tions of physician mobility are a disservice to the public interest, what sort of service do we offer the public if young students may progress through heavily subsidized undergraduate life sciences and medical education as well as paid postgraduate training, leading to an internationally recognized level of certification, only to set up practice unfettered outside the country that supported them throughout their training?

As in most arguments, the opposing views are not black or white but grey. Governments have not restricted mobility to spite physicians or to destroy the free flow of ideas, people and standards but, in good faith for the most part, to manage and plan for the needs of Canadians. Similarly, not all young physicians leave residency training and head south to the greener pastures of the United States. Many, although apparently not enough, show a strong sense of gratitude to and responsibility for the system in which they received their training. Alongside Smith's challenge to "give us ideas" I would add the need to find solutions that take the shrinking public purse into account and do not advocate an immediate need for private-sector revenue. Surely physicians and policy makers can find a way to work together to forge a solution that truly serves the public interest.

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New meanings for old quotation

The celebrations of the 50th anniversary of Victory in Europe Day brought to mind the famous quotation from former British Prime Minister Winston Churchill: "Never in the field of human conflict was so much owed by so many to so few." I would like to paraphrase this quotation to illustrate two modern-day medical issues:

- the clinician's view of the public's preoccupation with health and the pressure on physicians to diagnose and treat regardless of the appropriateness of the situation: "Never in the field of medicine was so much spent by so many to improve the statistics by so few."
- the clinician's response to the increasing pressure to avoid litigation: "Never in the field of medicine was so much spent by so many to avoid the hassles of so few."

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Interaction between physicians and the pharmaceutical industry

The three-step physician–pharmaceutical-industry tango has developed a new movement with the open dissension in the academic ranks ("Physicians and the pharmaceutical industry: a cautionary tale," by Dr. Gordon Guyatt, *Can Med Assoc J* 1994; 150: 951–953 and "Faculties of health sciences and the pharmaceutical industry: an effective partnership," by Dr. Jay B. Forrest, *Can Med Assoc J* 1994; 151: 1320–1322).

As a physician who depends on both old and new drugs to treat my patients, I am perplexed as to what is driving this increasing hostility toward the innovative pharmaceutical companies. Have the practices of the pharmaceutical industry changed? Have our clinical needs changed? Or has it become politically and ethically correct to criticize the pharmaceutical industry? As Forrest points out, the traditional relationship of cooperation and respect has become one of suspicion and, in many cases, hostility.

The industry is not without fault. Much of its promotional and marketing material, particularly advertising in medical journals, is distasteful, ineffective and a waste of money. The advertising and marketing agencies that create the advertisements have a vested interest in producing large, colourful and expensive advertisements. The industry has failed to work with these agencies to ensure that advertisements are relevant, effective and informative. The industry can also be criticized for its failure to understand physicians' needs and clinical perspectives and to develop effective and appropriate communications.

But the continuing criticism of the interaction between physicians and the pharmaceutical industry is a disservice to physicians, the industry and our patients. Physicians and the public are doubting the benefits of many pharmaceutical agents, and many of the newer agents are being discredited as ineffective, expensive and not of any clinical benefit. Such a perception is incorrect and clinically dangerous. Physicians should compare the drugs they studied as medical students to those available today. None of the medications I use as first-line therapy in allergy and respiratory medicine were available when I was a student. Would any clinician suggest that we could provide adequate patient care without inhaled corticosteroids, angiotensin-converting-enzyme inhibitors, ß-adrenergic blocking agents, histamine (H_2)-receptor antagonists, acyclovir, current antineoplastic agents and many of the newer antibiotics?

Much of the controversy concerns the implication that new drugs increase medical costs; in fact, there is considerable evidence to the contrary. The introduction of cimetidine (Tagamet) reduced the cost of ulcer therapy from $721 to $220 per day. Although the cost of drug therapy increased from $10 to $66 per day, hospital costs decreased from $602 to

$97 per day, and physician-related costs fell from $109 to $57. Hence, the introduction of cimetidine saved the Canadian health care system $77 million in 1989 alone.[1] Brand-name ß-adrenergic blocking agents resulted in a net annual saving estimated to range from $1.6 to $3 billion by preventing second heart attacks and an estimated $113 to $236 million a year by preventing or delaying surgery.[2] A reduction in hospital care costs in Britain of £447 million from 1957 to 1982 has been attributed to the introduction of new drugs.[3]

New drugs such as sumatriptan for migraine or inhaled corticosteroids for asthma have allowed patients to regain normal lives, to spend less time in hospital and to take less time off work or school. Such therapies are researched and developed by the industry at a considerable cost long before they reach the market. Indeed, according to the September 1994 issue of *Report on Business Magazine*, 21 of the 100 Canadian companies that spent the most on research and development in 1993 were from the pharmaceutical industry.

I take issue with Guyatt's contention that the medical literature is an effective method to transmit information about drug efficacy to busy physicians. Perhaps he and his colleagues have time to review all the literature, but most physicians do not. Furthermore, most drug trials are published in specialized journals that are not on most practitioners' reading lists. Personal contact between physicians and pharmaceutical representatives is an effective way to exchange information, and, in most cases, the information is presented professionally and ethically. Is it not the responsibility of the teachers and mentors of medical students to provide future physicians with the knowledge to allow them to evaluate the information provided by the pharmaceutical representatives about drugs? Controlling the transmission of pharmaceutical information by restricting contact is a serious form of censorship that has no place in a free and responsible society.

It surprises me that so many physicians responsible for teaching our medical students and young doctors should propose such restrictive guidelines as those adopted by the CMA[4] and McMaster University. These guidelines and the related discussions demonstrate a disrespect for and lack of trust in the intelligence and integrity of physicians. Those who present such policies appear to believe that physicians are incapable of assessing information accurately and making appropriate decisions.

Should we not work with the industry to help our pharmaceutical colleagues to interact with physicians in order to transmit information on new drug therapies effectively and accurately, rather than advocate a policy of isolation?

I suggest that those physicians who feel compelled to criticize the industry should take a step back and ask themselves whether they have a hidden or a vested interest, or whether they are caught up in political or ethical correctness. Could they be using the industry as a means to make their reputation or achieve personal advantage, or is the issue one of control? In fact, physicians are losing control over their patients' drug therapies.

There is an increasing interest by regulatory agencies in switching many drugs from prescription to over-the-counter (OTC) status as a cost-saving measure, both reducing physician visits and cutting prescription drug costs. This transfer to OTC therapy shifts the responsibility for drug therapy from physicians to patients and pharmacists.[5] The drug industry can advertise OTC products directly to consumers, which, I suspect, will be the opposite result of what Guyatt, and his colleagues critical of the industry, would advocate.

I implore all physicians and the pharmaceutical industry to work together, to return to the basic goals of improving patient care and function and to make the practice of medicine more effective and enjoyable. We can only achieve these goals if we are committed to effective communication and cooperation.

As Robert Kalina, publisher of the *Canadian Journal of Clinical Pharmacology*, wrote in the inaugural issue, "The success of modern medicine has been largely due to innovative drug therapies."[6]

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