Addressing the pharmaceutical industry's influence on professional behaviour

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Résumé : L'auteur formule des observations sur l'article rédigé par le Dr Gordon Guyatt et ses collègues (voir pages 405 à 408) dans lequel on décrit le mécanisme mis en place à l'Université McMaster de Hamilton (Ont.) pour protéger les résidents en médecine de l'influence de l'industrie pharmaceutique. Dans cet éditorial, on analyse particulièrement la réaction des enseignants à cette initiative — leur tendance à s'autocensurer.

A dispassionate look at passionately held beliefs can be among the more irritating of human activities, especially for those who may already be uncomfortable about the rectitude of their beliefs. There are few beliefs in current medical practice that are held with greater passion than physicians' confidence in their ability to resist the influence of the pharmaceutical industry on their professional behaviour. If this belief is to be challenged — and mounting evidence dictates that it must — the process of such a challenge must be thoughtful and take into account what we know of human behaviour, adult learning and the ethical principles of the parties in question.

The article by Dr. Gordon Guyatt and colleagues (see pages 405 to 408) offers a useful description of one such process as it applies to the interaction between residents at a Canadian medical school (McMaster University, Hamilton, Ont.) and the pharmaceutical industry. It is instructive to read this report carefully for an understanding of not only the process and outcome, laudable as they may be, but also the reaction to the issues of faculty and residents. The way in which some of the initial concerns were clarified and resolved as data were gathered is particularly interesting.

The process at McMaster University began with a historical review by a senior faculty member of the relationship between the medical faculty and the industry. This thoughtful report is worth reading by any institution undertaking such a task.

It took the focused commitment of a particular residency program chair to move the proposed guidelines for interaction with industry from discussion to implementation while avoiding the twin hazards that attend most attempts at behavioural change. The first hazard is the temptation of "holier-than-thou" zealotry, which stimulates a quick defensive reaction, a great deal of passionate debate and a division of faculty between the smugly sanctimonious and the smugly self-serving but does not elicit much concrete action. The second hazard is the "paralysis by analysis" that so often accompanies attempted action in an area marked by ambiguity and subject to pleas for ethical relativity, especially when resources are perceived to be dwindling.

Guyatt and colleagues achieved this by following some basic principles of scientific and ethical discourse. They first stated their assumptions: (a) the primary goal of industry is to show a profit, (b) the individual physician should not accept gifts from industry, and (c) the provision of grants should not result in increased access to trainees by the grant providers.

These assumptions are consistent with the CMA's policy on physicians and the pharmaceutical industry.[1] However, many faculty members viewed the description of the industry contained in the preamble to the guidelines as being too negative, despite the substantial evidence supporting that description. This tendency toward self-censorship should be cause for concern, especially since even a modified version of the preamble met with considerable opposition. Guyatt and colleagues are to be congratulated for addressing the issue of the preamble in their survey of the industry's response to the guidelines.

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Insofar as only 1 of the 18 industry representatives surveyed found the modified preamble negative it seems that the faculty's concerns were excessive.

None the less, this self-conscious attempt by the profession to refuse to state the obvious (and legitimate) motives of industry is the first of a "three-step dance" we tend to do with ourselves. The next step is to deny that industry–physician interactions are meant to influence physician behaviour to the benefit of industry. The final step is to deny that such influence is successful. Emerging data and the continued massive investment in these activities by successful companies should put paid to such illusions. But attempts to codify these interactions are consistently met with the kind of apologia reported from McMaster University. If anything, this underlines the importance of persisting with attempts at codification.

The next argument (one might say the next defensive line) is to deny the need for codification. In the case of McMaster University some faculty members argued for implicit rather than explicit guidelines.

It is somewhat reassuring that the principles of the guidelines found little opposition. However, concerns that the guidelines should be implicit rather than explicit and that their implementation might compromise industry funding, although refreshing in their frankness, are worrisome. Together with the affirmation by 50% of the industry representatives that implementation would likely lead to a decrease in funding, these concerns indicate an unhealthy relationship. It remains to be seen whether a decrease in funding will occur, and we will expect to hear more about this from Guyatt and colleagues. If there is a decrease, the experiment has grave implications far beyond the scope of training programs; if not, the discussion will have been a healthy one.

It will be increasingly important to report on and thoughtfully evaluate interactions between the medical profession and industry. The CMA's experience in developing its guidelines had some parallels to the process Guyatt and colleagues describe. Various groups' initial reluctance to rock the boat through the development of explicit guidelines gave way to their recognition, during dispassionate discussion, of the desirability of such a move.

The dissemination and implementation of the guidelines is another matter. The greatest disappointment of the CMA process has been the lack of effective implementation at the level at which physicians work and interact with the pharmaceutical and health care supply industries. There are many factors influencing this lack of implementation, not the least of which is ignorance about how physicians are influenced. Few studies have looked objectively at how physicians try to influence their colleagues. The studies that do exist are on the topic of continuing medical education.[2,3]

We are even less inclined to study the potentially greater influence of industry blandishments on our professional behaviour. Thus, the article by Guyatt and colleagues is important beyond the intrinsically significant issue of regulating the interaction between medical trainees and the industry.

Insofar as the process at McMaster University (which we trust will be emulated by other schools) develops a cohort of faculty and trainees able to address the broader issues implicit in the physician–industry relationship we will be well served. If we can move beyond the defensive irritability so often demonstrated by physicians secure in the belief that they are immune to the influence of industry we will have come far indeed. If the dispassionate example of Guyatt and colleagues is the first of many steps down that path the authors will deserve the gratitude of Canadian medicine.

References

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