By Dr Daphne Khoo

Ethics in Dealing with the Pharmaceutical Industry – Who Sets the Standards Anyway?

A few weeks ago I was sponsored by a pharmaceutical company to an overseas conference. Prior to departing, I was given a file with a detailed itinerary. The only noteworthy thing about this was that this itinerary largely resembled the programme of a conducted tour. A number of copies of this programme were given to other Singapore attendees – the actions were highly transparent. I spoke to one of my colleagues who generally deals with pharmaceutical companies more than I do and he said: "Oh, they're used to dealing with private … (a subspecialty that will remain unidentified)." Since I have often lectured my long-suffering staff, the pharmaceutical industry, the Endocrine and Metabolic Society of Singapore (while I was President) and have lobbied the Medical Board of the hospital in which I work about these practices, it was simply not possible to accept the hospitality offered. I asked the pharmaceutical representative why things had been done this way and she replied that private doctors sometimes wanted to know the social programme in advance before they would commit to accepting any sponsorship and so the preparations were required.

The links between medicine and the pharmaceutical industry are intricate and often symbiotic. It would probably not be an exaggeration to state that the attendance at scientific meetings and out-of-hospital CME activities would drop by some 80% to 90% in Singapore in the total absence of drug company support. With the exception of courses where degrees or diplomas are offered, doctors are largely used to their educational expenses being picked up by drug or device companies. A colleague once organised a CME event for which doctors were levied a charge of $10. A week before the event, only two doctors had registered. He decided to return the $10 to these two individuals and stated that the registration would be free. 400 doctors showed up. A few years ago, as President of the Endocrine and Metabolic Society of Singapore (EMSS), I proposed a change in the constitution to raise subscription fees from $10 (set in the 1970s) to $30 a year. There were protests from some members despite the fact that the cost of the dinner alone that we provide at the Annual General Meeting was far in excess of $30. Of course this subsidy was possible only because of extensive pharmaceutical support for EMSS activities.

Physicians worldwide have become heavily dependent on pharmaceutical companies to support educational programmes. Over the past few years, there has been much soul-searching about the appropriateness of these relationships. In 2002, the American Medical Association and the American College of Physicians introduced new guidelines governing physician-industry interactions. Leading journals such as the *New England Journal of Medicine, JAMA and BMJ* have featured numerous articles on the topic. A number of Academic Medical Centres including Yale in 2005 and Stanford in 2006 have introduced stringent guidelines governing relationships between faculty members and industry.

Why all the angst? Fundamentally the issue boils down to conflict of interests. Studies show that virtually all doctors receive some form of gift or payment from industry ranging from drug samples to honoraria or consultancies. Surveys in the US indicate that physicians generally feel that they themselves are not swayed by these practices but felt that the majority of their colleagues were. In a 2002 study reported in *JAMA* involving authors of North American and European clinical

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practice guidelines (CPG), 87% had links with industry (financial support, payment or equity). 7% thought that their own relationships with the pharmaceutical industry influenced the CPG recommendations while 19% thought that their co-authors' recommendations were influenced by these relationships.

It is no secret that industry targets those individuals likely to give the highest return on investment. In the private sector, this may mean individuals most likely to prescribe their product. In the public sector, this usually involves key opinion leaders including authors of CPGs, Presidents of societies, heads of departments as well as those individuals best placed to prescribe these drugs or introduce them into hospital formularies. In a *New York Times* article dated 21 March 2007, a former drug representative admitted that the industry essentially views physician-industry interactions as methods of manipulating doctors. This article arose from an analysis on records from Minnesota. Minnesota was the first of a small number of states in the US that now require drug makers to disclose payments to doctors. Records from that state indicated that the doctors most likely to receive funding from pharmaceutical companies were psychiatrists followed by internists, cardiologists, endocrinologists and neurologists. The implications are enormous because chronic diseases are expected to account for 75% of healthcare costs in the US. Increased drug expenses arising from these relationships could perhaps be justified if there was unequivocal evidence that clinical outcomes improve. However, at least in the context of diabetes, population-based studies such as NHANES III in the US and the data from the NHS suggest no significant improvement in HbA1c levels despite the numerous new diabetes drugs that have become available in recent years.

Back to my story. About two weeks after I returned, I received a call from a well-known reporter asking for confirmation that the described situation had arisen and whether she could have a copy of the file (which I had not kept). She asked if I thought the pharmaceutical company's actions were inappropriate. I explained their point of view. She next asked if the private specialists who had triggered this behaviour were to blame. I gave my opinion, which was that their actions were understandable.

In these matters, should the public and private sectors be held to different standards of behaviour and regulation? Cluster doctors are given conference leave to attend scientific meetings. Overseas conferences of this nature are coveted and rationed. Salaries during these periods are from public healthcare dollars and colleagues may be required to cover responsibilities. A private specialist's time, on the other hand, is largely his or her own and attending conferences may mean incurring financial losses.

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On the issue of prescriptions, public healthcare doctors generally feel no direct impact from drug or other patient expenses. They are often unaware of costs both to the patient and institution. The patients they treat tend to be less affluent and often have limited options in their care provider. In contrast, market forces in the private sector compel carefully considered financial decisions in drug prescription. My own opinion is that, the public sector, for the reasons cited, will always be held to different standards and levels of regulation and I accept this.

I acknowledge, however, that there are many who strongly disagree with me both within the medical community and the media. These individuals, including some prominent private specialists, argue that the same codes of appropriate conduct should be applicable profession-wide and that governance issues may in fact be even more vital in the private than the public sector. This is not meant to imply that private sector physicians are likely to be less ethical than their public counterparts. Many of the most highly respected doctors in the country are currently in private practice.

And so back to the original question – who should be responsible for setting these standards? Should the private sector remain largely unregulated? Should the public sector be held to higher standards? At the end of the day, if companies are one day forced to release into the public domain all records of physician-industry dealings, the question is whether the medical profession in Singapore will be able to stand up to the scrutiny. ■