any company if the grant was contingent on inclusion of materials specified by that company." Discussion was then undertaken with residents "whose criticisms" (plural) "led to a proposal" (singular) "that educational materials from the industry be submitted to the director of each clinical teaching unit." The article goes on to say that "the residents in general supported the guidelines with this modification." This seems to show that the residents were not completely happy with the process, and I am certain that all of them felt pressured to bring their attitudes in line with those of their teacher–evaluators. This is one inevitable result of a teacher–student relationship. It is interesting that Guyatt's colleagues required more modifications before the document was adopted.

I place no value on the straw poll of pharmaceutical industry representatives' views on the guidelines. Only 10 of the 24 respondents solicited found the presentation of the industry fair or very fair. It is safe to assume that the nonrespondents (some of whom I have communicated with) found the process "unhelpful or destructive."

The thesis of Guyatt's subsequent article, "Academic medicine and the pharmaceutical industry: a cautionary tale" (*Can Med Assoc J* 1994; 150: 951–953), is that he considers withdrawal of industry funding a threat. Why should pharmaceutical companies be obligated to fund education, research or other programs? It is surprising that the entire McMaster University Department of Medicine was not blacklisted in regard to pharmaceutical company support because it sanctioned the attitudes of Guyatt and colleagues. If refusing to provide money constitutes a threat, then I have been threatened by some granting agencies as well.

As an observer for 10 of the 15 years during which pharmaceutical companies have supposedly increased the intensity of their marketing, I agree with Judy A. Erola, president of the Pharmaceutical Manufacturers Association of Canada, that the opposite is true ("We need dialogue and discussion, not a new Berlin Wall" *Can Med Assoc J* 150: 955–956). The pharmaceutical representatives who call on me (many of whom also call on colleagues at McMaster University) are, by and large, knowledgeable, professional and as unbiased as they can be in their professional capacity. They keep the good of the patients in mind and often ask me when their product would be unsuitable so that they do not detail it to other physicians irresponsibly. Almost all continuing medical education courses outside of academic centres (and some within) are held through the generosity of pharmaceutical company sponsorship. Physicians know a biased speaker when they hear one, especially if they have discussed detailing during their training. Drs. Greenwald, Stopps and Danby were correct in advocating constructive, cooperative relationships with the manufacturers of our essential therapeutics.

W. David Colby, MSc, MD, FRCPC
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[Dr. Guyatt responds:]

Dr. Colby's letter has an angry, scandalized tone. His response reflects the intense feelings generated by the debate over the appropriate role of the pharmaceutical industry in residency training.

The sources of this intensity include physicians' ambivalence about accepting gifts from the industry and about the appropriate sources of information to guide their prescribing practices as well as the challenge to powerful commercial interests.

Colby perceives our approach to the residents as extremely patronizing. The key to our approach was to let them know that, if they did not want a policy, there would not be a policy, and that, if they did not like the draft policy, it would be changed. Colby correctly points out that there is a power imbalance between residents and faculty, and that not all residents felt happy with the guidelines. The power imbalance is an inevitable aspect of relationships between supervisors and trainees. If that imbalance implies that our approach to the residents was patronizing, then one must conclude that all interactions between faculty and residents are patronizing by nature. As for the fact that the residents did not all agree, the exchange of letters in *CMAJ* attests to the polarity of opinions on the appropriate role of the pharmaceutical industry in resident education. We set, and achieved, the goal of reaching a majority opinion with which most residents were comfortable.

Colby presents an interesting view of the industry in stating that "I find it surprising that the entire McMaster University Department of Medicine was not blacklisted . . . because it sanctioned the attitudes of Guyatt and colleagues." He implies that industry gift-giving is a form of promotional activity, that policies that deny industry the opportunity to give gifts to physicians-in-training threaten industry interests and that the industry is entitled to withdraw support if its interests are threatened in this way. If the industry representative who threatened withdrawal of funding in response to our policy had been willing to take this position publicly, the drama would have been played out very differently.

Colby asks, "Why should pharmaceutical companies be obligated to fund education, research or other programs?" They should not. However, the industry is unwilling to join Colby in defending its gift-giving as a form of promotional activity and its entitlement to withdraw support when its interests are challenged.

Why? If it did so, both parties in the interaction would have to acknowledge that physicians are on the take.

The industry prefers to present its gift-giving as philanthropy, implying that gifts do not depend on particular behaviour by the recipients. This allows physicians to carry on the "three-step dance" that Dr. Robert F. Woollard described in a recent editorial ("Addressing the pharmaceutical industry's influence on professional behaviour" *Can Med Assoc J* 1993; 149: 403–404). 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. The industry's stance that its gift-giving is philanthropic is inconsistent with the view that Colby defends: that if one does not behave oneself one should not expect to be a beneficiary. As a result, when individual industry representatives make explicit the link between gifts and physician behaviour, the public (which has accepted the myth that there are no such links) sees this as a scandal.

Physicians should refuse industry gifts and should look to sources other than the industry for guides to drug prescribing. In responsible training programs these values will be inculcated in the trainees.

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Physicians and Nurse Practitioners

I read with interest the letter from Dr. Nibhas C. De and the reply from editor-in-chief Bruce P. Squires (*Can Med Assoc J* 1995; 152: 11–12) concerning the front-page photo of the July 1, 1994, issue, which showed two people, one carrying a mug with the slogan "My doctor is a nurse practitioner."

I certainly agree with De that the photo gave the impression that *CMAJ* believes that a nurse practitioner is the equivalent of a physician.

Squires' reply, that the article on nurse practitioners was simply meant "to point out the situation that now exists" and that all editorial matter in *CMAJ* represents the opinion of the authors and not necessarily that of CMA, misses the point.

It is not the article that is the issue but the front cover, which suggested that a physician and a nurse practitioner are interchangeable.

De made the point that many physicians seriously question to what extent our professional associations represent our interests.

Some person or persons on the staff of *CMAJ* chose or had photographed that particular image with its implicit and explicit messages. It is impossible to believe that the staff of a professional journal are unaware that what appears on the front cover carries a certain weight and, at the very least, suggests endorsement.

This means that *CMAJ* either supports the position endorsed by the photo, is unbelievably journalistically naive, is unaware of being under attack from all sides, no longer represents the profession's interests at any level (as De believes) or, horror of horrors, all of the above.

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[The *CMAJ* Cover Committee responds:]

The cover photo of *CMAJ* does not *endorse* anything. Its purpose is to attract the attention of the reader and evoke curiosity about the contents of the journal. Nurse practitioners are *not* doctors, nor did we intend to suggest that they are. However, some have interpreted the cover photo this way. To us, the message was that, with the team approach that is emerging in health care, a physician may choose, under certain circumstances, to be cared for by a nurse practitioner.

We appreciate the sensitivities and difficulties associated with the growing recognition of nurse practitioners. Eventually, perhaps, professional overlap can be considered something more than a cause for conflict. In the meantime, we regret any offence caused by the photo.

Patricia Huston, MD, MPH
Jill Rafuse
Co-chairs,
CMAJ Cover Committee

Under the Influence of the Pharmaceutical Industry? Kick the Habit

Dr. David Rapoport, who described his day under the influence of the pharmaceutical industry (*Can Med Assoc J* 1995; 152: 15), has my greatest sympathies. So does his family. From his morning coffee poured in a cup with a drug-company logo to his final waking moment watching an industry video, he exposes himself to industry propaganda.

Dr. Rapoport, if you are so concerned about your susceptibility to the industry's subliminal messages, here are some suggestions.

- Get a coffee mug that says "world's greatest Dad," not "I luv ACE inhibitors."
- At breakfast, read the morning paper, not a medical journal.
- Try some classical music or an old Beatles tape instead of drug-company audiotapes while shaving or driving.