Gifts to physicians: a question of ethics

Q Does the $300 cap on gifts from pharmaceutical companies to physicians apply to such traditional activities as dinner presentations or “Speakers’ Bureau” educational meetings sponsored by these companies? In addition, how did this rule originate?

A You might understand the rule better if I answer your second question first. In December 1990, the American Medical Association’s (AMA) Council on Ethical and Judicial Affairs published guidelines regarding inappropriate gifts to physicians from industry representatives. Initially, 7 rules were promulgated so that physicians could avoid accepting gifts that were inconsistent with the Principles of Medical Ethics. The council subsequently issued an addendum that attempted to clarify the ethical guidelines in a question-and-answer format, with direct answers to specific gift situations.

Increasing physician awareness. Since these guidelines are now more than 10 years old, the AMA has become concerned that many physicians are not aware of their existence. In fact, media reports in early 2001 suggested there was an increase in gift-giving practices that did not adhere to these rules. As a result, in August 2001, the AMA established the Working Group for the Communication of Ethical Guidelines on Gifts to Physicians from Industry. This group is comprised of the AMA and more than 30 physician organizations, including the American College of Obstetricians and Gynecologists (ACOG), healthcare organizations, and industry representatives (both pharmaceutical companies and equipment manufacturers). Further, the ACOG Committee on Ethics updated its committee opinion on this subject in October 2001.

Defining who is affected. Most physician organizations, including ACOG, have incorporated the AMA Ethical Opinions/Guidelines into their own code of ethics, and many state and local medical societies have done the same. Translation: It is highly likely that these guidelines—or variations thereof—apply to you whether or not you are a member of the AMA. For example, some societies have adopted more specific gift guidelines. I suspect that the $300 cap on gifts that you mentioned is a state or local society rule because the AMA addendum states that gifts in excess of $100 are inappropriate.

Applying the rules. To answer your first question, dinner presentations are appropriate if the dinner is a modest meal. It should be similar to what a physician routinely might have when dining at his or her own expense. The educational component must have an independent value such as a presentation by an authoritative speaker rather than a sales representative from the sponsoring company.

As far as Speakers’ Bureau meetings are concerned, I assume you are referring to whole-day or weekend seminars with a number of authoritative speakers and Continuing Medical Education (CME) credit. These meetings are more questionable, especially when they are directly conducted by the pharmaceutical company or equipment manufacturer, with minimal participation, input, or control from an academic or accredited medical society sponsor or intermediary. As with dinner meetings, the guidelines permit only modest hospitality in connection with such programs. Rather, it is preferred that industry provide funds to academic institutions or accredited medical societies so they can conduct independent educational seminars.

A look at the key points. Following are some excerpts from the guidelines:

- Gifts should primarily entail a benefit to patients, not the physician.

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Assigning responsibility, liability for neonatal resuscitation

At the community, non-training hospital where I work, the administration states that it is the pediatrician’s responsibility to perform neonatal resuscitation. However, the pediatricians, as well as the anesthesiologists, contend that it is not their duty, ultimately leaving it up to the obstetricians. For their part, the Ob/Gyns are frustrated with this situation, especially in light of increasing malpractice lawsuits.

In this type of hospital, who is responsible for performing neonatal resuscitation? And who is at fault if this lack of a sense of duty leads to brain damage or death?

According to a recent joint committee opinion of ACOG and the American Society of Anesthesiologists (ASA), “Personnel other than the surgical team should be immediately available to assume responsibility for resuscitation of the depressed newborn. The surgeon and anesthesiologist are responsible for the mother and may not be able to leave her to care for the newborn even when a regional anesthetic is functioning adequately.”

This opinion reflects the Guidelines for Perinatal Care and the now defunct ACOG Standards for Obstetric-Gynecologic Services, which stated—as early as 1988—that a separate, specially trained individual (a physician, nurse-midwife, labor and delivery nurse, neonatal nurse practitioner, nurse-anesthetist, or respiratory therapist) whose primary responsibility is the care of the newborn infant should be present at every delivery or immediately available in the hospital. In addition, the documents placed the responsibility of developing protocols for the resuscitation of a distressed neonate on the individual hospitals.

The cost of time. The problem, of course, is economics. Pediatricians, neonatologists, and anesthesiologists who are not already assisting in the delivery have found that they are frequently uncompensated for “waiting around” for a neonatal resuscitation. As a result, many of them are reluctant to make themselves “immediately available” unless they already are in the hospital and simply can be paged to the labor and delivery room.

The joint committee opinion of ACOG and ASA attempts to address this issue in the following fashion: “The availability of the appropriate personnel to assist in the management of a variety of obstetric problems is a necessary feature of good obstetric care. The presence of a pediatrician or other trained physician at a high-risk cesarean delivery to care for the newborn or the availability of an anesthesiologist during active labor and delivery when VBAC is attempted and at a breech or twin delivery are examples.

“Frequently, these professionals spend a considerable amount of time standing by for the possibility that their services may be needed emergently but may ultimately not be required to perform the task for which they are present. Reasonable compensation for these standby services is justifiable and necessary.”

Weighing medicolegal risks. With regard to liability, hospital protocols have the same force and effect as standards of care in lawsuits. As a result, a pediatrician’s failure to obey your hospital protocols in the case of a dis-
tressed neonate could, and should, make him or her legally responsible if brain damage or death ensues. Unfortunately, if you were the delivering Ob/Gyn in such a case and you attempted the neonatal resuscitation yourself when the pediatrician failed to respond, you would likely be sued as well. The pediatrician would have primary culpability because of the violation of the hospital protocol, but since you provided care to the patient and a bad outcome occurred, a plaintiff attorney would probably name you in the lawsuit as well.

The good news is that the hospital also would be a co-defendant in this type of case. Therefore, you might want to bring this matter to the attention of your hospital administration. This sort of turf battle between Ob/Gyns, pediatricians, and anesthesiologists is a perfect example of how the system itself can lead to bad outcomes. The hospital administration would be well advised to revisit its protocol to provide financial incentive for the physician responsible for neonatal resuscitation—in this case, the on-call pediatrician. The best defended lawsuits are the ones that are avoided in the first place.

REFERENCES


Disclaimer: Mr. Heland’s comments reflect generally applicable legal principles. However, these comments should not be construed as constituting legal advice. Because laws can vary considerably from state to state and because each legal situation has its own unique characteristics, readers should consult their own attorneys about how best to manage a particular situation or issue.

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