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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 education (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.

Mark Greenwald, MD, FRCPC
Toronto, Ont.

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

on early exposure to the real world of problem-centred care, fiscal restraint and limited resources as well as to the presence of pharmaceutical companies with their own goals. Responsibility for ethical behaviour lies with the individual. I took the oath of Geneva (World Health Organization), not a promise to abide by Guyatt's guidelines.

Universities' funding of research has depended heavily on faculty clinical earnings, a situation in which clinicians support not only themselves but the pure researchers as well. Is this really any different from the pharmaceutical companies' funding education and research, ultimately benefiting their other corporate goals?

Both medicine and the pharmaceutical industry would benefit by collaboration, teamwork and funding within common guidelines or a framework of ethical behaviour. Surely Guyatt does not have a monopoly on virtue? Perhaps his administrator or CME director had an equally valid viewpoint?

Those who see themselves only as pawns of multinational corporations, who are intolerant of other points of view and who would sell themselves for 30 pieces of silver are all poor role models for the "real world."

Richard G. Stopps, MD, FRCSC
Hamilton, Ont.

I think it is regrettable that Dr. Guyatt chose confrontation in dealing with a situation he finds personally morally unacceptable.

How much more productive it might have been to develop a program that would teach his charges how to interact ethically with industry representatives. As things stand, these physicians will go out into private practice not only ill-prepared but prejudiced — an opportunity lost and a pity.

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[The author responds:]

Dr. Greenwald and the junior physicians with whom he spoke appear not to have read the article "Development of residency program guidelines for interaction with the pharmaceutical industry" (*Can Med Assoc J* 1993; 149: 405-408), by our Education Council, which described the development of the guidelines. If they had, they would not characterize our approach as patronizing. The process of guideline development began with spirited debate among the residents. They endorsed the guidelines as something they wanted for their program before the faculty committee's debate began. Greenwald's letter is filled with resentment toward academic medicine and ends with a note of disrespect toward young physicians, whom he describes as unable to communicate with their patients about drugs. Both attitudes are unfortunate.

Most of Dr. Stopps' letter concerns an issue addressed by neither the original article nor the cautionary tale — namely, industry funding of research. Our guidelines for interaction with the industry did, however, define the circumstances in which industry funding for educational activities is acceptable. Parallel guidelines for research settings could minimize the conflict of interest that researchers sometimes face when receiving industry funding.

All three letters raise questions of what ethical approaches we should inculcate in our young physicians. In the editorial that accompanied our initial article ("Addressing the pharmaceutical industry's influence on professional behaviour" [*Can Med Assoc J* 1993; 149: 403-404]) Dr. Robert F. Woollard described a "three-step dance" we tend to do with ourselves. The first step is to refuse to state the obvious: that the primary goal of the pharmaceutical industry is to make a profit. The next step is to deny that industry gift-giving is meant to influence physician behaviour to the benefit of the industry. The final step is to deny that such influence is successful. In

plain terms, industry gift-giving is bribery and is often successful. Our guidelines suggest that we should encourage our physicians-in-training not to accept bribes and that we should not allow our residency programs to be a party to bribery. This approach seems to strike Greenwald, Stopps and Danby as one that either does not teach our residents how to interact ethically with industry representatives or is unrealistic for real-world physicians. I believe they are underestimating their junior colleagues' potential for living without industry handouts.

Finally, the three letters assume that physicians must rely on biased information from the industry to guide their prescribing.¹ Alternative sources include academic journals, respected colleagues, the *Medical Letter* and increasingly sophisticated computerized information sources. Our experience is that physicians-in-training and community doctors can draw their information from these sources and provide optimal care while so doing.

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Reference

1. Wilkes MS, Doblin BH, Shapiro MF: Pharmaceutical advertisements in leading medical journals: experts' assessments. *Ann Intern Med* 1992; 116: 912-919

Involving surgeons in discussions of breast cancer surgery

It is unfortunate that none of the authors of "Variation in breast cancer surgery in Ontario" (*Can Med Assoc J* 1994; 150: 345-352) is a surgeon.

It is immediately obvious that there are two major factors to consider in a discussion of variations from one region to another in rates of