We will consider for publication only letters submitted by mail or courier (not fax) in duplicate, printed in letter-quality type without proportional spacing and not exceeding 450 words. Letters must not duplicate material being submitted elsewhere or already published. We routinely correspond only with authors of accepted letters. Rejected letters are destroyed. Accepted letters are subject to editing and abridgement.

Seules peuvent être retenues pour publication les lettres reçues par la poste ou par messager (non pas par télécopieur) en double dont la longueur n'excède pas 450 mots. Elles doivent être mécanographiées en qualité «lettre» sans espacement proportionnel. Les lettres ne doivent rien contenir qui ait été présenté ailleurs pour publication ou déjà paru. En principe, la rédaction correspond uniquement avec les auteurs des lettres retenues pour publication. Les lettres refusées sont détruites. Les lettres retenues peuvent être abrégées ou faire l'objet de modifications d'ordre rédactionnel.

Interacting with the pharmaceutical industry

With regard to Dr. Gordon Guyatt's article "Academic medicine and the pharmaceutical industry: a cautionary tale" (*Can Med Assoc J* 1994; 150: 951–953) there are other cautions here that should be understood.

There should be caution when academia presents itself as the be-all and end-all of medical practice, whereas the vast majority of physicians function outside academia and rely heavily on pharmaceutical companies for continuing medical aducation (CME). A very serious and additional caution about the applicability of guidelines is the leap from the academic environment to the broader real world; what may be appropriate in the ivory tower is often not workable for mere mortals.

I learned from Guyatt's tale that there are certain people who have the time, the inclination and, most important, the political agenda to present positions that they believe are universally acceptable. The all-too-silent majority of medical practitioners appear to have a much healthier and workable relationship with the pharmaceutical manufacturers of Canada.

After Guyatt's article was published there were discussions among clinical clerks, interns and residents; some of these occurred spontaneously and others after more formal initiation. At all levels of their training our future physicians were extremely disturbed by the patronizing attitude that the "academicians" have toward them. Most trainees claimed to have an independently functioning mind that was inherently critical or could be trained to be so. This tool could be applied to information received from not only pharmaceutical companies but also the academicians themselves.

Equally disturbing to these trainees was the impression that a political or philosophic war is being fought, again on the backs of the "younger generation." The picture is being painted of big, bad pharmaceutical companies without a full understanding being provided of whether any real evil is present. The reduction to simple black and white of only one aspect of a very large and complex interaction does not do the issue justice.

There was almost universal agreement that a protectionist and paternalistic environment is not the best one in which to teach trainees how to "deal with" drug companies in order to prepare them for the real world. There should be exposure to pharmaceutical companies, their representatives and the information they provide, so that trainees can exercise critical appraisal while they are still in the educational process.

These junior doctors believed that there is no need either for separate guidelines for house staff or for CMA guidelines and that attempts to "limit access" smacked of thought control.

Daily I am faced with students, interns and residents — the products of some of the finest medical schools in Canada — who can't communicate with their patients about drugs and who do not know how to gain access to pharmaceutical companies.

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Between the poles of greed or bribery and academic purity surely there must be an acceptable ethical position, even a compromise.

Many departments at McMaster University have found acceptable grounds for contract research and collaborative projects without compromising academic integrity; the Faculty of Health Sciences has functioned similarly.

In the case of greed or cost-padding by researchers the pharmaceutical company simply goes to a different university, one that is willing to carry out the research at more reasonable cost. This is not a threat but, rather, good business practice.

In fact the biggest threat appears to be that of Sackett and Guyatt, who, when they were refused residency research funding, pressured the same individuals and companies with multiple letters, demands and "rather wide distribution" if they did not receive satisfaction (at least as they saw it).

"Pure" research or teaching in clinical sciences cannot and probably should not function in a vacuum. Indeed, the entire McMaster approach in undergraduate medicine is based

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