading list of every medical educator and resident. The ACGME guide uses general competencies (4) as a framework for addressing our professional relationship with industry.

Using the professionalism competency, the ACGME guide highlights the importance of educating residents on “the inherent conflict of value between industry and the medical profession” and encourages 1) discussion of the various published guidelines on gift-giving to physicians (5); 2) full and appropriate disclosures by faculty and departments of industry sponsorships and financial interests.
including research; and 3) deliberation of institutional policy regarding suitable contacts between residents and industry representatives.

The ACGME guide goes on to discuss the role of other core competencies in this endeavor. The practice-based learning and improvement and medical knowledge competencies outlined in the guide require that residents learn not only objective and evidence-based information, but also the influence of promotional activities on their prescribing practices. They should understand the “purpose, development, and application of drug formulations and clinical guidelines” and issues such as “branding, generic drugs, off-label uses, and use of free samples.”

The systems-based practice competency places responsibility on sponsoring institutions to provide sufficient support to create and maintain more conflict-free educational environments. Additionally, there is a need to increase resident awareness of the costs of prescribing and awareness of the resident’s role in patient advocacy in the realm of pharmaceutical costs. Finally, interpersonal and communication skills competency can be applied to helping residents manage their encounters with industry representatives and deal with patient medication requests, especially following direct-to-consumer advertisements. These competencies apply not only to residents, but also to faculty and practitioners. The new American Board of Medical Specialties’ Maintenance of Certification requirements have adopted the same general competencies as residency training (6).

**Concerns About Promotional Activities**

Promotional activities and marketing techniques are used because industry has data to support their effectiveness in increasing sales. Through information obtained from pharmaceutical distribution companies, industry can track the precise number of prescriptions each physician has written on a particular drug both before and after a particular sales intervention. Hence, they can accurately evaluate the efficacy of their programs.

While marketing and promotion call our attention to new and helpful medications, they also distract us from still useful medicines that are no longer patent protected and thus no longer detailed. Examine any residency program in the U.S. and review the number of bipolar patients who started with lithium, compared to those who were initially treated with anticonvulsants. Review the patient logs of residents and note their clinical experience with tricyclic antidepressants, monoamine oxidase inhibitor (MAO) inhibitors and benzodiazepines. Not that checking patient logs is feasible or even permissible in this era of the Health Insurance Portability and Accountability Act (HIPAA), but speak to training directors and you will undoubtedly find a paucity of resident exposure to these time-tested and effective treatments.

There are additional behaviors of concern for residents and faculty alike. When residents are recruited to present pharmacological data using talks and slides written and created by industry representatives in exchange for a sizable honorarium, they must be able to analyze this conflict of interest.

Our faculty must model and do likewise. “Tuition talks” (presentations given in exchange for honorariums used to offset the costs of offspring education) are tempting yet also potentially corrupting. Full-time academic faculty bring with them the imprimatur of their medical schools. It behooves full-time academic faculty to choose carefully the content of their presentations and avoid biases. In neglecting to do so, they may leave the impression that their medical school also endorses a specific product. Residents might also question the objectivity of a faculty member in the classroom after hearing a presentation from that same faculty member at a dinner talk the previous evening. Additionally, academic researchers must be free to publish the results from their clinical research, whatever the outcome.

**Social Contract**

When our profession does not uphold our part of the social contract, society will respond. If we, as a profession, do not regulate ourselves, then society, through its legislators, will do so via statute. We have already seen this happen. When we as psychiatrists did not respond adequately to regulate ourselves regarding patient-therapist sex, state legislatures passed laws criminalizing the act (7). When medicine failed to recognize the vast literature on the impact of sleep deprivation on job performance and did nothing to stem medical mistakes resulting from house staff fatigue, Congress threatened and continues to threaten to regulate resident duty hours (8).

Following published guidelines will not guarantee an educational environment free of bias and commercial interests. To fulfill our social contract and maintain our patients’ trust, we must recommit ourselves to our patients and commit ourselves to exceeding guidelines regarding medicine and industry. We must apply not only the letter of the core competencies, but also their spirit. Avoiding conflicts of interest will require constant vigilance. Perhaps