The Pharmaceutical Industry in the Nursing Home: No Such Thing as a Free Lunch

SIR: In recent years, the pharmaceutical industry practice of "detailing" physicians has come under increasing scrutiny. In particular, the implications of practices such as giving gifts to physicians and paying physicians to attend informational sessions have become a concern, and most medical associations have issued guidelines to address this issue.[1]

The pharmaceutical industry has apparently decided to start targeting the long-term-care (LTC) market. It has recently come to our attention that, in our region, certain pharmaceutical companies' representatives have begun offering free educational seminars, complete with a complimentary lunch, for nursing home staff members. Sometimes a physician speaker, sponsored by the drug company, will present, but, more commonly, the pharmaceutical representative him/herself will present information on a new psychotropic drug or a new indication for an existing drug. There is usually no physician present at these sessions, which are targeted at nurses and nurses' aides. As a result, those most familiar with these drugs and their potential positive and negative effects are not present to provide some degree of balance to the staff who are present and who thus may come away with a very (positively) biased view of the agent being discussed. It appears that this strategy is a very deliberate one, with the goal of getting the nursing staff to approach physicians with the idea of initiating the drug being detailed. In fact, we have received phone calls from nursing homes requesting that a patient's antipsychotic medication be changed to the drug recently described at one of these "informative" luncheons. LTC staff are particularly vulnerable to these marketing approaches, because of their limited budgets for required continuing nursing education and the offer of free education (and food); they also free nursing home administrators and directors of nursing from the task of putting together educational programs themselves.

The issue of "undue influence" of the pharmaceutical industry on LTC staff seems to us to be a major problem in the offing, and we would be very interested to hear about others' experiences. We also would raise the question of what the response of The American Association for Geriatric Psychiatry (AAGP) should be to this problem. Certainly we, as individuals with a stake in our own patients' health, need to be proactive about this and educate nursing home administrators about the potential conflicts of having unbalanced presentations by pharmaceutical industry staff, and we can also offer our presence at such events, or offer to present our own, hopefully more unbiased, information.

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Dr. Wengel is on the speakers' bureau for Pfizer and AstraZeneca. Dr. Burke has been provided honoraria for speaking by Forest, Janssen, Abbott, and Pfizer. He has research support from Forest, Merck, GlaxoSmithKline, and Cyberonics.

Reference

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Comment on Wengel et al.'s Letter: Physicians and the Pharmaceutical Industry

SIR: Wengel et al. [*see above*] provide valuable observations regarding the pharmaceutical industry's recognition of nursing homes as an area for direct marketing. They note that nursing staff, in the absence of physician colleagues, may be especially vulnerable to biased presentations; and despite evidence to the contrary, there are persistent concerns about the use of psychotherapeutic agents as chemical restraints.[1,2]

As Wengel et al. point out, the potential for mischief is obvious. Yet, there may be benefits, as well. There have been marked changes in prescribing patterns in nursing homes, some of which have been driven by regulatory mandate as well as scientific data. For example, over the last decade, there has been a 59% decrease in the use of antipsychotics and a 97% increase in antidepressants.[3] It remains unclear whether the shift to antidepressants represents better care, better detailing, or a defense against the view that an antipsychotic in the nursing home is a chemical restraint until proven otherwise. However, the pharmaceutical industry's interest in long-term care is unlikely to diminish, nor should it, given the need for advances in the pharmacologic treatment of nursing home residents. But who polices the content of presen-

tations in the nursing home to ensure that undue influence from industry representatives is minimized, if not prevented?

At the American Association for Geriatric Psychiatry (AAGP) annual meeting, special steps are taken to guard against undue influence by corporate sponsors of scientific sessions. When a program is proposed for presentation, corporate sponsors sign an agreement that their products cannot be promoted, either directly or indirectly. The content of the presentation cannot be "scripted" by industry agents, and advertisements cannot be displayed. Before the meeting, AAGP volunteers review all material to be presented and may require additional speakers, the inclusion of potentially unfavorable data regarding the products, changes in content to correct perceived bias, and caveats about off-label use or preliminary findings. When data are provided by the industry but not published, they must be clearly labeled as such. Also, Board members and trainees are assigned to each industry-supported presentation to provide feedback from direct observation. When presentations have seriously deviated from the vetted material, privileges to submit at subsequent annual meetings have been suspended. AAGP, not the industry, sets the standards for reimbursement of travel and for honoraria, such that no hidden "extras" are allowed for the presenters. These cumbersome procedures and safeguards are required for accreditation of Continuing Medical Education credits but are also enforced by the Annual Program Committee to avoid any appearance of improper influence. However, short of barring pharmaceutical representatives from the nursing home or having an institutional review process, the staff will always be vulnerable to bias. And AAGP cannot act as the overseeing authority. What AAGP can do is to raise awareness among our members, as well as related organizations, so that undue influence can be anticipated, recognized, countered, and prevented from recurring.

Nursing facilities and those of us who practice and teach in them need to openly seek the correct balance between taking advantage of the opportunity to use industry support to educate staff and becoming an odious advertisement for a product. Some facilities may choose to forgo the experience altogether. Others, through the medical director or other administrative entity, can set guidelines for the ethical use of industry-generated educational materials. Awareness of the potential for harm is the first step toward protecting all the interested parties, the residents, the practitioners, the facility, and the industry. This is why the letter from Wengel et al. is so timely.

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3. Health Care Financing Administration: *http/www.hcfa.gov/Medicaid/exactv2.htm*, 1999

Coma With Accidental Single Dose of an Atypical Neuroleptic in a Patient With Lewy Body Dementia

SIR: The neuroleptic sensitivity syndrome is a diagnostic criterion for Dementia with Lewy Body (DLB).[1] Some reports suggest that sensitivity to atypical neuroleptics occurs less frequently and is less severe,[2] and that antipsychotic agents with low D_2 antagonism might ultimately prove appropriate in patients with DLB.[3] We report a case of severe neuroleptic sensitivity to a single accidental dose of clozapine 175 mg; a low-level D_2 antagonist:

An 86-year-old man was diagnosed with DLB on the basis of a 6-year history of progressive memory, language, gait, and functional impairment, parkinsonian signs, marked visual hallucinations, and fluctuating confusion. In 1999, he had been withdrawn from risperidone 0.5 mg daily because of the development of a sensitivity syndrome. He had not been able to walk and was unable to raise himself from a chair.

His medical history included an allergy to sulfa drugs, type 2 diabetes, stroke, deafness, myocardial infarction, pulmonary embolism, and osteoarthritis.

Two years ago, he was admitted to a long-term care hospital with agitation and functional decline. His medications on admission were L-thyroxin 0.1 mg, donepezil 10 mg, coumadin 3.5 mg po once daily, and trazodone 75 mg at bedtime. His admission vital signs, laboratory work, and general medical examination were unremarkable.

A few months after admission,