HEART OF THE MATTER

Whose Responsibility Is Postgraduate Education?

A recent analysis indicates that the medical profession in general—and cardiology in particular—has received a lot of free meals and trips under the heading of professional education. The analysis reports that cardiologists have more of these "perks" than does any other group surveyed, including primary care doctors, anesthesiologists, and general surgeons (N. Engl. J. Med. 2007;356:1742-50). The implication of the survey suggests that cardiologists' therapeutic decisions are heavily influenced by industry. That's probably not too far from the truth. But the real issue is, Who is out there to educate the cardiologists about the newest drug or device if industry does not do it?

BY SIDNEY GOLDSTEIN, M.D.

The pharmaceutical industry, by default, now provides almost 75% of all postgraduate education. The rapidity of the development of new drugs and devices that has occurred in the last decade has been overwhelming and has necessitated a close relationship between the developer and the practitioner. Any delay in application of the new device or drug by cardiologists is viewed as incompetence or ignorance.

It was not long ago—30 years—when β-blockers were introduced for the treatment of acute MI. Information based on clinical trials of more than 6,000 patients showed that the mortality of acute MI could be reduced by 45% if all patients received that class of drug. In spite of these data, almost 15 years after their publication fewer than 25% of patients were receiving β-blockers at the time of hospital discharge.

The National Institutes of Health at that time was not interested in carrying the message, even though one of the three major trials, the Beta Blocker Heart Attack Trial, was sponsored by the National Heart, Lung, and Blood Institute. Some concerned cardiologists approached the only drug company that sold a patented β-blocker at that time to help raise awareness of the importance of β-blocker therapy within the cardiology community. A number of symposia and dinner programs were organized to encourage the use of any β-blocker, some of which were generic, for the treatment of acute MI. We were modestly effective in increasing the usage to just under 50%. Yes, we were paid to give the talks and doctors did get a lot of free meals, but the message ultimately got out.

β-Blockers have been incorporated as standard therapy, but getting there was not easy. And it took over a quarter of a century to do it. Similar comments can be made about ACE inhibitors in heart failure: The ultimate introduction into clinical practice took almost a decade after the drugs were shown to be effective. In contrast, spironolactone was shown effective in heart failure in a trial sponsored by a pharmaceutical company. But because the drug was already off patent, the company felt that it had no responsibility to teach doctors how to use it, resulting in a significant increase in morbidity and mortality when spironolactone was used at the wrong dose and in the wrong patients.

Last year, a group sponsored by the American Board of Internal Medicine Foundation and the Institute on Medicine as a Profession called for academic medical centers to take the lead in eliminating potential conflicts of interest with drug companies by stopping "common practices" that included accepting funds for travel to CME meetings and serving on speakers' bureaus (JAMA 2006;295:429-33). If implemented, that will turn the clock back to the period in which the introduction of new drugs and devices proceeded at a glacial pace. It would be largely free of pharmaceutical support, relying heavily on a medical education system that currently provides little access or support for postgraduate education.

A number of for-profit companies have emerged to provide postgraduate education in part supported by merged pharmaceutical funds. At the same time, the Internet has become an accessible source of medical information. None of these, however, takes the place of the personal interaction between a clinical scientist involved with the R&D of new medical science and a listening audience.

Without question, we'd all feel better if we did not have industry editing our presentation slides and telling us what to say. It is an unhealthy environment in which to educate physicians. But the academic medical centers need to step up to the plate and provide that support. So far there they have not even reached the batting circle. ■

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LETTERS

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