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THE ROLE OF THE PHARMACEUTICAL INDUSTRY IN POSTGRADUATE MEDICAL EDUCATION

Demands for more, and better, postgraduate education in clinical pharmacology and therapeutics have not just been a twinkle in the eye of our Section and its Journal, The British Journal of Clinical Pharmacology (Binns, 1974; Herxheimer, 1976). Groups as disparate as the Sainsbury Committee (1967), the Royal Commission on Medical Education (1968), the Anglo-American Conference on Continuing Medical Education (Lancet, 1974), the Medico-Pharmaceutical Forum (1975) and the British Labour Party (1976), have all vociferously promulgated the importance of continuing education in drugs and drug therapy. Indeed, a Private Member's Bill was introduced to Parliament during its last session (Hansard 1976) which would have prohibited any doctor from prescribing all but a few drugs unless he (or she) had fulfilled an annual 'quota' of postgraduate instruction in clinical pharmacology and therapeutics.

In this continuing debate, the role of the pharmaceutical industry is crucial because of the blurred distinctions between advertising, promotion, information and education. The initiative of the Medico-Pharmaceutical Forum in establishing a Working Party 'To review the present and consider the desirable future role of the Pharmaceutical Industry in the continuing education of doctors and to make recommendations' is therefore welcome. The Working Party has now issued a 'Consultative Document' for circulation (and comment) to a wide variety of individuals and organisations involved in the practical aspects of postgraduate medical education. The document consists of a series of statements, interspersed with a number of questions, which respondents are asked to consider.

Let me state from the outset that I fully acknowledge the positive contributions which the pharmaceutical industry has made in the past: that they have been the main innovators of a wide variety of valuable therapeutic compounds; that they have provided considerable funds for the development of academic clinical pharmacology; that they have been generous in their sponsorship of scientific meetings, symposia and projects which would otherwise have never been possible; and that many scientific journals rely on revenue from pharmaceutical advertising. Furthermore, I accept that the pharmaceutical industry is a profit-based enterprise; that its profits are essential if its is to attract further investment; and that its profits provide the financial resources for new drug development. None of this justifies the opening paragraph of the Consultative Document which I quote in full:

'Through its research the pharmaceutical industry has made available numerous products whose effective use requires the doctor to be better informed and more discriminating than ever before. Most of the knowledge concerning these products is generated by the industry and this has to be applied before their potential can be realised. In recent years communications between the industry and the profession have also undergone evolution. Contributory factors are the development of about 300 postgraduate medical centres, group meetings, the popularity of audio-visual aids, the demand for more factual information on drugs, and the relatively weak academic contribution both to the development and teaching of medicinal therapeutics'.

This opening paragraph is likely to cause offence to members of this Society, and to pharmacologists and clinical pharmacologists world-wide. Is the Working Party unaware that it is this 'relatively weak academic contribution' which has provided almost all the fundamental knowledge underpinning industry's success? Has it forgotten, or has it never known, the contributions of past and present members of this Society towards understanding how these drugs act and interact? Is the Working Party really ignorant of the progress made by clinical pharmacologists in maximizing efficacy, minimizing toxicity, and reducing variability in the response of individuals to drugs? We may be numerically weak in both Universities and (especially) the Health Service, but this in no way justifies such a dismissal of our contributions.

These opening remarks form the foundations of a case built with flawed logic. For the document continues by making the assertion that the pharmaceutical industry's right to continue its current marketing practices is inscribed on tablets of stone; that these practices are in the best interests of the profession, the community and, presumably, the industry; and, by implication, that it is the task of postgraduate teachers to fit themselves in, as best they can. One of the questions posed in the document synthesizes the Working Party's attitude: 'How far can the legitimate commercial interests of the industry be reconciled with the educational needs of the profession?' What the Working Party should be asking, is which of the pharmaceutical industry's promotional and advertising practises are counter-productive to good postgraduate education, and what should be done to neutralize their effects?

The industry spends about £40M–£50M per annum on promoting its products (Lancet, 1976). Some of this money is spent on advertising in

journals, mass mailings, meetings, film shows, and free samples. A small sum makes available to the medical profession an assortment of trivia (writing implements, torches, pen-holders, ash-trays, even calculators and medical bags) with the largesse of Victorian explorers giving beads, bangles and mirrors to native chieftains. The real promotional thrust, however, comes from the 3000 representatives calling predominantly on about 24,000 general practitioners. This investment is justified by the Working Party thus: 'The industry is profit-based and manufacturers can only survive if their products are actively sold. Long experinece has shown that the best means is by personal dialogue between trained representatives and practitioners, supported by the written word, films, advertising, etc. *All consideration of the role of industry should be seen in this context*' (my italics). It is clear that the industry's prime contribution to postgraduate medical education is through these representatives whose activities must cost the industry (and ultimately the British tax-payer) some £20,000,000 per annum. Does the community get good value for money? If the present parlous state of drug prescribing is anything to go by we do not, but the evidence for this is poor. However, in a recent questionnaire survey (Eaton & Parrish, 1976) of 382 general practitioners, 181 (47%) felt unable to form an unbiased assessment of a new drug; and 132 of these doctors claimed that 'drug company activities' contributed to this bias. Furthermore, of the 201 (51%) practitioners who claimed to be able to get an unbiased assessment of a new drug, only 15 (7.5%) regarded 'drug companies' as the source of this assessment. Few representatives are medically qualified, and their activities are uncontrolled and unscrutinized by independent sources. Although their claims must by law comply with the terms of their Product Data Sheet, the personal nature of their contacts with the profession means that the veracity of their reputed statements to individual doctors, is almost impossible to establish. Moreover, the commercial nature of their encounters with the medical profession mitigates again unbiased comparison with alternative forms of treatment.

If the education role of the industry's representative force is negative, what chance have the 48 consultant and honorary consultant clinical pharmacologists against a representative force of 3000? Others who have considered this problem have suggested that the Health Service should employ its own representatives. However, unless these were numerically equal with those in the industry they would be unlikely to help. Moreover, the electorate is unlikely to relish the prospect of ultimately paying for both 'maleducation' as well as 'remedial education'.

It is obviously difficult to review the role of the industry in postgraduate medical education in isolation, but if the Medico-Pharmaceutical Forum's Working Party wishes to make a serious contribution to the debate, it must ponder some fundamental issues:

1. It should consider what other positive actions the pharmaceutical industry could take, in addition to its sponsorship of scientific meetings, etc. For example, the talented and knowledgeable scientists in individual company's research departments rarely speak to general medical audiences about the drugs they have developed. Furthermore, the industry should be persuaded to contribute a fixed proportion (say 5%) of its promotional budget towards establishing a fund, administered by the medical profession, which would support teaching and research into clinical pharmacology.
2. The Working Party also needs to decide whether the industry's representatives make a positive, neutral, or negative contribution to postgraduate education in drugs and drug therapy. If the contribution is detrimental, the Working Party will have to examine ways of changing the situation. The Sainsbury Committee envisaged that this form of promotion should be forbidden when alternative arrangements for continuing education had been developed. Whilst I, for one, would not mourn the demise of the representatives, removal by legislation is unlikely to be acceptable in a democracy. Some restriction on their numbers and the frequency of their contacts with the profession, as well as widespread supervision of the contents of their 'briefs', should be considered.
3. Finally, the Working Party will have to attempt to discover why the medical profession has for so long tolerated the industry's less desirable advertising—marketing—promotional—educational practices. The way in which the profession has, by implication, endorsed these gives no cause for pride. For in the end, it is the profession which will determine how the pharmaceutical industry markets its products, and what its role in continuing education shall be.

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