Hotel-Based Medicine



The last 20 years have seen extensive growth in a form of medical communication, that may be termed "hotel-based medicine." Pharmaceutical companies, professional societies, and other organizations organize small and large conferences, continuing medical education (CME) programs, promotional dinners, advisory board meetings, webcasts, podcasts, and other modern communications. Programs in elegant hotels are often quite pleasant and interesting, particularly compared to the lesser ambience that characterized traditional CME. Nonetheless, certain aspects of these programs may be termed "hotel-based medicine," which may detract from the ostensible purpose of increasing knowledge concerning diagnosis, assessment, and treatment of diseases. Further, both financial and temporal resources may be wasted, to the detriment of sponsors, physicians, and patients. In hopes of improving potential benefits of these conferences, a few examples of "hotel-based medicine" are cited below:

1. "Hotel-based medicine" may involve "promotional" talks, in which a speaker must show a specific PowerPoint "slide deck." The speaker is given no option to omit slides that she/he feels may be unclear, add slides of her/his own that she/he feels might clarify a point more effectively than those provided by the sponsor, or change slides even if errors are present. This widespread practice is presented by sponsors as a strategy to prevent presentation of "off-label" indications, which could result in fines and other punitive actions by the US Food and Drug Administration (FDA). Well known "opinion leaders" often may be listed as the "faculty" and may contribute to the slide deck. However, generally it is apparent that the primary preparation is by nonphysicians commissioned by the sponsor. Limited understanding of clinical care often is evident, suggesting that the contributions by experienced clinicians listed on the faculty often are minimal.

2. "Hotel-based medicine" may include directives by speakers that often do not reflect actual practices of the speaker. For example, many programs suggest that quantitative measurement with formal joint counts and/or a patient questionnaire should be included in each visit of each patient with rheumatoid arthritis (RA). Further, the slide deck may suggest that a disease activity score (DAS)[1] or derivative such as a clinical disease activity index (CDAI)[2] should be used to support treatment decisions. However, most visits to most rheumatologists do not include a formal joint count[3], so these indices are not available. Further, although programs have been developed to encourage rheumatologists to use patient questionnaires in usual care[4], most of the presenters have no experience with patient questionnaires in their own patients. Nonetheless, performance of joint counts, calculation of a DAS or CDAI, and inclusion of a patient questionnaire often are presented as usual practice at usual rheumatology visits, although the data presented are unlikely to be those of the presenter.

3. A "typical" patient often is presented as representative of "all" patients. For example, physicians may be queried: "How do you treat a patient with an incomplete response to an anti-tumor necrosis factor agent (TNF)?" or "How do you treat a patient who has a high erythrocyte sedimentation rate (ESR) and only a few swollen joints?". The program suggests that a single clear course of action generally is appropriate for a given "typical" patient.

Our examples of the limitations of "hotel-based medicine" are presented here so that we can begin to address them, as discussed below.

1. The practice of requiring a speaker to show a specific set of slides without variation might be eliminated. The stated basis for prohibition of any changes in slides — to avoid mention of "off-label" indications — may not be met anyway, as restrictions are limited only to slides. Speakers may (and sometimes are encouraged to) verbalize personal opinions not found on slides, or respond to questions from an audience member, which may include off-label information.

Ironically, any treatment of many rheumatic "orphan" diseases, such as vasculitis and polymyositis, is "off-label," as no drugs have a designated FDA-approved indication. In some senses, a restriction on discussion of "off-label" use of drugs may be an important disservice to advances in treatment of patients with these diseases, which often have morbidity and mortality comparable to cardiovascular or neoplastic diseases[5]. Perhaps the FDA might encourage a frank

and open discussion based on the clinical experience of practicing "thought leaders" in a manner that is less encumbered by company restrictions, rather than discourage consideration of these diseases.

A concern about mention of off-label indications could be met by including a knowledgeable "monitor" from the sponsoring pharmaceutical company at each presentation. A representative of the sponsor often is present, but generally is not expected to perform this function (which rarely is a problem anyway). An informed monitor could point out any slide, comment, question, or response by a speaker or attendee that presents "off-label" information, to prevent this potential problem far more effectively than using a fixed slide presentation. A fixed slide presentation should be presented by an employee of the sponsor, rather than by an ostensibly independent physician. A talk by a physician should include an option to add to or subtract from material provided by the sponsor, to reflect her or his viewpoint, interests, and experience — as should be expected by a physician audience.

2. Perhaps speakers should be required to "practice what they preach." A speaker who advocates a certain practice, whether performing a formal quantitative joint count in each patient, asking patients to complete a self-report questionnaire, or ordering a magnetic resonance imaging (MRI) scan in patients with early arthritis, might indicate how frequently these actions are performed in her/his practice. Instead of asking speakers to sign a statement that their presentation will not include mention of "off-label" indications, why not ask a speaker to indicate how often all clinical practices advocated are actually included in her/his clinical care? If a speaker has no personal experience concerning the frequency and use of a practice in her/his care of patients, she/he should note that or avoid mention altogether.

3. The optimal answer to how to treat a "typical" patient almost always is: "It depends on the patient." Treatment of individual patients with rheumatic diseases may vary according to levels of disease activity and damage, comorbid diseases, age, socioeconomic status, general optimism and pessimism, family history and experiences, attitudes about risks of therapy versus "risks" of disease[6], all of which may enter into clinical decisions. For example, a patient with early RA who might have only 2 swollen joints, but whose mother had rapidly progressive deforming RA with premature mortality, may ask for anti-TNF therapy at the first visit, while a poorly educated, uninsured patient who has 18 swollen joints, ESR of 100, and functional disability, pain and global status scores of 6–7.5 on a scale of 0–10 might suggest that she or he is (inappropriately) more afraid of the side effects of methotrexate than the "side effects" of RA. Oversimplified patient scenarios have led to oversimplified "marketing messages" that are poorly relevant to standard clinical care. One further consequence has involved oversimplified and fixed criteria by reimbursement agencies for approval or disapproval of certain therapies in specific patients, without recognition of important differences in treatment of individual patients. While the "typical patient" may provide a good launch for discussion, "rules" regarding how to treat all patients described by simple generalizations can be harmful to many individual patients.

Meetings and conferences at hotels, restaurants, resorts, and other pleasant venues can be informative and entertaining, but "hotel-based medicine" detracts from their value. Medical education and communication are best served with evidence, including evidence from the speaker's own experience and knowledge, rather than "eminence-based," "eloquence-based," and "elegance-based" medicine[7]. Genuine educational programs, in which speakers are free to present information based on evidence and data from their own clinical care, including variation for different patients, would better serve both the sponsors and the rheumatology community, than some aspects of "hotel-based" medicine.

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