We need dialogue and discussion, not a new Berlin Wall

Judith A. Erola, PC

Résumé : Judith Erola, présidente de l'Association canadienne de l'industrie du médicament, s'inscrit en faux contre les arguments présentés par le Dr Gordon Guyatt dans l'article précédent. Elle affirme que ses déclarations semblent indiquer qu'il n'est pas convaincu que ses collègues soient capables de prendre des décisions éclairées relativement aux «positions d'ordre éthique dans divers domaines».

I am pleased that *CMAJ* shared with me an advance copy of Dr. Gordon Guyatt's Viewpoint article, Academic medicine and the pharmaceutical industry: a cautionary tale. I must admit that had I not known the identity of the author, I would have immediately assumed that it was written by someone from another time and place, and certainly not by a physician operating in the health care environment of the 1990s.

The relationship between the medical community and the pharmaceutical industry, as represented by the Pharmaceutical Manufacturers Association of Canada (PMAC), long ago evolved into one in which both constituencies acknowledge that in many instances their areas of interest and points of view will and do differ. Nevertheless, they recognize the importance of dialogue and discussion in matters of mutual concern, and the benefits to be gained through the exchange of ideas and information.

This spirit of mutual respect has characterized the interaction between the PMAC and various national medical associations, such as the CMA and Royal College of Physicians and Surgeons of Canada, certain medical specialty societies and some academic institutions. That spirit was also apparent in the development not only of the PMAC's Code of Marketing Practices, which covers the relationship between the pharmaceutical industry and its stakeholders, but also in those organizations' development of guidelines relating to the conduct of their own members.

I am not saying that either party has readily embraced the point of view of the other, but the consultations have been conducted in accordance with the principles of a free society, the freedom of speech and association, and respect for the views of others.

An excellent example of the degree to which these relationships have evolved is the PMAC Marketing Practices Review Committee, which adjudicates allegations of infractions of the PMAC code; it has two representatives from the medical community, whose participation enhances the level of understanding between our two sectors.

Recognizing the importance of the consultative process, the PMAC contacted some 60 stakeholder groups for input during the 2-year study and review that led to the development of its Code of Marketing Practices. Because revisions to one of the code's sections are now under consideration, we are again involved in a consultative exercise. Adherence to that type of process indicates our desire to work creatively with all partners in the health care system.

While the PMAC recognizes the right of any organization to develop unilaterally codes and guidelines of conduct for constituents, in today's health care environment the system's partners must relate to one another, in one way or another. Accordingly, excluding key stakeholders during the development of policy that affects them indicates a rather archaic philosophy that has no relevance in today's environment.

Further, attempting to restrict unduly the access of physicians-in-training to an industry whose medicines and supporting information will play a critical role throughout their careers will neither enhance their knowledge nor contribute to the health of their patients, either now or in the future. Physicians-in-training must certainly continue to benefit from the wisdom and experience of their peers, but I would assume that having entered a residency program, their level of intelligence is great enough to allow them to make an informed decision.

I am pleased with Dr. Guyatt's quotation of an industry official who "sincerely hoped that the guidelines of McMaster can be brought much closer to the Canadian Medical

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Association guidelines both in spirit and form." Let me assure him that had the PMAC been consulted in the development of his document, we would have expressed precisely such a hope. The CMA's own policy summary, Physicians and the Pharmaceutical Industry [Update 1994] (*Can Med Assoc J* 1994: 256A–256C), is intended to apply to practising physicians as well as to those in training. While individual institutions must ensure that internal guidelines reflect their special circumstances and interests, it is surely reasonable to assume that such guidelines should also reflect standards common to the medical community at large.

Contrary to some of the innuendo contained in the article, the PMAC does not attempt to influence debate through threats or intimidation, or such irresponsible activity as "major reprisals" or "subtle reprisals." Indeed, I am astonished by the degree to which the article makes use of doubtful inferences and statements based on suspicion.

Consider this statement: "I *surmised* [my italics] that the activities of the senior industry official and the PMAC and the pressure that had been brought to bear . . . represented drug industry attempts to intimidate the faculty leadership."

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Or this one: "I *suggested* [my italics] industry representatives believed that by putting pressure on organizers of another program, they may indirectly influence policies of the postgraduate training programs."

Such statements of conjecture indicate a high degree of irresponsibility and only serve to diminish the level of professionalism in the interaction between the academic medical community and the pharmaceutical industry.

PMAC members provide substantial funding for continuing medical education programs and are key supporters of research and development at Canadian universities, hospitals and medical research facilities. We did not achieve this distinction through threats of "reprisals" or "withholding funding," but rather by trying to work collaboratively with our partners to meet the current and future social and economic needs of society.

Dr. Guyatt's article concludes by cautioning readers to resist intimidation, and states that bluffs will evaporate if they are called. Is he so unconvinced about his colleagues' ability to make informed decisions that he feels the need to warn them about possible compromises to their "ability to make ethical stands in various areas"? ■

Concours de dissertation en éthique médicale Logie Date limite : le 1er juin 1994

Le *JAMC* parraine de nouveau le Concours de dissertation en éthique médicale Logie ouvert aux étudiants de premier cycle en médecine des universités canadiennes. Cette année, les prix sont de 1 000 $ pour le lauréat, de 750 $ pour la deuxième place et de 500 $ pour la troisième, mais le *JAMC* se réserve le droit de suspendre certains prix ou la totalité de ceux-ci si la qualité des textes est jugée insuffisante. Le jury est formé d'un groupe de rédacteurs de l'équipe scientifique et de celle des informations générales du *JAMC* qui choisiront les lauréats en fonction du contenu, du style de rédaction et de la présentation des manuscrits. Les dissertations doivent être dactylographiées à double interligne et compter au maximum 2 500 mots, y compris les références. Les citations et les références doivent être conformes aux «Exigences uniformes pour les manuscrits présentés aux revues biomédicales» (voir *J. Assoc. Méd. Can.* 1994; 150: 159–167). Les auteurs choisis devront remettre leur dissertation sur une disquette. Les dissertations choisies seront remaniées quant à la longueur et à la clarté, et conformément au style de la revue. Les auteurs recevront une copie remaniée avant la publication. Veuillez faire parvenir vos textes à l'attention du Rédacteur aux informations générales, *JAMC*, CP 8650, Ottawa (Ont.) K1B 0G8.