Survey: Most Physicians Have Ties to Industry

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Nearly all physicians have ties to the pharmaceutical or device industries, ranging from accepting drug samples to serving on a speakers' bureau, according to a survey of physicians across six specialties.

The study found that 94% of physicians surveyed reported some type of relationship with industry. The most frequently cited interaction (83%) was receiving food in the workplace. A majority of physicians surveyed (78%) also reported accepting drug samples.

Fewer physicians, about 35%, reported accepting reimbursement for admission to continuing medical education meetings or other meeting-related expenses, and 28% said they received payments from industry for professional services such as consulting, speaking, serving on an advisory board, or enrolling patients in clinical trials (N. Engl. J. Med. 2007;356;1742-50).

Physicians contacted by this news organization said that while the study raises important issues, it is not a cause for alarm since many of the industry interactions outlined in the study are essential and appropriate.

Eric G. Campbell, Ph.D., of the Institute for Health Policy at Massachusetts General Hospital–Partners Health Care System in Boston, and his colleagues surveyed 3,167 physicians working in anesthesiology, cardiology, family practice, general surgery, internal medicine, and pediatrics. Of those surveyed, 1,662 completed the questionnaire for an overall response rate of about 52%. The study was supported by a grant from the Institute on Medicine as a Profession.

The type and extent of reported interaction with representatives of the pharmaceutical and device industries varied by specialty, the researchers found. For example, cardiologists were more than twice as likely as family physicians to receive payments for professional services, such as consulting or work on clinical trials.

Family physicians held the most meetings with industry representatives, on average about 16 meetings per month, according to the study.

Practice setting also played a role in the interaction. Physicians in group practice were six times more likely to receive drug samples than were those working in hospitals, clinics, or staff-model health maintenance organizations. Physicians in group practice were also three times as likely to receive gifts and nearly four times as likely to receive payments for professional services.

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The study did not assess the appropriateness of the relationships with industr; however, the researchers concluded that the variations in relationships by specialty may indicate a need for guidelines that are specific to specialties and practice settings.

In an interview, Dr. James King, president-elect of the American Academy of Family Physicians, said, "I don't think it's a major cause for concern."

Dr. King said he was not surprised by the survey findings, especially since it is a common practice for physicians to accept drug samples in an effort to save their patients money. Most practices are likely operating within the guidelines set out by the American Medical Association, he said. The AMA guidelines recommend that gifts should primarily have a benefit to patients and should not be of substantial value. For example, modest meals and textbooks are acceptable under the AMA guidelines, but cash payments should not be accepted.

The relationship with industry should continue to be watched and addressed, said Dr. King, and he recommended that physicians review their own ethical guidelines from time to time and refuse to accept any gift that would inappropriately influence their prescribing habits.

The main responsibility of physicians who do have relationships with industry is to ensure that patients' interests always come first and to disclose any financial conflicts, Dr. Jack Lewin, CEO of the American College of Cardiology, said in an interview.

ACC has a policy requiring disclosure of industry relationships for anyone involved in the group's activities, he said. "We really do have a firewall." However, many of the relationships between cardiologists and industry are necessary and appropriate, Dr. Lewin said, since industry is the main source of research on new treatments. But more can be done to reduce concerns about potential conflict of interest, he noted. For example, an increase in the number of publicly funded independent reviews of drugs and devices and increases in federal research funding would help to clarify some of the gray areas of cardiovascular care, he said. ■

Familiarity Is Beginning to Ease Burden of Part D Hassles

San Diego — In the second year of Medicare Part D implementation, physicians continue to struggle with prior authorization requests and other hassles, Dr. Kay M. Mitchell said at the annual meeting of the American College of Physicians.

Although some of the paperwork burden remains, the prescription drug program is generally easier to manage now because patients and physicians are more familiar with the rules, said Dr. Mitchell, a geriatrician and a professor in the department of community internal medicine at the Mayo Clinic in Jacksonville, Fla.

"It's still going to cost us time and money," Dr. Mitchell said. "It doesn't matter how much we've worked at it."

For example, physicians continue to see requests for prior authorization and step therapy, said Neil M. Kirschner, Ph.D., ACP's senior associate of insurer and regulatory affairs. In addition, in 2007, several drugs were approved under both Medicare Part B and Part D, which could create denials, he said.

Officials at the Centers for Medicare and Medicaid Services are working on this issue and recommend that physicians write the diagnosis and "Part D" on the prescription, Dr. Kirschner said.

Physicians might experience some relief in terms of prior authorization and exceptions if their patients haven't changed drug plans, Dr. Mitchell said. CMS officials announced that prior authorizations and exceptions approved by a drug plan in 2006 are expected to continue this year if the beneficiary remains in the same plan and the expiration date hadn't occurred by Dec. 31, 2006. However, if the beneficiary changes plans, physicians might have to go through the same process again. And even when patients remain in the same plan, some physicians have still received prior authorization requests, she said.

When you are faced with prior authorization, Dr. Mitchell suggested, save time by having the patient collect the authorization forms and bring them into the office. In her office, this saves office staff 20-35 minutes per prescription, she said.

Some physicians have decided to deal with the extra Part D paperwork by either hiring additional staff or designating staff to deal solely with Part D prior authorizations, denials, and appeals, Dr. Mitchell said. Some physicians use general office staff while others use nursing staff. Dr. Mitchell said she prefers to have one of her nurses work on Part D issues because she is already familiar with the patients and their medications.

Dr. Mitchell also recommended that staff members who are working on Part D issues attend continuing medical education meetings that focus on Part D.

During the course of Part D implementation, Dr. Mitchell also learned that insurers may ask for documentation justifying a switch in medications. To simplify that process, she recommends, keep a sheet in the front of the chart with information on medication changes. ■

Voluntary Reporting May Convert To Pay for Performance After 2008

San Diego — Within the next few years, Medicare is likely to move from a system of pay for reporting to pay for performance, Jeff Flick, a regional administrator for the Centers for Medicare and Medicaid Services, said at the annual meeting of the American College of Physicians.

Mr. Flick, who is based in San Francisco, predicted that Congress is likely to approve funds to continue the Medicare Physician Quality Reporting Initiative (PQRI) in 2008. However, in future years the program is likely to convert to a pay-for-performance system, he said, which could be similar to the system being developed for hospital value-based purchasing.

"I believe we're not going to move away from this," he said.

PQRI is a voluntary program that will let physicians earn a bonus of up to 1.5% of their total allowed Medicare charges during the last 6 months of 2007 for reporting on certain quality measures. Congress authorized the establishment of the 6-month pay-for-reporting program last December as part of the Tax Relief and Health Care Act of 2006. Changes to PQRI—and actual implementation of a pay-for-performance system—would require additional legislation from Congress.

Officials at the Centers for Medicare and Medicaid Services have selected 74 quality measures that can be used by physicians across specialties. If four or more measures apply, physicians must report on at least three measures for at least 80% of cases in which the measure was reportable. If no more than three measures apply, each measure must be reported for at least 80% of the cases in which a measure was reportable, according to CMS.

ACP has estimated that the typical internist will be able to earn about $1,500 for reporting over the 6-month period. But the amount earned will depend on the case mix of the practice, said Robert Doherty, senior vice president for governmental affairs and public policy at ACP.

"If you look at this program, it's one that can teach us a lot for the future. It's not the answer," Mr. Doherty said. "But if you do participate, you'll learn a lot about the program."

A "weighted" performance payment would take into consideration the impact and the additional work related to measures for chronic diseases, he said.

But physicians who choose to participate in the program will have a chance to learn about the quality of care they are providing and to get ready for pay for performance, Mr. Flick said.

Physicians will also be sending the message to Congress that they are not afraid of quality, he said.

What is fundamentally driving the program is the need to move toward value, he said. CMS is currently receiving data on hospital, home health, and nursing home quality, but not on physicians. "We need data," Mr. Flick said. ■