Dermatologists and the Pharmaceutical Industry

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The relationship between the pharmaceutical industry and physicians is an enduring subject of interest for many people, one which potentially involves life and death decisions, large sums of money and powerful, specialized groups in society. The role of dermatologists in this game is relatively humble, but with the advent of the more costly new biological treatments the debate becomes more pertinent for us as well.

Health-care costs constitute a considerable financial burden on modern welfare societies. They are predominantly made up of salaries for staff and direct costs of treatment. In some cases the costs of medical treatment is significantly fluenced by high drug costs, while the drug costs are notoriously low in other specialities. Dermatology is generally a very inexpensive speciality, in spite of the large number of patients and the significant impact of skin diseases. It may be argued that the relative impact of skin diseases in economical terms is much larger than previously estimated, as patients with pure dermatological diseases are often otherwise healthy. An effective treatment therefore can restore them to complete health and thereby benefit not only patients but society as well. This is often in contrast to patients with e.g. chronic heart diseases who must often continue at lower level of physical functioning even after treatment.

The use of topical therapy may be one of the most cost-effective forms of therapy available. When dermatologists are criticised by other specialities for being the doctors who just prescribe topical cortico-steroids, this shows a great lack of understanding by some of our colleagues. The reason behind the popularity of topical corticosteroids is that they are close to being ideal drugs for treatment of disease: They are effective, easy to use, have a low potential for side-effects and are inexpensive. The total Danish market for topical treatment, including antifungals, corticosteroids and other drugs approved for topical use was 346 million Danish kronor (DKR) in 2003, and increase of less than 10% over the 1999 prices. This may be compared to a total Danish market for cardiovascular drugs of 2112 Million DKR, NSAIDs alone of 398 million or oral contraceptives of 215 million DKR (2003).

The relationship between doctors and the pharmaceutical industry is influenced by a number of factors. One important element is the social contract between physicians and society. This is particularly true in countries with predominantly state-funded medicine, such as the Nordic region where doctors' prescriptions influence de facto management of public funds to a much larger degree than in other countries. The physicians' contract with society forms the basis of the professional role and requires that each physician judiciously and faithfully makes the most effective use of the resources at their disposal for the benefit of the patients. Any factor which may influence this process and jeopardize the content of the social contract should be examined by all involved parties. The appeal of the topic, however, ranges beyond the narrow confines of state-subsidised medicine. A recent critical book by a previous editor of the New England Journal of Medicine has drawn attention to the dangers of the pharmaceutical industry as a corruptive force in medicine. It has been suggested that research funding provided by the pharmaceutical industry may be tainted by the inevitable and absolute needs of commercial interests. In consequence, some purists believe that only publicly-funded, independent pharmaceutical research should form the basis for treatment. On the other hand, the high levels of drug testing now required are largely based on the experience of the pharmaceutical industry, and legislative requirements

have grown to such proportions that the resources of an industry are necessary for the conduct of modern Good Clinical Practice trials.

In Denmark, this is echoed by an ongoing debate regarding a possible stronger regulation of contact between pharmaceutical industry and physicians, and the provision of state funding for clinical trials. The awareness of potential problems has already led to a significant degree of self-censorship in the industry, curtailing levels of promotion and marketing by enforcing greater focus on medical-scientific content. The topic is, however, open to debate, and the outcome is difficult to predict.

What may legitimately be said is that the patients, the dermatologists and the pharmaceutical industry have obvious and natural common interests. These interests can, of course, be corrupted by any one of the parties, but it need not be so, of which the fact that inappropriate behaviour rarely occurs is convincing evidence. A strong professional identity and code of ethics in all parties involved can prevent criticism of collaborative ventures. For dermatologists it is essential that all decisions are first and foremost taken with a view to help and protect patients. The strong common aims of developing and using the best drugs for the treatment of patients, have the potential to be a significant positive force in dermatology by providing a forum for sustained development and independence for all involved.

Relations with the Pharmaceutical Industry in Sweden

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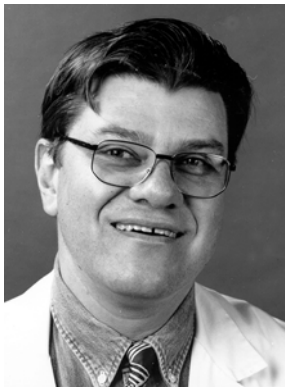

Every day, dermatologists at university hospitals receive more than 300 pages of new scientific information. For many years, doctors in Sweden have had a good relationship with the pharmaceutical industry. The education and information about their products have been of great value in clinical practise. However, a few doctors have not understood where the limits are in regard to contact with the industry. Compared to other sections of society, doctors have a closer collaboration with the industry and what we think is normal is considered bribery by others.

In any case, I think it is important to have rules concerning the cooperation with the pharmaceutical industry. New rules have been introduced in Sweden but the problem is that several county councils have their own rules, often more strict.

The general rules in Sweden say that a maximum of 50% of an educational trip may be paid for by industry. No personal invitations are allowed. Instead, the invitations should go to the head of the clinic who then selects the member of the staff that should come in question for the educational trip.

The more strict rules will have implications for our education but perhaps not as much as we thought. Most of the cost for education comes from allowing doctors to educate themselves during working hours instead of taking a vacation.

The last annual education meeting for private practitioners in Sweden was held without financial support from industry. I think the programme committee did a very good job.

It is extremely important that public employers set aside enough money for further education of doctors. There is a risk that this will be diminished. In view of the rapid expansion of knowledge it is important that enough resources are reserved for education. In other professions, such as e.g. airline pilots, enough money is set aside for education. Who would like to fly with an airline company that has decreased education for pilots?