Contemporary Themes

Doctors and the drug industry in Sweden

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When Dr Gunnar Wennström, now deputy director of the Swedish National Board of Health and Welfare, was a medical student in the 1950s he and his fellow students became concerned about whether they were being seduced by drug companies. At that time, as he put it: "If you wanted a party you rang up the drug company and they provided you with lots of information on their products but also with food and drink." The students decided that they were being seduced, and such sponsorship was stopped. Then what Dr Wennström described as a "very hot debate" began.

Now 30 years later Swedish doctors have taken several steps to ensure that their relationships with drug companies (and manufacturers of medical equipment) are thoroughly responsible. They have untangled themselves from the drug companies in a way that has not yet happened in Britain. The Swedish public, parliament, and the media have also been concerned about the relationships and they have wanted assurances that doctors are not being seduced, bribed, or corrupted. The drug companies too (and particularly the five large Swedish ones) have welcomed the changes.

Inspired in part by the setting up of the working party of the Royal College of Physicians of London that is looking at the relationships between doctors and the drug industry in Britain, I went to Sweden for a few days at the end of last year to look more closely at what has happened there. I spoke to doctors from large hospitals, the government, the Swedish Association for Medical Sciences, and from a Swedish drug company.

Agreements on an "independent stance"

The debate over the relationships between doctors and drug companies raged at its most furious in Sweden in the '60s and '70s, and culminated in written agreements among the Central Association of County Councils, the two associations of drug companies (one of Swedish companies and one of foreign companies), and the Swedish Medical Association. The Central Association of County Councils participated in the agreements because the county councils own the hospitals and pay the salaries of doctors, including those of most general practitioners.

I have copies of four of these agreements, the first being in 1978 between the drug companies and the Swedish Medical Association. Though the documents have been translated, even in coherent English they are hard to read and rather reminiscent of international treaties. A key sentence emerges, however, from the 1981 guidelines for doctors attending drug company sponsored functions. The guidelines were produced by the advisory body responsible for pharmaceutical information, which contains representatives from the county councils and the drug companies. "It is desirable," they

Steps that must be taken by doctors wanting to do research on a drug in Swedish hospitals

(1) For clinical trials on unlicensed drugs, for clinical trials on healthy volunteers, and for clinical trials for new indications with licensed drugs—that is, almost all drug related research—approval must be obtained from the National Board of Health and Welfare.

(2) Permission to proceed must be obtained from the hospital ethical committee.

(3) If funds are needed then grant applications must be made to the Swedish Medical Research Council or other grant giving bodies (but in practice most drug research is sponsored by the companies).

(4) If the hospital is associated with a university then money granted for research must be paid into the university bank.

(5) If patient files and computers are going to be used in the research then permission must be obtained from the National Delegation for the Use of Computers.

(6) The hospital drug committee must be told of the research.

(7) The hospital board of directors must be informed and it will initiate negotiations between the drug company and the county council to ensure that the drug company meets any extra expense incurred.

state, "that such functions be conducted in such a way that employee [doctors] and company adopt towards each other the independent stance which is expected under the present circumstances and also imperative from an ethical point of view."

The agreements go on to state that whenever drug companies want to organise meetings for doctors they must inform the local county council, or the central association if it is a national meeting, and have the meeting approved. This applies not only to meetings where the company wants specifically to inform doctors about its products but also to educational and scientific meetings at which providing information on particular products may not ostensibly be the aim of the meeting.

The county councils are concerned first about which doctors are attending the meetings: they must be convinced that those attending have a bona fide interest in the topic under discussion—that is, that it is relevant to their specialties. If they can possibly afford it the county councils will pay the costs of doctors participating in the meetings. Only if they cannot or will not pay will the drug companies be allowed to pay for travel, food, and accommodation. No payment is allowed for those simply listening, and payment is allowed for lecturers only after approval from the county council.

These agreements are, however, more general than particular,

and by the time that they were produced many doctors and hospital departments had already changed their relationships with drug companies. Specific policies had been adopted on when drug company representatives would be seen and in what circumstances and on how much hospitality would be accepted from the companies.

Professor Lars Böttiger, who was head of the department of medicine at the Karolinska and who now works for the Swedish drug company KabiVitrum, described to me the policy that his department adopted many years ago for seeing representatives from drug companies. Firstly, the representatives are not allowed to appear in the department any time they like: they must come and speak to all the doctors at once, and they must apply to the head of the department. Secondly, the department limits the number of representatives that are seen, and Professor Böttiger guessed that on average only twice a year would there be meetings with drug company representatives. Thirdly, the representatives have to tell the head of department what they are going to say. If the head thinks that the company has nothing new to say or that the scientific evidence to support its assertions is poor then the representatives are not allowed to come. Fourthly, the drug company representatives are given only a short time to make their case (usually 15 minutes and usually at the beginning or end of a routine doctors' meeting). Fifthly, the representatives are not allowed to hand out free gifts (pens or pads), and, finally, if the scientific quality of their presentation is poor then they are not invited back.

The department of medicine at the Karolinska probably adopts a stricter policy than most departments, but the doctors whom I spoke to thought that most hospital departments in Sweden had a policy along these lines. Furthermore, most if not all of the 10% of Swedish doctors who are general practitioners employed by the county councils in health centres adopt similar policies.

The practical results of these policies are that there are fewer meetings between doctors and representatives of drug companies than there used to be and the quality of those meetings is much higher. For instance, many of the presentations are now given by doctors working for the drug companies rather than by lay representatives. Dr Wennström from the National Board of Health and Welfare pointed out that the drug companies have a right (even a duty) to put over new information; he and others were just anxious that their information should be as objective and scientific as possible and should be accompanied whenever possible by relevant information from other sources.

The board, which is responsible for organising the six to seven years of postgraduate training that all Swedish doctors have to undergo, is particularly anxious that drug companies should have nothing to do with the six week long theoretical courses that are part of the training. But Professor Gunnar Ström, professor of clinical physiology at Uppsala and who sat on (and chaired) many of the committees concerned with organising postgraduate education, described to me how he had incorporated presentations by drug companies into a course that he runs for doctors who are about to become medical teachers in his university. The week long course is entirely on educational techniques, but the drug companies come on one evening and supply food and drink as well as a presentation on one or more of their products. The twist is that the drug companies are rated by the students on the quality of their presentation. One that is presented well and in an unbiased way will win a small award from the course, and these awards are now much valued by the drug companies.

Information on drugs

The main worry over the relationships between doctors and drug companies is obviously that doctors may be overinfluenced by commercial promotion when it comes to prescribing and, indeed, may prescribe when some other action would be better, and therefore the quality of information that they are given on drugs is vitally important. Swedish doctors now have two bibles for prescribing. One, the *Farmaceutiska Specialiteter Sverige* (FASS), is published by the joint association of the Swedish and foreign drug companies.

The other, *Läkemedelsboken*, is published by the National Association of Pharmacies, a government organisation. All pharmacies in Sweden are owned by the government.

FASS lists all the 2400 drugs available and gives all relevant prescribing information (indications, dosage, contraindications, side effects, etc). The information in FASS is dictated exactly for most of the drugs by the National Board of Welfare (the only exceptions are some old drugs). The information thus has medico-legal importance, and a doctor strays outside it at his peril.

Läkemedelsboken is constructed quite differently. It is built around conditions rather than drugs, and on each condition there is an essay written by an acknowledged Swedish expert. The expert then lists at the end of his essay all the drugs that he has mentioned, but full prescribing information is not given. Next the book lists all the other drugs that might be used for the condition that have been approved by at least one of the drug committees from each of the 24 counties. (Most hospitals in Sweden have a drug committee, and each of the 24 counties has one as well.) The book also says which county drug committees have approved the drug. Finally, below a line that must be ominous for the drug companies are listed all those drugs that have not been recommended by any of the committees. Professor Böttiger edited the first five of these biannually produced books, and he imagines that eventually those drugs that are below the line will disappear.

The controls on the advertising of drugs to doctors are similar to those that exist in Britain. The drug laws require that advertisements give generic names and do not mislead. In addition, a voluntary board, organised by the drug companies but chaired by an eminent doctor, examines drug advertisements and deals with any complaints about them.

Doctors doing drug research

Another important relationship that may develop between a doctor and a drug company is when the doctor undertakes research on one of the company's products. A new regulation was introduced by the Central Association of County Councils in 1982 that is relevant to this relationship. It states that whenever a drug company has sponsored research in a hospital then there must be a written understanding between the company and the hospital to ensure that the former pays for any extra expense incurred, and most drug research is, I was told, sponsored by drug companies.

Professor Ström calculated that as a result of this new regulation there are now up to seven distinct and formal steps that any doctor wanting to do drug research in a hospital may have to take. He also thinks that many Swedish doctors are not aware of all these steps. The steps are shown in the box—most, of course, apply also to research projects that have nothing to do with drugs. Professor Ström thinks that because potential researchers now have to take these steps the number of drug related research projects has fallen but their quality has risen. It was calculated a few years ago that 1000 to 1500 such projects were started a year in Sweden; about half of those were eventually reported, and only about a half of those reported were thought to be scientifically acceptable.

Doctors' Kivik fair

Thus all is not roses in Sweden. Dr Wennström, for instance, thinks that there is still room for limiting the influence of drug companies on doctors and increasing the amount of objective and neutral information to doctors on prescribing. Because all drugs in Sweden are sold through government controlled pharmacies, he points out, it would not be hard to take a little more from the drug companies and spend it on postgraduate information.

But my overall impression was that doctors are much less closely linked with drug companies than they are in Britain. Many of the practices that occur regularly in Britain—for instance, giving pens, pads, calendars, and even more expensive gifts, and the winning and dining of doctors at functions of dubious educational value—

happen little or not at all in Sweden. Nevertheless, the public and the media there are still concerned about commercial pressure on doctors, and ironically my visit to Sweden coincided with an enormous medical congress that is held each year and attended by half of all the doctors in Sweden. There are some 1500 seminars, symposia, and lectures, but there are also immense exhibitions of drugs and medical equipment. The companies are careful to give away nothing more expensive than coffee or ice cream, but still some of the journalists who visit the fair are struck by the commercial overtones.

While I was in Sweden, one of the two Stockholm newspapers

carried a report on the fair under the title "Doctors' Kivik fair." The Kivik fair is a famous cattle fair held each year to the accompaniment of strip shows and all sorts of salacious "tingletangle" as the Swedes call it. The report elaborated on the "greedy looks" of the doctors and on their "expensive suitcases bleached by the sun they have encountered attending conferences in Tokyo, San Francisco, Honolulu, and Rio. . . ." Doctors do truly have to be very careful with their image (15 December, p 1699).

I am especially grateful to Professor Lars Böttiger for help in preparing this article.

Prescribing: the power to set limits

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Abstract

This paper discusses drawing up a restricted list of 245 drugs for use in an inner London group practice, based on a review of prescribing patterns in November 1982. The likely impact of the recent proposals by the Department of Health and Social Security to limit drugs available for prescription under the National Health Service on this project and on patient care is considered. We conclude that generic prescribing and a limited list of drugs may improve the quality of prescribing and be the only way to curb prescribing costs but that a limited list should be flexible, responsive to patients' needs, and applied to all prescribing. There should also be a mechanism for consumer feedback and regular revision of the list.

Introduction

Prescribing is a focal point of contacts between doctors and patients and one indicator of the quality of medical care given.^{1,3} It is also relevant to the marketing strategies of drug companies and media disclosures about the hazardous effects of specific drugs. Most recently prescribing has become the target of government attempts to limit National Health Service expenditure.⁴

Critics have called for limits to the range and cost of drugs prescribed, and some have argued strongly for "generic substitution." The Greenfield report proposed that pharmacists be allowed to substitute cheaper generic preparations for more expensive brand name products unless otherwise stated by the prescribing doctor.⁵ This recommendation was seen by some to threaten both the profits of drug companies and the clinical autonomy of the medical

practitioner. Though drug companies argued that generic preparations were not equivalent to specific brand name products, the BMA supported the recommendations of the Greenfield report provided they were not compulsory.

The recent proposals by the Department of Health and Social Security have side stepped the controversial issue of "generic substitution," which would potentially apply to every prescription, and introduced a restricted list for eight categories of drugs.⁴ The effect of these proposals will be to limit the service available to patients under the NHS by making the full range of drugs available only to those who are able and willing to pay.

Hospitals have for many years used drug formularies to limit the range and cost of prescribing. Pharmacy and therapeutics committees select which drugs hospitals buy, and these alone are available to the prescribing physician. Apart from the mass of advertising publications produced by the drug companies and the results of drug trials published in the medical journals, some attempts are made by the DHSS to influence the quality and type of drugs prescribed by general practitioners.

Prescribers' Journal, *Drug and Therapeutics Bulletin*, drug cost histograms, and publications from the University of Southampton's Drug Surveillance Research Unit are distributed free to general practitioners. Prescribing patterns in general practice have been described,^{6,7} and information on prescribing and morbidity has been used for critical review to improve prescribing habits.⁸⁻¹⁰ Harris *et al* showed a selective reduction in prescribing by a group of general practitioners who, after receiving information about their prescribing decisions, prescribed fewer drugs and more often chose generic preparations.¹¹ Clinical pharmacologists have worked with a group of general practitioners to produce a booklet recommending treatment policies for common conditions and have attempted to assess the effects of peer review and discussion on prescribing patterns.¹² Some general practitioners have compiled their own restricted list of drugs.^{13,14} The encouragement of general practitioners to engage in self audit before decisions and definitions of "appropriate prescribing" are imposed from outside the medical profession has, however, been overtaken by events.¹⁵

We drew up a restricted list of drugs for use in an inner London group practice with a list of over 13 000 patients. This was one outcome of a larger project to review and change antibiotic prescribing. The doctors (seven partners and two trainees) made a carbon copy of all prescriptions for 21 days in December 1982, and this forms the data base of the work discussed here. The doctors were presented with details of the frequency and range of items prescribed and decided to draw up a restricted list of about 250 different preparations to guide everyday prescribing practice.

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