An Unexpected Lesson

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about the efficacy of a treatment for a stroke victim, however, I stood to gain professional or financial benefit from her participation in the clinical trial.

We firmly believe that in the presence of clinical equipoise, if available, participation in clinical trials should be offered to patients and families, but then again whose equipoise anyway? In our special circumstance how could we approach somebody to participate in a clinical trial testing the efficacy of a device in improving the outcome of stroke and then turn around and say that we could treat him or her with the same device outside the clinical trial?

While disclosing potential conflicts of interests might be useful for these patients and their families, that still may not be helpful to them as they struggle with how much to trust the person presenting the information. Then there is the added issue of how the information is presented, which is known to influence the decision makers.

As I struggled with this decision, the decision, thankfully, was made for me. We could not find a person who could give consent on behalf of the patient and therefore, we could not offer her participation in the trial. This brings up an additional issue; how is it that we could invoke emergency treatment and justify the treatment with the device anyway? In the end, we did not treat her with the device as the intracranial vessel that was initially blocked was now open in the diagnostic angiography.

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Laura E. Hodges

Physicians’ interactions with the drug industry can erode trust not only with their patients, but also with the students they teach in the clinic. I learned this first-hand when I started my clinical rotations as a third year medical student. On my first month-long rotation, I was assigned to a hospital with a policy that restricted the presence of pharmaceutical representatives on the premises. Representatives were never seen on the hospital floors or in resident workrooms, and drug promotional paraphernalia was at a minimum. If I saw an occasional pen with a drug logo on it, I knew it had to have come from outside of the hospital. In this, my first full-time month spent in a clinical environment, it never occurred to me that my attending physicians might teach me anything but the most up-to-date evidence-based information.

My assumptions changed during my second rotation, when I was assigned to a hospital with a much more permissive policy towards pharmaceutical representatives. The first patient I saw was a woman with congestive heart failure, a condition commonly seen in hospitals. CHF has a fairly standard set of treatments, a major component of which is one or more diuretic medications. The diuretic allows a person with CHF to urinate excess fluid out of her system, thereby decreasing the fluid load on her weakened heart. The classes of diuretics used for this purpose are common, familiar to any medical student who has taken a course in pharmacology.

The night after meeting my patient, I prepared for morning rounds and created a treatment plan for her. While I was still new to formulating a treatment plan, I felt fairly confident that the diuretic I’d chosen was an appropriate choice.

On rounds the next morning, I gave the standard presentation for my patient’s case, and ended with my suggestion to use one of the standard diuretics as part of her treatment. My attending, however, had a different idea. “Her sodium levels are low. Diureseall* might be better for her hyponatremia.”

My team and I gave him a quizzical look. “Diureseall?” I said.

“It’s an ADH inhibitor.” He answered our question before we could fully formulate it.

Like any good medical student, I knew that ADH stood for anti-diuretic hormone, a hormone that is naturally produced by the brain when the body

* Diureseall is a fictitious drug name created to protect all parties involved in this true story.
needs to retain fluid; it does this by causing the body to produce less urine. An inhibitor of ADH would reverse this process and cause the body to create more urine, thus acting as a diuretic. However, beyond this basic knowledge, I had never learned about this class of drugs in my fairly thorough pharmacology class. I also had never heard of it as a treatment for congestive heart failure. I said as much to my attending.

“It’s a new drug, recently released on the market,” he said to me. “If you come with me to my office after rounds, I’ll give you an article about it.”

We finished rounds after a couple of hours and I walked with him back to his office. He asked me friendly questions about myself: where I grew up, what I studied as an undergraduate, what specialty I thought I might like to go into. He told me with enthusiasm about his work as an internist and his schedule for the rest of the day. After riffling through a few draws in his desk, he found the article and handed it to me.

Instead of the rough photocopy I had expected, the article was printed as a stand-alone brochure, on nice, heavy stock paper and in full color. I was immediately impressed by the brochure format, as I had never seen a journal article in this form before. The article was of a randomized control trial of Diureseall, and the logo of the well-known journal it was published in was prominently displayed at the top. I thanked my attending for the article and handed it to me.

As I sat down with my frozen dinner of pasta primavera that evening, I started to look over the Diureseall article. The handout was thick and glossy, and I tried to imagine where my attending could have gotten a copy like this. I remembered some patient education brochures I had seen earlier that day. They were obviously published by a pharmaceutical company, and prominently displayed the name of the medication they were selling on the back of the brochure. I noted them because I hadn’t seen sponsored handouts like that on my previous rotation at the other hospital. In fact, I had noticed several new things that day: a mug next to a computer with the name of an antidepressant printed on its side; a model of an plaque-caked artery with the name of a lipid lowering drug on it; and a pharmaceutical company-sponsored lunch at the noon conference for our department.

I inspected the article in front of me for any logo or other small sign of who might have published the handout. There was no indication of who had printed it, but it looked suspiciously to me as though a pharmaceutical representative who was promoting the new drug had handed it out.

As I started to read the article, I noticed several significant limitations in the study methodology. When I finished, I thought about the standard diuretics used in CHF and realized that the findings of this study printed on glossy thick paper were not sufficient to justify the use of Diureseall over the other gold standard drugs. I also noticed that there was no mention of the cost of Diureseall anywhere in the handout, and so had no information about the cost-effectiveness of the drug.

I put down the article and I could not help but wonder: Why did my attending give me this article? Did he not see the glaring limitations I noted? Was it merely coincidence that a pharmaceutical representative promoted the drug to him? During our training, it’s common for attendings to give articles to students about the most current therapeutics and diagnostic procedures. The article my attending gave me was meant to be educational and help me understand why Diureseall might be a better choice for our patient than any other drug. Even if Diureseall did turn out to be the best choice for our patient, the article I was given was not sufficient to justify the choice of the drug. The lesson my attending taught me by giving me this article conflicted with the principles of evidence-based medicine I had learned up until that point. The next morning, I arrived at rounds ready to discuss what I learned from the article and prepared to argue in favor of using the standard diuretic I originally suggested. Before I even had the chance to present my update for the morning, the senior resident gave us a brief update: he had checked with the hospital’s pharmacy yesterday afternoon and found that they did not have any Diureseall in stock because of the extremely high daily cost of the medication. My resident had already used his prescribing power...
to go ahead and put the patient on the diuretic I initially suggested.

“I can’t believe it costs so much!” my attending exclaimed. “I thought it would be interesting to try it out, but not at the price.” My attending looked genuinely surprised and more than a little disappointed, but we went ahead with a regimen of standard diuretics. Happily, our patient recovered and was well enough to go home after a few days.

I’m still not 100% sure that my attending received that article from a pharmaceutical representative. Even if he hadn’t, the environment of pharmaceutical representative promotion at our hospital caused me to consider this as a strong possibility. It was this suspicion that in turn caused me to question the reasoning that led my attending to choose Diureseal over any other drug. Whether or not there was an influence from pharmaceutical marketing, the environment in which our interaction was situated led me to suspect some level of industry influence on my education.

This was not the only interaction I had with an attending and the pharmaceutical industry. A week after this event, I noticed a pharmaceutical company flyer that was posted in the resident workroom. The flyer was for a dinner and educational talk being held at our hospital in a few days. After a week of being surrounded by patient education handouts and plastic educational models of knee joints and uteruses emblazoned with various brand name drugs, I was not surprised to see an industry-sponsored event advertised in the workroom for medical trainees. What did surprise me was the speaker: it was one of the faculty physicians at the hospital who had given my cohort of students a lecture just a few days ago.

My heart sank as I thought back on the content of the lecture she gave us. Was this a topic she also covered in industry-sponsored lectures? Where had the information come from? Because she was faculty at an academic medical center, I assumed that what she taught us was based on the most impartial and evidence-based information she could find. Was it possible that the content of her sponsored lectures was influenced, even in some small way, by industry funding? Was it possible that this influence also affected the lectures she gave to students?

I do not have the answers to these questions. I have no way of reading into the thought processes of my professors. As far as I know, I am being given teachings based on the most up to date, evidence-based, gold standard medical practices. Of course, even if my instructors’ teachings are influenced by their interactions with the pharmaceutical industry, I can’t believe they are promoting drugs on purpose. After all, pharmaceutical marketing works in large part because it works on a subconscious level. I’m sure that if any of us were shown direct proof of the effects commercial marketing has on us, we would be shocked to see impressions we had no idea existed in us. While I cannot be certain that my instructors have been influenced by their interactions with industry, the possibility exists. I am left to wonder if an academic medical environment that is welcoming of pharmaceutical marketing is conducive to building trust and providing quality medical education to students.

Am I on call for the entire Midwest?

Anthony A. Mikulec

Almost all physicians take call as part of their job. Call responsibilities can be broadly divided into two categories: responsibility for a physician’s own patients after hours and providing coverage for hospitals and emergency rooms (ERs). It is the second of these which is by far the most contentious. Call arrangements between physicians and hospitals vary greatly based on physician specialty, employment status (hospital employed vs. private practice), and local health care market conditions. In general, physicians would prefer to take no ER call, as patients who come to the ER for health care tend to have no insurance or Medicaid and tend to come at inconvenient times, while hospitals would like