Doctors and the pharmaceutical industry: time for a national policy?

Jennifer H Martin, Christopher Beer, Raymond G Morris and Matthew P Doogue

TO THE EDITOR: We share Millar's concerns about the conflicts of interest that influence the genesis and adoption of clinical guidelines[1] specifically, and the lack of independent assessment regarding information provided by the pharmaceutical industry generally. Iain Chalmers puts it succinctly:

> I do not blame industry for trying to get away with anything that is normally considered to be its primary purpose, which is to make profits and look after its shareholders' interests. It is our profession that has colluded in all of this and been prepared to go along with it — we are the people to blame because we need not have stood for it.[2]

We believe the reasons behind this acquiescence are complex, but worthy of discussion.

A strong and viable pharmaceutical industry is essential for clinical improvement. Similarly, clinical involvement in industry research is necessary. We would not debate either of these statements, but we are concerned about the failure of our profession to stand back and exercise careful scrutiny of data. Classic examples are thalidomide in the 1960s and, more recently, the cyclooxygenase-2 (COX-2) inhibitors, but many less dramatic examples can be

found, such as gatifloxacin or rosiglitazone. This failure on our part harms both patients and the standing of our profession. A recent article in this Journal suggested this failure of physician leadership may in part be due to the comfortable position we cultivate with industry,[3] relationships that go beyond the business transaction of providing independent medical advice for a consulting fee.

Further, the role of "key opinion leaders", cultivated by industry, is reinforced by criteria for hospital accreditation and university promotion, leading to disproportionate value being placed on service to company boards (which is often paid and of modest time commitment) compared with service on hospital, state and national regulatory and quality committees (which is usually time-consuming and unpaid). The presupposition in this discrepancy is that physicians on the company circuit are better physicians than those who are not.

We should all support the recommendations of Millar,[1] Olver and Haines,[3] and Van Der Weyden,[4] including those for true independence and transparency of guideline development and dissemination, strengthening ethical administrative structures and placing appropriate value on public service. Upskilling of clinicians in epidemiology and critical analysis is thus urgently needed so the incremental benefit and costs of new therapies can be objectively examined.

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1 Millar JA. Genesis of medical thromboprophylaxis guidelines in Australia: a need for transparency and standardisation in guideline development. *Med J Aust* 2009; 190: 446-450.
2 Royal College of Physicians. Innovating for health. Patients, physicians, the pharmaceutical industry and the NHS. Report of a Working Party. London: RCP, 2009: 4.
3 Olver IN, Haines IE. What changes are needed to the current direction and interpretation of clinical cancer research to meet the needs of the 21st century? *Med J Aust* 2009; 190: 74-77.
4 Van Der Weyden MB. Doctors and the pharmaceutical industry: time for a national policy [editorial]? *Med J Aust* 2009; 190: 407-408. ❑