

Letters to the Editor

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Editor, Letters to the Editor Section

Editor's Note: Send letters to the editor to jscherger@ucsd.edu. 858-232-8858. We publish Letters to the Editor under three categories: "In Response" (letters in response to recently published articles), "New Research" (letters reporting original research), or "Comment" (comments from readers).

New Research

The Role of Industry in Brand or Generic Drug Recognition

To the Editor:

Residency training programs are an important target for pharmaceutical marketing efforts. Significant time and effort is spent providing young physicians with regular meals, detailing information and various paraphernalia promoting individual medications. While residents believe that gifts from drug companies can influence individual prescribing habits, they do not believe that they themselves are affected.¹ One way in which physicians are potentially impacted by pharmaceutical detailing is purely semantic. All medications have both a generic name and a trade name. Trade names of commonly prescribed medications have become part of the lexicon of popular culture in the United States. Preferential use of trade names can provide unintended bias toward a particular commercial product. This study's purpose was to determine the extent to which a cohort of federal physicians preferentially used generic or trade names when referring to medications commonly prescribed in the primary care setting.

Methods

Following institutional review board approval, 42 family medicine residents and 18 faculty were

surveyed at training sites within the Uniformed Services University Primary Care Education and Research Learning (PEARL) practice-based research network (PBRN). Surveys presenting 10 common primary care conditions (viral respiratory infection, diabetes, asthma, urinary tract infection, depression, hypertension, hyperlipidemia, gastroesophageal reflux, low back pain, and headache) were distributed to faculty and residents at participating sites. Respondents were asked to list the three medications they most commonly prescribe for each condition. Respondents were also asked to estimate the government-negotiated pharmaceutical cost for each medication they listed. Categorical responses were analyzed with the chi-square statistic and cost estimates compared using an

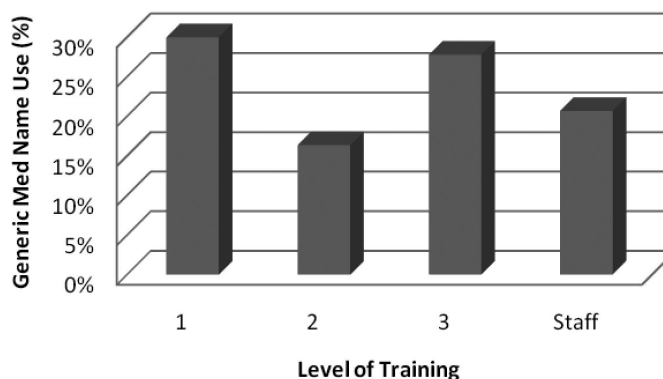
independent sample *t* test. Our pilot study was adequately powered to determine a 30% difference in preferential use of trade or generic medication names.

Results

Nine of 18 faculty (50%) and 22 of 42 residents (52%) responded. On aggregate, physicians used trade names in well over 70% of their responses (Figure 1). Residents in the first year of training were most likely to use generic medication names. Senior residents and staff were more likely to use trade names ($P<.05$). Neither faculty nor residents were able to accurately estimate wholesale federal medication costs. Residents and faculty significantly overestimated medication costs, faculty to a lesser degree than residents ($P<.05$).

Figure 1

Use of Generic Medication Names for Common Primary Care Conditions



Discussion

The role of pharmaceutical support in medical education has come under increased scrutiny in the past several years.² Despite the often ubiquitous presence of pharmaceutical representatives in many hospitals, residents feel they are immune to the influence of pharmaceutical detailing on actual prescribing habits.³ Our pilot work argues differently and adds several other important findings to this body of literature. First, it suggests that physicians are more likely to preferentially use trade names when prescribing common medications as they progress through training. This preferential use of trade names provides a subtle element of complimentary corporate “advertising” within the clinical environment. The fact that this trend only increases with clinical experience is concerning. Our respondents were also largely unaware of the cost of the medications they most commonly prescribe.

Our findings highlight the need for ongoing physician education to eliminate pharmaceutical bias. While a small sample size and federal physician status limit the generalizability of our findings, our results suggest an important semantic bias in the use of common primary care medications, one that worsens over time.

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Attitude Change Following a Homeless Clinic Experience

To the Editor:

It has been proposed that the care of medically underserved patients is more likely to fall to primary care physicians than to specialty care physicians.¹ More family physicians are needed, and engaging physicians in work with the underserved can be difficult.

The Family Medicine Residency program at West Virginia University initiated a multidisciplinary Homeless Care Clinic in April 2006. Family medicine residents and faculty, as well as psychology, nursing, and social work trainees, were involved in comprehensive patient-centered assessment and treatment. Second-year family medicine residents spent three to four afternoons in the Homeless Care Clinic, totaling 16 to 20 hours of service. Residents also had the opportunity to participate in a Street Rounds program mentored by a family physician faculty member.

Residents completed two measures before and after the Homeless Care Clinic experience: the Attitudes Toward Homelessness Inventory (ATHI)² and the Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI).³ Higher scores on the ATHI and HPATHI indicated more positive attitudes toward homelessness.

Demographic information was collected on each patient, along with type of care received. Since

initiation of the clinic, there have been a total of 552 encounters with 210 different patients. Patient ages ranged from 18 to 69, with male patients comprising 77% of the patient population. About 50% of the patients lived at the local homeless shelter, while 10% slept on the streets at the time of their visit. More than half of the patients demonstrated symptoms of serious mental illness. Clinicians estimated that patients in 13% of visits had such significant health problems that they were at risk for death. Family medicine residents participated in 93 visits, along with nursing students (seven visits), social work students (75 visits), and doctoral students in psychology (152 visits).

Following the clinic experience, responses on the HPATHI to the statement “Homelessness is a major problem in our society” reflected a statistically significant increase, along with responses to the statement “I feel comfortable being part of a team when providing care to the homeless.” It is notable that none of the 27 items on the ATHI demonstrated a significant change, and that only two of the 23 items on the HPATHI demonstrated a significant change. Out of the 27 items on the ATHI, responses post-clinic experience increased on 15 items, decreased on 11 items, and stayed the same on two items. Out of the 23 items on the HPATHI, responses post-clinic experience increased on 10 items, decreased on 11 items, and stayed the same on two items.

It is puzzling why attitude change was not more positive, since other residency programs with a homeless clinic experience have noted attitude improvement, as measured by the ATHI, following a 2-week intervention.^{4,5} In the cited curriculum, the training intervention was multifaceted. Residents were asked to participate in lectures, see homeless patients in a variety of settings beyond the clinic, par-