Build bridges with pharma—but keep patients in mind

PERSONAL VIEW Ian Gilmore

The preparation, prescribing, and dispensing of drugs have been intertwined with the practice of medicine for centuries and the close relationship between doctors and the pharmaceutical industry has been key to many therapeutic advances. However, the integrity and value of these close links have been criticised within and without the medical profession, most particularly in the past decade. We have to be concerned, for instance, by findings suggesting that some parts of the industry, through sponsorship, wield a pernicious influence on the integrity of the published science base (BMJ 2003;326:1167–70). Equally disquieting is the suggestion that many doctors are unduly affected by industry sales messages.

Ongoing scrutiny of the industry’s relationship with the medical profession is necessary and healthy, but we should not lose sight of the shared commitment to long term improvements in patient care, which ultimately drives intersectoral collaboration and innovation. With this belief in mind, a multidisciplinary working group formed nearly a year and a half ago, under the aegis of the Royal College of Physicians, and has just published a report, Innovating for Health—Patients, Physicians, the Pharmaceutical Industry and the NHS.

The starting point was clear. Throughout much of the NHS, academic medicine, and the pharmaceutical industry, the relationships needed to deliver innovation are badly damaged. The aim was to draw a line under past confrontational debates and set out, on the basis of the evidence presented to us, the conditions necessary for a flourishing culture between these sectors. It quickly became apparent that the key to the future was culture. Transparency and communication can promote a more strategic exchange of ideas. But if the best of each sector is to be harnessed, then trust needs to be restored.

Education is one of the most contentious areas. Clearly, students need to be protected from undue pharmaceutical marketing. However, medical schools do not always adequately prepare new doctors for prescribing, and a stronger, more consistent undergraduate curriculum is recommended. Many of the same issues pertain to doctors in training, where education programmes are overdependent on industry support.

Although the pharmaceutical industry does have something legitimate to contribute to education, its institutions must work harder to disseminate and enforce the Association of the British Pharmaceutical Industry (ABPI) code of practice. Equally, royal colleges and faculties, with NHS institutions, need to rethink their role in postgraduate education. Doctors too must take greater financial responsibility for their own postgraduate education.

A survey of the RCP’s Patient and Carer Network revealed substantial anxieties among lay people about access to and information about medicines, independence of doctors, adverse drug reactions, and participation in clinical trials. Moreover, the funding of patient organisations by industry can be unhealthy. A more patient-centred culture in devising drugs policy could deliver substantial gains in access, information, independence, adherence, safety, and inclusion in trials while rebuilding patients’ confidence in the way medicines are developed, trialled, and made available through the NHS.

Finally, the pharmaceutical industry is clearly not confident about its future in the UK, about the government’s commitment to clinical research, or about working with the NHS to optimise patient care. Part of this difficulty has been the weak incentive system in the NHS to support clinical research. Clinicians seem suspicious of industry activities. As a result, collaboration between the private and public sectors has been fragmented and strategic dialogue between industry, academia, and the NHS is now missing. To redress this problem, the NHS needs stronger research leadership—clinically and managerially—and a better alignment of incentives to promote and sustain research and research careers.

To some these objectives will seem idealistic rather than realistic. Some submissions to the group pointed to a climate of suspicion, mistrust, and prejudice. Individual physicians expressed concern that the RCP was embarking on this work at all, and we were warned that the industry might “see this exercise as another way to achieve their promotional ends.” Other contributors took a more hopeful view, and indeed we have much to build on. While recognising the weight of past scepticism and concern about such collaborations, the working party began and ended its work with the view that a flourishing and virtuous set of relationships could be created, provided that their primary endpoint was always kept firmly in mind—the health and wellbeing of the patient.

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See EDITORIAL, p 308, NEWS, p 313, ANALYSIS, p 326
Skin Deep

Composed by David Sawer, libretto by Armando Iannucci.

For performance details see www.goskindeep.com

Rating: ★★★★☆

-from Morning to Midnight. Sawer decided that a biting satire on human vanity needed a librettist of comic genius and recruited Armando Iannucci, the radio and television writer famous for his merciless dissection of politics in The Thick of It and for lampooning modern television with I'm Alan Partridge. Iannucci, Italian Scottish and raised on opera from an early age, jumped at the chance. Neither man, it seems, had written an operetta before.

The advance publicity relied heavily on the promise of a caustic libretto. Funny posters appeared all over Leeds. The BMJ and at least one journal of plastic surgery sent reviewers to check out whether Iannucci would do to doctors what he had done to politicians and television presenters. As the orchestra tuned up we leaned through the scholarly programme notes and wondered whether snide English word play would be appreciated by the coproducers, Bregenzer Festspiele and Royal Danish Opera.

The creation of Skin Deep began in 2002 with an approach from Berlin’s Komische Oper, which specialises in operetta, to the British composer David Sawer, who had just been nominated for a Laurence Olivier award for his dark, full length opera From Morning to Midnight. Sawer decided that a biting satire on human vanity needed a librettist of comic genius and recruited Armando Iannucci, the radio and television writer famous for his merciless dissection of politics in The Thick of It and for lampooning modern television with I'm Alan Partridge. Iannucci, Italian Scottish and raised on opera from an early age, jumped at the chance. Neither man, it seems, had written an operetta before.

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You know right from the start when an evening is going to be terrific. You also know very quickly when you are in for a long haul. In both cases the auditorium falls silent, though it does so in quite different ways. The Skin Deep audience wanted so much to be amused or outraged or moved—to feel something, at least—but nothing was happening.

The doctors began to understand what patients are talking about when they come in asking for Viagra. What on earth was the matter? The singers were superb. The words were indeed clever (the film star was planning a world tour, doing “the chateaux and the chat shows”), and the production had some witty touches, with a large curtain being drawn across the stage, like a screen around a bed, whenever an operation was imminent.

In the end, though, opera is all about the score. Unfortunately Skin Deep has, to use a surgical metaphor, minimally invasive music. Low notes and thoughtful silences may be great for melodrama, but operetta requires a certain momentum. A bit of allegro con brio can bring a willing audience through a silly plot, and Skin Deep—knowingly, of course—has one of the silliest. Face transplantations are always going to confuse an audience, however much the unfortunate director tries to guide us through the post-ironic labyrinth. We don’t need to believe the story (witness The Pirates of Penzance or Midsomer Murders), but we do like to have some inkling of what’s going on.

Doctors got off lightly—much more so than, say, the legal profession in Gilbert and Sullivan’s Trial by Jury. Indeed, for those of us who enjoyed medical school revues in our youth there was a nostalgic pleasure in watching a cast dressed in surgical caps and gowns making joke after joke about genital organs. Remember? The instantly effective intragluteal anaesthetic? And that perennial standby, Remember? The instantly effective intraglutual anaesthetic? And that perennial standby, the television commentator with a hand held microphone? Ah, happy days.

On such evenings it is comforting to be part of a Yorkshire audience. During the interval one woman was genuinely self critical: “Well, I’m sure I’m missing something.” At the end a gentleman near us quietly asked his companion, with a perfectly straight face, “Will you be buying the CD?” Our final applause was scrupulously fair. After all, this was the second night of the run, with only the singers, dancers, and musicians taking their bows, and they really had done well. We kept clapping until the curtain fell, though only just. As we left we avoided looking at one another, but that’s normal in Leeds. Perhaps it will go down big in Manchester.

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A dish best eaten cold

Not only have many doctors been distinguished writers, of course, but many distinguished writers have been the sons or daughters of doctors. I leave it to epidemiologists to decide whether more distinguished writers have had medical parents than could be expected by chance—but so, at any rate, it seems to me.

Among the writers whose father was a doctor was the German playwright Frank Wedekind (1864–1918). His father had been, among other things, physician to the sultan in Constantinople. An ardent democrat, he joined the revolution of 1848 in Germany but emigrated to the United States after its defeat and then returned to Switzerland.

Like many an ardent democrat Wedekind père was a domestic tyrant, and young Frank hated him. He left home to lead a raffish life, choosing as friends people such as Willi Rudinoff, described as an “actor, acrobat, painter, and imitator of animal noises,” and Willy Gretor, “painter, writer, business man, and swindler,” one of the best forgers of that period. Wedekind his father was a domestic tyrant, and young Frank hated him.

Wedekind died in 1918, just before the end of the first world war, after a minor operation that he insisted on having despite suffering from a chest infection at the time. There’s patient autonomy for you. One of his disciples, Heinrich Lautensack, gave the eulogy at his funeral, in the course of which he declared Wedekind to be the Messiah and Wedekind’s disciples to be the disciples of the Messiah. A clear thinker with a dislike of jargon, he could quote Oscar Wilde (“Each man kills the thing he loves”), Shakespeare (“Give sorrow words”), or (rather alarmingly) George Bernard Shaw (“Never hit a child except in hot blood”). Wedekind had a mean turn of phrase himself and a surprisingly unblinkered view of childhood. Babies and young children are “selfish, jealous, sexy, dirty, and given to temps, obstinacy, and greed,” although there is no doubt that he liked them anyway. His opinions were strong and direct: all research “is a gamble, and we have to put our money on the horses we happen to fancy”; “that punishment is efficient as a means of control I believe to be one of the great illusions of western civilization.” For his special field of study he chose the removal of children from their homes to residential nurseries or hospitals, believing that such action could have serious ill effects and that “preventive measures might be possible.”

The first lecture lays out themes that are expanded in the following five and revisited and explored again in the last. Bowlby comes out as an early feminist (“Let us hope that as time goes on our society, still largely organised to suit men and fathers, will adjust itself to the needs of women and mothers”) and admits to a “cautiously optimistic view of human nature.” He considers the crucial roles of ambivalence and conflict and how humans regulate these, considers conflicting emotions as a normal state of affairs, and recognises the limitations of psychoanalysis: “To the clinician the learning theorist seems always to be struggling to cram a gallon of obstreperous human nature into a pint pot of prim theory.”

Through the lectures the seeds of future research can be seen sprouting from his reflections: lifespan and intergenerational approaches, ethology, loss and mourning, maternal separation, disturbed personality development, the secure base, exploration, trust, resilience, and the effects of anoxia at birth are all touched on as well as attachment itself. Bowlby wasn’t satisfied with food and sex as the conventional rationales for the development of affection, which he saw as an essential human need. In the last lecture he looks at therapy, both family and individual, and the role of the therapist: “Finally he must never forget that, plausible, even convincing, though his own surmises may seem to him…in the long term it is what the patient honesty believes that must be accepted as final.” This book is a great introduction to a questioning thinker.

First published 1979

Consisting of seven lectures that John Bowlby gave between 1956 and 1977, this book introduces and explores subjects that are still at the forefront of child and adolescent psychiatry today. It is impossible to overestimate Bowlby’s influence on subsequent psychiatric research and practice. The acknowledged “father of attachment theory,” he focused on child development, though his interests were far wider.

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The rise of the consumerist

The computer records heave and groan, while patients’ paper records occupy three shelves, having almost consumed an Amazon forest. What lurks within is a dark jungle of tropical allergies, fierce letters of complaint, torrents of investigations, bizarre surgery, and, always, the distant howls of litigation. The list of diagnoses snakes through the record, lined by huge banks of medication. This is not Munchausen’s, but the emergence of a newly evolved breed—an extreme manifestation of modern medicine: the medical consumerist.

Created by the big bang of two seemingly opposing forces, the liberal notion of “patient centredness” and the capitalist idea of “the patient customer,” the medical consumerist is now the absolute monarch of care. You might not believe reported symptoms or think that they are relevant, but you are unable to challenge the power of the patient directly. In primary care we use containment strategies: temporising, suggesting complementary treatment, and even placebos (well couched in medical legal verse). But if the patient wants to be referred for investigation we have no choice. Many doctors have simply given up, saying “It gets them out of our surgery for a while.”

The hospital sectors, where symptoms are less questioned and the medical model is stronger, duly investigate and duly offer designer diagnoses, or broaden soft off-the-peg ones. One diagnosis leads to another. When doctors do start questioning diagnoses it is too late and, anyway, we are far too fearful of being accused of paternalism or a posting on an NHS approved website to intervene. The fire is fanned by tabloid magazines and shopping channel TV medicine, underpinned by the corrosive introspection of wealth and time. Patients are left with bankrupted wellbeing. But worse still, this individual excess denies the basic healthcare needs of others.

How do we protect consumerist patients from themselves? In this time of world crisis there are opportunities for change. For some countries the only rational and logical response is to nationalise health care and protect patients from the distortion and greed that may come with consumerism. But in general we need to challenge the absoluteness of patient centredness and save patients with one simple word—no (said nicely).

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The first George W

When a politician sneezes or mops a brow, flunkies panic and rivals circle greedily. When that politician is leader of the world’s largest democracy, any hint of less than tip top health commands global attention. Of America’s 44 presidents so far, eight have died in office, while many have had life threatening episodes, ranging from Franklin D Roosevelt’s paralysing illness (probably polio) to George W Bush’s encounter with a pretzel. But no US president has borne such ill health—nor suffered so much at the hands of his doctors—as the first.

Broad shouldered and more than 6 feet (1.8 m) tall, George Washington (1732-99) battled with no fewer than 10 bouts of serious illness—as well as innumerable minor ailments. Obsessive about his health, he meticulously detailed in his diaries his physical trials and triumphs and his favoured remedies. An ardent fan of the humoral medicine of the day, he enthusiastically volunteered to be bled and blistered; but hedging his bets with the numerous quack therapies on the market he also bought a pair of Elisha Perkins’s popular “tractors” with their persuasive claims for pain relief.

Before he even dreamed of becoming president, at 17 years old he contracted the “ague” (probably malaria) and two years later smallpox. An attack of pleurisy was followed by influenza then dysentery. Downing large quantities of Dr James’s powders—“the most excellent medicine in the world”—Washington found his complaints lingered “in spite of the efforts of all the sons of Aesculapius.”

By the time he took the oath of office in 1789, Washington sported glasses, was deaf to a degree, and wore false teeth. Within six weeks of his inaugural speech he was laid low again, with an abscess on his thigh that took three months to heal. Weathering further attacks of “agues” and “fevers” he survived his presidency to retire to his Mount Vernon estate in 1797 in the hope of a long and well deserved rest.

It was not to be. In December 1799, after riding all day in a storm, Washington took to his bed with a sore throat for which he gamely asked his overseer to bleed him in the absence of any professional aid. The next day his lifelong friend Dr James Craik and a fellow physician, Dr Gustavus Brown, bled the founding father twice more. And despite the objections of a third physician, Dr Elisha Dick, who proposed a tracheotomy to help the expiring pioneer to breathe, the doctors took a fourth donation of blood, amounting to a grand total of between four and six pints (1.9-2.8 litres). Overwhelmed by his infection—possibly diphtheria or acute epiglottitis—and weak from blood loss, Washington died.

Although his latest successor would be well advised to forgo the pizzas and cigarettes to ensure a long and healthy presidency, at least he no longer needs to avoid his doctors. Wendy Moore is a freelance writer and author, London wendymoore@ntlworld.com

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