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Aligning Aspirations and Realising Ambitions:

*the challenges of the new era of
engagement between experts
and the pharmaceutical industry*

By Emma D'Arcy



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European CME Forum: First Annual Meeting

A KeywordPharma **Conference Insights** review

by **Eugene Pozniak**

ThePharmYard product code kwp025

Published February 2009

ISBN-13 978-1-905676-24-8

An in-depth report from the First Annual Meeting of the European CME Forum organized by NetworkPharma and Siyemi Learning, held in London 4–5 November 2008.

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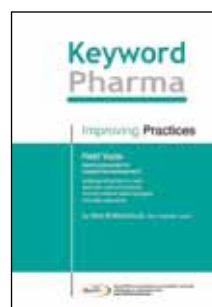
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Aligning Aspirations and Realising Ambitions:

the challenges of the new era of engagement between experts and the pharmaceutical industry

First published May 2009 by NetworkPharma Ltd

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A CIP catalogue record for this title is available from the British Library.

ISBN-13 978-1-905676-26-2

Managing Director: Peter Llewellyn; Editor: Chris Ross; Production/editorial: Gill Gummer; Typesetting and artwork: Blenheim Colour

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Aligning Aspirations and Realising Ambitions:

the challenges of the new era of engagement between experts and the pharmaceutical industry

Emma D’Arcy

Executive summary

Interaction between the pharmaceutical industry and healthcare professionals has long been the subject of great scrutiny. Despite helping to produce significant advances in medical care, industry/physician collaboration still manages to evoke widespread criticism – from the media, right down to the grass roots of the medical profession; some journalists dismiss Key Opinion Leaders as being “drug representatives in disguise”, whereas many medical students regard the drug industry as a “necessary evil”. Recent calls for a “comprehensive ban on all industry funding of continuing medical education” show that a tipping point is fast approaching. So what does the pharmaceutical industry need to do to improve the perception of industry/physician interaction and deliver true value to its most important customer group: the patient?

Progress depends on addressing a series of key challenges. The contribution that physician–pharmaceutical industry interactions (PPII) make to medical science needs to be assessed objectively. The industry must move away from the ‘command and control’ mentality with which it has often approached collaboration and instead encourage transparent engagement with all stakeholders, to align aspirations towards a shared goal – the improvement of human health. The adoption of web and multimedia technologies will undoubtedly enhance the sector’s ability to interact with its customers, and promises significant cost savings. At the same time, efforts need to be made to provide medical students with formal education about the pharmaceutical industry, to ensure tomorrow’s doctors don’t have today’s doubts and yesterday’s knowledge.

This *Expert Review* describes how the physician and the pharmaceutical professional need to adopt, activate and align aspirations to create physician/pharmaceutical harmony (– ‘pharmony’). It concludes by recommending that it is time to stop condemning PPII and to start considering better ways to serve the real ‘opinion leaders’ in the debate – patients.

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About the author



Emma D'Arcy is a communication strategist for the pharmaceutical and healthcare industry. With a heritage in medical communications, Emma has worked with pharmaceutical companies, the medical profession, research organisations and patient groups for 15 years, completing every type of communication project across almost all disease areas.

As an advocate for the pharmaceutical industry and a passionate believer that aligning the aspirations and ambitions of all stakeholders in healthcare is key to improving outcomes for patients, Emma is frequently invited to comment on the positive aspects of working with the pharmaceutical industry and to author articles about the industry. This has included running workshops, focus groups, advisory boards and global initiatives on topics as far-reaching and politically sensitive as lowering drug prices in Africa, establishing promotional literacy through the medical community and even promoting the importance of encouraging women to take up a career in science. In 2008, Emma co-founded myphid.com – the only professional networking site for the pharmaceutical industry and the medical community to work openly and transparently in a new era of engagement.

Emma oversees the annual ACTIVATE conference on industry–physician interactions, and was recently published/has publications pending in the *BMJ*, *PM Europe*, *PharmaFocus*, *PLoS* and the *Journal of Medical Marketing* about the challenges surrounding the value of interactions.

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Behave differently. Be a presence. Build your identity.

Aligning Aspirations and Realising Ambitions:

the challenges of the new era of engagement between experts and the pharmaceutical industry

From cooperation to condemnation

Why are we so enraged about physician–industry relationships?

- Healthcare consumes US\$2 trillion annually, 17% US GNP
- Profits from poisons
- Manipulate, influence, embellish
- Spin not science
- Money matters more than medicines
- Omnipotent power over presence
- 97% of residents are branded
- 94% of physicians interact with pharma
- Only 6 US medical schools are free of influence from industry
- \$14–19bn spent by industry ‘marketing’ to doctors per year
- 1 rep for every 9 doctors
- \$8–45k spent by industry per doctor per year

Table 1. Scepticism surrounds the intent of industry’s interactions with physicians.

The perception of appropriate interactions between doctors and pharma has changed dramatically. Considerable scepticism surrounds the intent of industry and there are concerns regarding the vulnerability of doctors in the relationship (Table 1). In 2008, this seemed to come to a head when journalists openly questioned whether medical experts working with industry – labelled Key Opinion Leaders (KOLs) – were “drug representatives in disguise”.¹ Stringent guidelines were introduced across medical schools, calls for publicly accessible registers of every interaction were echoed, and politicians established a crusade of ‘outing’ KOLs who had worked with industry and not fully disclosed their financial links. After several years of engagement about relationships, a slow-building defence of the value of these interactions has started to mount. In February

2009, the *BMJ* dedicated an issue to try to address positively the challenges of establishing, nourishing and sustaining relationships between industry and medical professionals.^{2–4} From cooperation to condemnation and now to a vision of collaboration, this is not a new debate, but it remains a fervent one.

Lambasting the ‘influence’ of industry over physicians is a startling contrast to the collegiate atmosphere that has produced so many advances in medical care in the past. Reluctant physicians have been thrust under ‘confessional’ spotlights – where any type of interaction is first condemned... and then considered, itemised and often discounted for being tarnished by the touch of industry involvement.⁵ It once denoted an impressive status of calibre if, as a research or academic physician, you partnered with industry and, reciprocally, sponsors were named in appreciative honour. The alliance was one of respectful mutuality to search for scientific causes and cures.

The environment needs to evolve to return to a hybrid of coalescence, with the shared goal of improving human health

Today, the nature, depth and consequences of this alliance is one of the most inflammatory issues in healthcare. Impassioned views are polarised from puritanical demands (physicians pledge no interactions with industry) through to pleas for realism (collaborations being essential to scientific advances). There is equanimity in each argument:

- financial gains from relationships might influence prescribing habits and reinforce a culture of entitlement⁶ (i.e. I deserve/I expect/I demand...)
- ethical issues are allowed to conflate a natural commercial symbiosis, which ultimately benefits patients through the production of new/improved compounds.⁷

The only agreement is that the environment needs to evolve to return to a hybrid of coalescence, with the shared goal of improving human health.

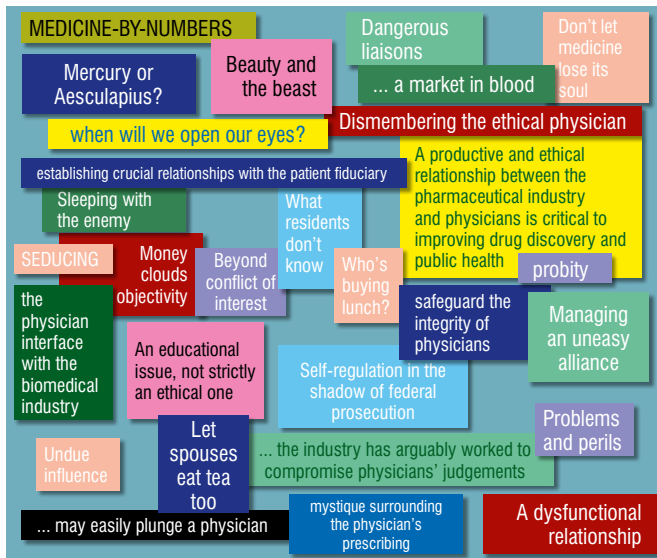


Fig. 1. The headlines and hysteria that position industry–physician relationships as negative.

The challenges

Cauterising the criticism: more guidelines and governance are not the solution

At present, increasingly stringent guidelines have been introduced across Europe, which reflect the more severe situations in the USA where, in some states, the ‘Sunshine Act’ has been adopted – reporting the volume and type of interactions paid to physicians in connection with marketing activities.⁸ Industry is criticised for the amount of money it spends on nourishing relationships with KOLs (estimated in the USA at \$8–14k per doctor per year)⁶ and doctors are cornered into making multiple conflict of interest statements about who they work with; little, if any, information is communicated about the altruistic or medical benefits of such collaborations.⁷

The nature and consequences of the relationships between physicians and pharma are regularly debated in both the specialist and public media. A cursory review of the wording used in different media is given in Figure 1 to highlight the ‘victim–persecutor–rescuer’ drama triangle that has developed, and is based on questionable ‘evidence’ that interactions or ‘entanglements’ are bad, that pharma is bad and that physicians are easy prey. Amidst the diatribe, we can’t ignore the fact that prestigious research from pharma, and from affiliations with pharma, provides valuable medical products, and that longevity and life quality increase thanks to them. Furthermore, a free society permits people to ‘promote’ beliefs – even to promote them hyperbolically. However, anti-relationship ‘facts’ so frequently quoted provide little substantiation that overall the ‘entanglements’ referred to are unhealthy. Thanks to KOLs and relationships with them, paid-for innovation reaches patients.

The recent call for a “comprehensive ban on all industry funding of continuing medical education” in the USA and

through several leading medical publishers⁹ indirectly labels all industry professionals devious and all medical professionals inducible. Hysteria notwithstanding, the issue is not selflessness but quality of content. If there truly is evidence that all company-sponsored education is a perversion of education then we should consider that calmly and fairly. Ultimately, we must make sure that ethical issues or professional complications do not hinder the production of new or improved treatments that would benefit patients.¹⁰

We can't ignore the fact that prestigious research from pharma, and from affiliations with pharma, provides valuable medical products

The key questions and challenges are:

1. what value do these physician–pharmaceutical industry interactions (PPII) give to benefit medical science and patient care?
2. what key transitions in thinking need to prompt everyday changes in relationship management?
3. what are the everyday improvements and new methodologies that will underpin future interactions?
4. how are companies striving today to achieve a better sense of alignment and transparency surrounding the nature of their interactions for tomorrow?
5. how will tomorrow’s doctors and pharmaceutical professionals engage and interact as a result of the changes we are trying to effect today?

Challenge 1

Recognising the importance of aligning aspirations and realising ambitions

Pharma and medical professionals are recognising that responsible leadership is no longer about influencing opinion but is instead about aligning aspirations and realising ambitions.¹¹ Doctors want to champion patient needs and pharma wants to safeguard a positive presence in healthcare, committed to addressing these needs.

A point on which all agree is that both pharma and healthcare professionals need to focus on the shared goal of improving human health. We have lost sight of shared aspirations between medical and pharmaceutical professionals. It is in both parties’ interests to ensure that pharmaceutical products are safe, effective and useful, and it is not credible to imply that healthcare professionals are easy victims of an industry that is readily able to fool them. Many physicians find it condescending that they could be viewed as being malleable to ‘marketing ploys’ and unable to conduct an ethical exchange with industry.

The popular media is keen to publish stories about drugs found to be unsafe, doctors who have succumbed to financial incentives and reports that negative data have been withheld. This no doubt fuels fears that interactions with industry erode medical professionalism. Yet there are numerous examples of incidences in which industry awards grants for scientific meetings that are important to the research community or sponsors clinical projects without an expectation that promotional information will be included or used. However, this type of news is not considered very newsworthy. Pharmaceutical professionals are often disappointed that their commendable efforts to improve health and expand treatment options for patients go relatively unnoticed.

Many physicians find it condescending that they could be viewed as being malleable to 'marketing ploys' and unable to conduct an ethical exchange with industry

It is in industry's interest to research, develop and produce drugs that help healthcare professionals excel. The industry must achieve this within a highly regulated environment in which government, trade associations, professional society and individual company codes of practice are all in place to protect scientific values and medical integrity. Medical innovation may be hindered if we further limit the industry from interacting with experts. Medical professionals and industry researchers may find it equally frustrating if this limits their professional aspirations.

Pharma is often held responsible for the rising costs of healthcare. Companies are rewarded for the risks taken to develop products when a successful treatment reaches the market. Yet it is easy to ignore that products developed within pharma have consistently delivered improvements in human health for the past three decades. As Thomas Stossell, Professor of Medicine at Harvard, describes, "Today's much more effective, innovative, and safe medicine resulted almost entirely from technologies developed by private companies."⁷

It is in industry's interest to research, develop and produce drugs that help healthcare professionals excel

At worst, industry capitalises on our desire to live longer, healthier lives. As such, it is a victim of its own success in meeting our desires. When industry, physicians and academia collaborate, the proven most likely result is expediency in producing new treatments. The first step to recover the value of PPII is to accept that both parties need to assume accountability for the transparency and outcomes of their collaborations.

Challenge 2

Key transitions in perception: from position to presence and activity to alignment

Industry has, on occasion, approached its collaborations with a 'command and control' mentality that does not sit comfortably with the medical profession or the public. A transition in thinking needs to occur to restore faith in the necessity to interact. Instead, industry will need to 'engage with and encourage' many different types of medical and healthcare expert in a better way of working in which all stakeholders accept responsibility for the public interpretation of their interactions.

Industry will need to 'engage with and encourage' many different types of medical and healthcare expert

As such, pharmaceutical and medical professionals are recognising that responsible leadership is no longer about influencing opinion, but is instead about transparent alignments. Having a 'collaborative presence' at certain points along the treatment-decision pathway is more powerful than influence because it reflects a sincerity of interaction.

Presence is the ability to inspire confidence and instil the belief that something proactive can be sought and achieved. It should be shared thinking that: physicians want to use their presence within the community and with the industry to assert and voice the needs of the patient; and that the industry wants to safeguard a positive presence in the field of healthcare that is committed to helping scientists and researchers to address patient needs. In parallel, and by aligning these aspirations, we will keep unravelling disease complexities and finding pharmaceutical solutions as treatment options to help solve them.

Responsible leadership is no longer about influencing opinion, but is instead about transparent alignments

It is likely that we will witness the creation of new types of practical and conceptual 'alignments' that will be adjudicated or harnessed by outside parties to secure their validity. It is predicted that these alignments will be categorised into science/research-based assignments, professional skills development, social proofing projects and educational topics, amongst others. Leading communication and consultancy companies are investing considerable research time to help their pharmaceutical clients adapt and adopt new models of working with experts through professional alignments.

Challenge 3

Making everyday improvements: acknowledging the value of the clinical-commercial interface and engaging transparently via ‘mutual’ technologies

One suggestion, to try to allay fears about influence and poor interactions, is to include more teaching of pharmacy and drug development within medical training and as part of continuing medical education (CME). The pharmaceutical industry claims that 35% of the estimated \$9–14bn it spends each year on pharmaceutical marketing goes towards educational support.¹² If pharma-sponsored CME is no longer allowed it may result in tomorrow’s doctors having to practise yesterday’s medicine.¹³

Recently, a qualitative year-long consultation was completed, comprising in-depth interviews with more than 50 key contributors to this debate (the author carried out the interviews with the sponsorship support of Adelphi Communications – a medical education company). This working group, called INTEGRITY (INternational Ethically-GoveRned Interactions and Trust body), was founded as a voluntary, non-profit-making, independent, multidisciplinary task force of therapy leaders, policymakers, ethicists and commercial communication experts to evaluate the benefits and difficulties of PPII.

The INTEGRITY group concluded that there are three distinct improvements that can be made easily without bombarding either party with more stringent regulations:

1. improving promotional literacy
2. adhering to ‘good relationship practice’ (GRP)
3. engaging authentically and transparently in an environment where all voices broadcast equally.

1. Improving promotional literacy – Industry and medical associations are currently working together to agree the content of programmes to improve promotional literacy among medics at under- and postgraduate levels. Key objectives will be to ensure that medical professionals:

- know how to disentangle commercial reasoning from clinical applicability
- can adequately judge the methodological qualities of clinical trials
- understand comparative outcome measures used in clinical trials
- are able to eliminate emotive and authoritative distortion to facilitate subjective assessment of data.

2. Adhering to GRP – Despite many sets of guidelines existing worldwide, and recognition that there are already at least four hierarchical boundaries to protect scientific values and medical integrity while preserving

innovation,¹⁴ research by the INTEGRITY initiative showed that some doctors do not consult them regularly as part of everyday practice. Many doctors express the view that most guidelines focus too heavily on matters of hospitality, which they believe misrepresents their efforts to remain ethical and appropriate in their interactions with industry. There is also concern that guidelines written by industry are used in political competition between companies. In fact, many doctors prefer to adhere to their own personal code of integrity about interactions with industry. This is likely to change as legislation tightens to further restrict and regulate the actions of medical professionals. A guide to GRP has been drafted for discussion and validation (Table 2).

Answering three simple questions before commencing an alignment will protect the integrity of each party

- Does the interaction, or series of interactions, encourage scientific exchange of information or lead to an enhanced skill that will ultimately benefit the care of people living with disease and/or enhance the knowledge of those aspiring to help people to overcome, manage or better understand a medical condition?
- Does this interaction require a minimal level of promotional literacy and contextual arbitration to guarantee it is an interaction of merit – be that in the form of a discussion, debate, exchange of experience, education/knowledge update, personal opinion or release of specific product information?
- Is there any possibility that this interaction could be viewed as an inappropriate activity which could damage the perception of any of the participants’ integrity and intentions to engage in a positive collaboration that furthers medical scientific understanding?

Table 2. Good relationship practice.

3. Engaging authentically and transparently in an environment where all voices broadcast equally

There is a public expectation that industry will reduce the amount of money spent on activities to engage with the medical profession. This, together with legal limits on financial exchanges and a demand for more transparent associations, will accelerate the adoption of more web and multimedia technologies that have public/extended access for review and approval.

Despite many sets of guidelines existing worldwide, research by the INTEGRITY initiative showed that some doctors do not consult them regularly as part of everyday practice

Doctors have become increasingly dismissive of the ‘product-biased’ sales representative visit (>30% are regularly cancelled and >70% of meetings last

<5 minutes) and are fast becoming ardent fans of the use and applicability of user-generated forms of interactions, such as professional web-based networks, blogging, podcasts and discussion forums. It is estimated that 360 million people in the USA searched online for health information in 2006 and that doctors spend up to 2 hours each day on blogs, networking sites or e-learning applications. This is driven by a sense of community and honesty as well as the constant availability, immediacy and transparency that such tools provide. Online facilities and learning in this way also cut out the 'middle man' and the persuasive potential of 'food, flattery and friendship' to affect the clinical interpretation of information – the doctor is to be impressed by the data not the dynamic individual sitting in front of the desk. Reciprocally, e-networks and tools provide a 'politeness filter' in which the industry receives a brutal appraisal of what the physician truly thinks of products/the company/the approach that is not sugar-coated because the doctor is trying to be diplomatic. Launched in 2006, Sermo.com, for example, is a physician-only professional network that claims to help doctors 'know more, know sooner'.

- International hub for best-working practice between pharma and healthcare professionals
- Only global forum where all stakeholders in medical science have an equal voice
- Assembles all types of committed healthcare professionals to make innovative alignments with their peers
- Allows personal goals and passions about medical science to be shared responsibly
- Activates collective, and personal, clinical and commercial aspirations

Table 3. www.myphid.com (MY physician/PHarmaceutical IDentity) – the international hub for good relationship practices.

As with all innovations, however, it takes several attempts to iron-out wrinkles; although Sermo boasts affiliation with the American Medical Association, critics are concerned that by cutting out the opportunity for industry to engage on the site, the scope for authentic dialogue is cauterised, which may be a huge failing in terms of the accuracy of product information that is debated and the chance for professionals to align transparently. Physicians and industry have both expressed a desire for the communication conduit to be widened rather than narrowed and are very concerned that unsubstantiated 'anecdotes' do not usurp clinical findings. Furthermore, ambiguity remains about where the legal accountability resides if product information is discussed without the manufacturer present, if confidential patient data are reviewed with a potential 'global' audience or if poor clinical practices result from opinion rather than evidence. There are grey areas and blind spots to resolve. Accordingly, second-generation networking models and e-learning tools are in development to bypass these problems and offer better solutions to the overall communication crisis. www.myphid.com,

for example, is the only physician and pharma hub that invites all healthcare stakeholders to broadcast, and has progressed the Sermo model of engagement to a higher level. This has potential for profound and dynamic changes in the inputs, outputs and public perceptions of PPII (Table 3).

Clearly, web 2.0 tools are helping doctors and the public to interact more readily and engage in ways that should prove useful in the longer term. This is not to say that we will see the eradication of traditional types of interactions, such as advisory boards, the co-publication of articles for the medical literature or sponsored conference activities, but e-media learning technologies are more than a passing phase and while most of industry is watching and waiting before immersing itself in these environments, physicians are already in them and asking industry to join them. In taking the plunge, pharma needs to ask itself, therefore, if it can jump from a 'command and control' method of interaction to one where instead it seeks to 'engage and encourage'. Certainly the medical community is waiting and watching pharma to see if it is brave enough to make the leap.

Challenge 4

Motivating companies to continue to drive internal changes to improve external relationships

Pharma and the medical–scientific community are keen to address these challenges and make the necessary moves to improve interactions. This is evident from the cacophony of activity and debate about the issues, including the increased frequency of articles in the medical literature, the rising popularity of lobbying groups for/against PPII and the magnetism of key conferences, including the ACTIVATE-09 conference, which is the only event with a highly proactive agenda to improve and develop interactions (Table 4) (see www.myphid.com for more information).

Pharma and the medical–scientific community are keen to make the necessary moves to improve interactions

The industry is determined to defend the ethics and principles that underpin the ways it interacts with external experts. A commonality across large, small and specialist companies is that the criticism of how they 'influence' the medical profession is both unjustified and unsubstantiated. The successes of the relationship are rarely celebrated and the manner in which industry strives to protect and respect interactions goes unnoticed. Gerry Thompson (Marketing Director, EMEA, Stiefel) explains that "our vision is to be the world's most valued and respected dermatology-focused specialty pharmaceutical company. We are rigorous beyond

consumer standards and, as a privately owned company, we have family values that inculcate how we interact with experts and how we motivate ourselves internally, be that through adherence to formal compliance requirements or simply a desire to understand, listen to and give value to our customers' needs."

Being part of the new era of engagement

- Translating together: aligning clinical and commercial aspirations to further medical science and improve outcomes for patients
- Establishing trust and belief in a collaborative culture
- Building alignments from an educated perspective
- Communicating the value of authentic interactions
- Activating change to produce outcomes

One day. One focus. One outcome

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Table 4. Aims of ACTIVATE-09.

Like Stiefel, Copenhagen-based Lundbeck Ltd is yet to instruct a formal 'KOL management system', but is keen to make sure it promotes an environment that is synergistic with, and sympathetic to, a sense of reciprocity in the shared goals of industry and clinicians to find therapeutic solutions. Jeff Taylor (Professional Relations Manager, Lundbeck UK & Head of Operations, Lundbeck Institute UK) knows that the visibility of industry's involvement in altruistic projects is prone to scepticism, but cites the Lundbeck Institute UK as one of many examples where "the medical community was initially cautious but now esteemed scientists have openly voiced their appreciation and respect that Lundbeck have provided truly educational forums and seminars that have helped physicians to improve their clinical skills and enabled them to conduct critical appraisal of products." Industry exudes a very strong sense of corporate responsibility that permeates to its everyday interactions with doctors.

At medical device/consumer health company Allergan, Simon Freedman (Marketing Director, Europe, Africa, Middle East) sums up this relationship perfectly and contests Moynihan's opinion of leaders as puppets¹ by explaining, "policies, protocols and public policing of relationships aside, as long as you're asking, not demanding, a professional to do something they're comfortable with, then the relationship should be very straightforward. You give the data; ultimately it must be the expert's conclusions not the company's. We work in the most regulated industry and there is a lack of understanding amongst the public about just how strict those regulations are. Checks and balances are inherent and PPII are highly protected. Problems arise only when people try to push boundaries to communicate a specific message that is not supported by data – and usually, that is not tolerated by the medical or pharmaceutical professional. Of course there are guidelines for compensating the time that clinicians who are at the top of their game require to work with industry on projects, but fundamentally the relationship is transparent and serves several beneficial purposes for patients."

In a similar vein, Pfizer has developed a specific management approach that focuses on "living a shared agenda" with customers/KOLs and has clear lines of delineation. This is in addition to the company's standard operating procedure for customers, which has been in place for 3 years. The new management approach is considering formalising guidance on activities with individual experts. The intention of setting this precedent would be to strengthen both the company's integrity and the perceived integrity of the individual with whom they will work. Walter Sheloff [Customer Effectiveness Manager (KOLs) European Business Effectiveness, Pfizer] has been working to fine-tune management approaches around KOL interactions and is enthusiastic about how new policies can improve the perception of how industry conducts its relationships with experts. He describes how the company is urging its employees "not to view doctors as KOLs for Pfizer but as experts in their field that Pfizer can engage with and learn from". Pfizer immersed itself in a series of 'listening exercises' with key customers, recognising that the perceptions of how it wants to work with the medical community "needed to change, needed to be seen to change and need to be meaningful". Pfizer wants to "actively look for opportunities to work with experts, recognising that [they] are experts too and share patient-centred objectives".

Companies are starting to 'state their position' with regard to the efforts they make in relationships with the medical community. There are now public declarations about spending-caps and laudable moves towards transparency and accountability (both ethical and financial) of interactions. Most companies now have a distinct code of practice on how to interact, and stringent compliance procedures that are regularly audited. But an individual's conduct is also a living thing and, fundamentally, pharmaceutical professionals are driven by strong moral values that are fully embedded in their everyday practices. It is usually a pharmaceutical professional's aspiration to engage with external experts on a solid ethical footing and with a shared research focus. Alarmingly, these very individuals have become invisible in the determination by the media to position industry as negatively as possible. An appreciation and complementary change in perception by the medical publishers to give equal voice to communicate the positive aspects of alignment between both parties is essential. We must proactively praise individuals within the industry for their dedication to scientific endeavour.

Challenge 5

Looking further forward because tomorrow's doctors have today's doubts with yesterday's knowledge

As experienced practitioners start to defend the value of interactions, and as pharma begins to self-regulate relationships by imposing stricter protocols and payment caps for working with the community, we are now witnessing the anti-industry lobby switch attention

towards the way that companies approach medical students or newly qualified doctors.

Echoing the arguments about influence that have gone unopposed and are at best poorly substantiated, we are now beset by further histrionic headlines such as “Only 6 medical schools free of industry influence” in the USA and “Pharma is banned from Stanford”. If we stymie these interactions will there be a dearth in understanding among tomorrow’s medical experts about how the drug development pipeline works?

Two questions result from this current melange:

1. what do medical students actually believe about working with/for industry?
2. is the medical community (future and established) adequately trained to interact with industry (i.e. does it have an acceptable, working level of ‘promotional/development/commercial literacy’)?

Medical students are confused about how industry works and how to work with industry

– www.myphid.com assembled a small forum to survey the opinions of medical undergraduates, ranging from 1st to 5th years, at two prestigious medical schools in the UK. Although the numbers were too small to allow statistical significance to be inferred, the ‘research’ was insightful in determining grass-roots thoughts on the role of drugs companies and the challenges of relationships in the future.

Opinions among students regarding the role of industry and the contribution it makes to advances in medical science were highly polarised. Described as a “necessary evil”, many students admonished the prices that industry charges healthcare organisations compared with generic producers, and several articulated uneasiness about “unethical practices in the Third World”. Notably, when pressed, this subgroup struggled to cite actual examples of poor practices. Industry’s production of ‘me-too’ drugs was heavily criticised, as was the focus on “producing drugs for diseases of the wealthy”. In general, there appears to be some hostility towards making profit out of healthcare, but also an understanding that drugs wouldn’t get made without the innovation of companies. Interestingly, despite voicing what appeared to be ‘anti-industry media soundbites’ rather than facts, most of the group expressed sympathy for the poor regard and suspicion under which pharmaceutical professionals have to operate. One student summarised the dichotomous belief that is frequently expressed: “it’s difficult to be ethical if you have to make money”. In contrast, some of the group remained more realistic and positive in their observations, “they’re just like any other business; their shareholders are their priority, and within the current system and financial climate, looking after that isn’t immoral. We wouldn’t have as many drugs without them – universities just wouldn’t be able to compete.”

Asked to describe the operation and infrastructure of industry, most of the knowledge of the focus group

regarding the basic processes and phases of drug development was fairly accurate, although vagueness was apparent regarding details of clinical trial design – notably use of surrogate markers, different disease populations and translation into clinical significance. There was some awareness of the differences between companies, and the clinical areas they focus on, especially among those more exposed to promotions and clinical practice.

With regard to the manner in which industry interacts with students, “freebies and hospitality” were frequently mentioned. By the time students had reached their 5th year on the curriculum, all conveyed that they “had had their fair share of free pens and sandwiches”. The downturn in more promotional interactions has been recognised, however, and the receipt of more clinically useful equipment is appreciated. However, the commonly expressed view was that “you never get anything for free – it’s implicit they’re wanting something in return”. There was considerable distrust surrounding promotional “drug lunches”, and suspicion about where education ends and promotion begins, with a common feeling conveyed that “drugs reps don’t give a fair appraisal of the drug. They’ll not focus [sic] on side effects, fail to differentiate absolute and relative risk, and show statistics that compare efficacy to a placebo rather than its competitors.” Questioned as to whether any companies particularly stand out (negatively or positively) in the way they interact was met by a generalisation: “they’re all equally smarmy”.

Opinions were also divided on the ‘use’ of KOLs by industry and how the medical scientists they are expected to regard with reverence choose to interact with industry; some were very opposed: “it’s a betrayal of trust”. Others took a lighter view: “it’s potential employment!” Sponsored information leaflets and educational materials funded by industry are considered “useful”, but drug company websites are regarded with scepticism: “I’m sure that the information is right, it probably has to be, but I wouldn’t trust its balance. Independent sites like e-medicine and webMD I would trust more.”

Notably absent was a desire to work directly for the pharmaceutical industry. Asked if they knew of actual roles for medical professionals within the doors of industry, or if they had considered the benefits of working in the industry, students demonstrated an alarming ignorance and disturbing absence of opinion. Perceptions stem from media rhetoric rather than informed understanding of the aims, objectives or infrastructure of the pharmaceutical industry. Will ignorance continue to breed an unsubstantiated contempt?

Current levels of drug development and promotional literacy about the industry and how it communicates about products are insufficient at the student level

– The formal education of medical students about the pharmaceutical industry,

the drug development process and appropriate ways in which interactions should be conducted is recognised as being woefully inadequate. It is even difficult to ascertain the time given over to training about the pharmaceutical industry in medical school.

The formal education of medical students about the pharmaceutical industry, the drug development process and appropriate ways in which interactions should be conducted is woefully inadequate

This concern was replicated in this myphid forum – there was a universal response from those coming to the end of their course that medical curricula do not include formal education about appropriate interactions with industry. The majority of information about industry is gained during clinical placements, from peers who have had bad experiences with industry or from media outlets. Not surprisingly, therefore, the final-year students in the myphid forum felt that this basic on-the-job education in statistics, research methods and judging sources of funding leaves them exposed and unprepared regarding how to assess drugs accurately and how to establish good practices in their relationships with industry. Overall, students lack confidence in their interactions with industry, which serves to perpetuate their burgeoning sense of distrust towards industry.

Students were generally in favour of a more formal “promotional literacy” agenda (i.e. being able to comprehend how and why industry markets products as well as receiving better basic education about clinical pharmacology and the clinical trial culture and data it produces). But they questioned where any of this could be fitted into the already demanding medical curriculum. Some students admitted that much of their defensive wariness of pharma companies may be due to ignorance of their practices or the drug development environment – “cynicism is our only weapon”. Compounded by what was described as “the overwhelming competitiveness of drug sales reps, which means they can be a bit forceful”, most of the students in the forum felt that, despite the crowded curriculum, more and better training to increase development, commercial and promotional literacy was essential. They recognised that ultimately their ability to care for patients is compromised if they cannot engage knowledgeably with industry.

The mismatch between trainees’ preparation for interacting with pharma and their level of exposure has led to the introduction of new courses and codes of practice in a number of US medical schools, and is starting to be considered with increasing importance in the UK. In February 2009, for example, the Royal College of Physicians (RCP) in the UK published recommendations from an 18-month-long Working Party they had convened to evaluate the benefits and

difficulties of interactions between the pharmaceutical industry, physicians, academia and the NHS. As part of multiple recommendations from this Working Party, there was a clear concern that good prescribing practice should be learned at medical school but that “traditional courses in clinical pharmacology and therapeutics have been squeezed in an evermore pressurised curriculum”.¹⁵ Coupling this with an error rate in prescribing that manifests alarmingly in the first few years after graduation, and the call for educational funding from industry to be culled, we are evidently at an impasse; we need to dramatically improve training about the development, delivery and prescription of pharmaceuticals, but we don’t trust that funding from the industry will be distributed appropriately. This failure of trust is a major obstacle that has led the RCP Working Party to state that “industry has a distinctive voice that students deserve to hear” and to recommend that a more collaborative culture between industry and physicians must be created.

This isn’t just a problem at the student level. A study, published in *Psychological Science in the Public Interest* in 2007, called many healthcare professionals “statistical illiterates”. The study found that a lack of understanding about statistics and efficacy/safety reporting resulted in misinterpretation about pharmaceutical products – either embellished understanding of benefits or over-concern about adverse effects that, in some cases, could have devastating consequences for patients.¹⁶

According to the study, “many doctors, patients, journalists, and politicians alike do not understand what health statistics mean”. It seems that improving the perceptions of industry’s intentions and increasing the ability to interpret drug development data is not a need that is solely limited to students. Medical schools and drug companies have their work cut out to ensure a basis for harmonious physician–pharma interactions in the future.

Conclusions

Ultimately, the physician and the pharmaceutical professional will need to adopt, activate and align aspirations to create the physician–pharmaceutical harmony – ‘pharmony’ – that patients and the public are anticipating. Pharmony will only be possible when all participants have an equal voice within a welcoming environment. It is time to stop condemning PPII and start considering better ways to collaborate to serve the real ‘opinion leaders’ in this debate – the patients.

More corporate social responsibility initiatives from industry, particularly in the Third World, may go some way to resolving some of the ethical reservations that people hold, as would greater transparency in marketing and promotions. What might also help would be making a more positive case for the progressive role of the drugs industry in promoting human health. It is important to acknowledge the reality that industry’s potential to create

new drugs cannot easily be matched by academia or government; pitching this in the right way could turn interaction with drugs companies from a “necessary evil” into a positive good. However, to what extent any of these measures can remove the media scepticism about interactions remains to be seen.

The future of interactions between industry and the medical community will be about openly aligning aspirations and ambitions

The rise in popularity of social networking amongst ‘younger doctors’ and medical students is making its voice heard, however, as a solution to more transparent interactions. Web 2.0 tools, which rely on ‘user-generated content’, should be part of the infrastructure to develop a more collaborative community. Loathe it or love it, the medical community of the future – the Facebook/Twitter/Bebo generation – will insist that the immediacy of blogs, podcasts and discussion boards alter the manner by which relationships are conducted. Become extinct or evolve; the future of interactions between industry and the medical community will be about openly aligning aspirations and ambitions.

A tipping point is fast approaching, therefore, to prompt a shift in how, why, where and when parties will interact. Furthermore, joint responsibility for interactions must ensue (i.e. it will not be acceptable that because industry is more likely to be penalised for inappropriate interactions then industry will bear the brunt of that responsibility). KOLs, like industry, will need to be clear and consistent about their relationships. The shift will see us evolving to a new environment of more authentic engagement in which all stakeholders in the relationship are willing to align professionally to realise their clinical and commercial aspirations. This requires a parallel shift in which we recognise that these relationships are not about ‘influencing KOLs’ but about encouraging commendable collaborations with all types of healthcare ‘Key Experts’ – pharmaceutical and medical alike. An honest interaction between Key Experts – where each recognises the importance of the other’s contribution – will be more powerful than trying to influence perceived positions of power between parties because it confirms that both sets of professionals are committed to improving outcomes for patients.

Remarkable scientific innovations will be translated into health gains via a cooperative academic, research and medical triumvirate. Headlines, bickering and utopian ideals aside, the public simply wants relationships that give results. It is time, therefore, to activate change in the relationship between the medical community and the pharmaceutical industry – recognising that all healthcare professionals have a voice in the debate because all healthcare professionals share the same desire: improving outcomes for patients through better treatment options.

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European CME Forum: First Annual Meeting

A KeywordPharma **Conference Insights** review
by **Eugene Pozniak**

ThePharmYard product code kwp025

Published February 2009

ISBN-13 978-1-905676-24-8

An in-depth report from the First Annual Meeting of the European CME Forum organized by NetworkPharma and Siyemi Learning, held in London 4–5 November 2008.

Executive Summary

The European landscape for continuing medical education (CME) is diverse and complex. The absence of a common framework across the region has led to individual countries developing their own national objectives and building a range of systems, each at differing stages of advancement. While similarities in approach exist, the key European markets demonstrate notable differences in both style and in how CME is being implemented. Nevertheless, a widespread appetite for collaboration and sharing best practice is driving European CME forward.

Despite such a fragmented and disparate environment, efforts to develop a recognised system for CME accreditation across Europe and to establish a harmonisation of credits and practices are progressing. Definitions of CME remain subjective and discussions continue as to whether it should just address levels of knowledge and competence, or go further and have a positive effect on clinical performance. Determining which activities actually constitute CME is similarly challenging: activities such as e-learning promise to provide the engine for CME in the future, whereas the accreditation of satellite symposia remains contentious. Meanwhile, traditional activities such as conferences and workshops continue to dominate.

In such an evolving climate, two central issues for CME development in Europe resonate loudly: the quality of programmes and the impact they have on clinical practice. Stakeholders remain determined to ensure that education is not only free from commercial bias but that it also promotes participation that leads to better clinical outcomes.

This Conference Insights report provides an in-depth review of the first annual meeting of the European CME Forum held in London, UK on 4–5 November 2008. It examines the development of CME activity across Europe, providing perspectives from the full range of stakeholders: healthcare professionals, medical societies, pharmaceutical companies, medical communications agencies and CME accreditation bodies. It explores the need to set quality standards in European CME, and to achieve harmonisation across the region. It shares implementation strategies and assesses how best to measure their success. It also looks at the critical aspect of funding, providing a basis for guidelines on how to manage conflicts of interest, avoid commercial bias and, crucially, raise standards. Clearly, maintaining a balanced relationship between healthcare professionals, CME organisations and the pharmaceutical industry remains pivotal to the future of CME.

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About the author

Eugene Pozniak is Programme Director of the European CME Forum and also Managing Director of Siyemi Learning, an independent European CME provider. He has worked in the medical sector for 20 years. Following a degree in chemistry, he initially worked across various functions in marketing and medical communications. Since 2000, he has been working exclusively in CME.

As well as managing CME-accredited meetings, Eugene developed the first pan-European CME-accredited e-learning (launched in 2002), national CME-accredited portals and has been working on European journal CME. In addition, he has developed a number of bespoke CME and 'non-CME-non-promotional' projects. Eugene has experience of CME across Europe, the USA, Asia Pacific and Latin America.

In 2006, Eugene founded Siyemi Learning, an independent provider of CME programmes and related services; he also supports the European CME-CPD Academy, an independent platform for accredited e-learning in Europe.

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Published by Palgrave Macmillan

ISSN: 1745-7904

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