

Academic drug detailing: an evidence-based alternative

It's a little known service to physicians offered in 5 provinces. One, though, recently axed its program, while another may soon follow suit.

It could be called a distant and poor cousin of pharmaceutical detailing because it too hopes to influence physician prescribing patterns. But there's no commercial interest in academic detailing. Its aim is to visit doctors or otherwise disseminate evidence-based information about specific drugs, or classes of drugs, after conducting impartial, independent reviews of their efficacy. The long-term goal is simply to promote optimal prescribing.

Is there a need for such a creature?

As one of just a handful of academic detailers in the country providing independent, analytic advice about pharmaceuticals to doctors, Dr. Michael Allen wryly notes it's axiomatic for Canadian physicians to believe they aren't in any way influenced by the subtle pitches of pharmaceutical detailers. "But they think that their colleagues are," the director of the Dalhousie Academic Detailing Service adds.

The scale of those divergent forms of detailing, however, are hardly comparable. The pharmaceutical industry spends an estimated \$500 million annually meeting with doctors and clinical pharmacists to promote the use of their medications and boost sales. Industry watchers say such outlays for promotion, and the number of detailers working doctor's offices, continues to rise. According to the Hay Group, a global human resource consultancy, there are 5500 to 6000 pharmaceutical sales representatives in the country. The IMS Health Group says there are roughly 5700 people employed as representatives or managers of those representatives — about 1 pharmaceutical sales rep for every 11 doctors.

By contrast, public efforts to promote optimal prescribing are altogether mod-



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Publicly funded efforts to promote optimal prescribing, such as academic detailing programs, have modest budgets and staffing compared with pharmaceutical industry efforts.

est. According to an August 2006 study of academic detailing conducted by the University of Victoria's Drug Policy Futures team and entitled *Show me the Evidence*, Canada's 5 provincial programs had a combined work force of 10.2 positions. The study concluded such programs are invaluable, even though their budgets range between \$75 000 and \$500 000 per year. The best funded, in Alberta, was recently discontinued, while the most modestly funded, in Manitoba, awaits word on renewal.

Modest fund also typifies other publicly funded initiatives aimed at providing evidence-based drug information, such as University of British Columbia's Therapeutics Initiative and Health Canada's Canadian Optimal Medication Prescribing and Utilization Service (COMPUS).

The Therapeutics Initiative, which conducts comprehensive systematic reviews of drugs or classes of drugs and mails the information out to the province's doctors and pharmacists, receives \$1.5 million per year from the BC and federal governments.

COMPUS, an off-shoot of the Canadian Agency for Drugs and Technolo-

gies in Health, was created in 2004 to promote optimal prescribing. Modelled on the Australian National Prescribing Service, it received \$19.5 million over 5 years to conduct 3 to 4 drug studies per year for use by policy-makers, provincial drug plans, prescribers and patients. Its first major study, on proton pump inhibitors, is slated for release this spring.

Ontario's Institute for Clinical Evaluative Sciences has occasionally reviewed classes of drugs, but spokesperson Julie Dowdie says the non-profit organization's mission isn't to directly promote better prescribing so much as to research effectiveness and efficiency within the broader health care system.

In short, the magnitude of publicly funded initiatives to promote evidence-based drug choices, compared with the pharmaceutical industry's effort to influence sales, is nothing short of what Allen calls "a case of David and Goliath."

Academic detailing's goal is to familiarize physicians with such concepts as relative risk reduction and uncertainties surrounding data about specific drugs, Allen says. Essentially, it promotes "critical thinking. Because of the evidence-based approach we use and the informa-

tion we present, they are now more critical of the information they get from other sources and that includes pharmaceutical reps.”

The Dalhousie program, which began in 2001, has annually received between \$200 000 and \$300 000 to conduct 1 or 2 reviews per year on topics chosen

through a provincial survey of doctors.

Dalhousie disseminates its findings through office visits with physicians but its 4 counterparts in other provinces employ a range of methods.

Saskatchewan's RxFiles Academic Detailing Program visits roughly two-thirds of the province's physicians annually, but

Program Director Loren Regier says the 10-year-old, \$315 000 per year initiative also conducts sessions at medical conferences, issues newsletters and email updates through the Saskatchewan Medical Association, and electronically compiles a compendium of its drug comparison charts, which it publishes periodically as a book that is distributed to every doctor in the province.

The next edition, slated for release this month, will cover over 55 therapeutic areas. “We're getting to be pretty comprehensive on the core areas.”

The discontinued 7-year-old Alberta Drug Utilization Program (ADUP), by contrast, relied primarily on written reports to disseminate findings. Two years ago it began meeting with physicians face-to-face, says Program Administrator Don Phillipon, a professor of strategic management and health policy at the University of Alberta. The \$500 000 per year program provided visits to physicians in 2 (Calgary and David Thompson) of Alberta's 9 health regions, reaching about 100 physicians. When it was axed, Calgary authorities were so disappointed they found a way to resuscitate it within city boundaries.

Phillipon can't comprehend why ADUP was scuttled. “It's hilarious.... I teach a course comparing health systems, and pharmacy is one of the areas we comment on because this is the area of the Canadian health system that's most disorganized when you compare it to other countries with universal health systems. And here was an initiative that was really looking at utilization issues and it was discontinued.”

Alberta Health and Wellness Communications Director Michael Shields says ADUP's limited scale proved its undoing. “The program, while providing evidence of effectiveness in changing prescriber behaviour, was not viewed as cost-effective if scaled to the entire prescriber community. There are over 7100 prescribers registered in Alberta, ADUP reached only 250 physicians in 2 areas in the province.”

Prescription Information Services in Manitoba faces a similar fate. Executive Director Shawn Bugden says future funding for the \$300 000, 4-year initiative is in abeyance, despite its self-evident value. “It means that a physician can sit down

“This is the kind of information we need”

There's no doubt in the mind of clinical pharmacist Dr. Aaron Tejani, the co-ordinator of clinical research and drug information for British Columbia's Fraser Health Authority (FHA), that academic detailing has a indispensable role to play in the daily decisions that physicians and pharmacists make.

Tejani, whose duties include serving as pointman for the FHA's 12 acute care hospitals in meetings with pharmaceutical reps, says that becomes apparent many days that he meets pharmaceutical detailers. Last summer, for example, Tejani met with a Pfizer Inc. representative who pitched the use of acetylcholinesterase inhibitor donepezil (sold as Aricept for the treatment of Alzheimer's disease) to treat mild cognitive impairment (MCI), an off-label indication.

Tejani promptly hauled out a *Therapeutic Letter*, an academic detailing publication produced by the University of British Columbia's Department of Pharmacology and Therapeutics (April-August 2005;56). It indicated: that an unpublished clinical trial of the drug involving patients with MCI demonstrated no benefit in terms of preventing or delaying progression toward Alzheimer's disease; that several trials had suggested just 16% of people with MCI go on to develop Alzheimer's; and that there wasn't a known correlation between the 2 disease states.

“A 16% conversion rate is relatively small, so treating all people with MCI would be, in my mind, dangerous, especially when you have trials showing some of these drugs cause harm,” Tejani says.

Pfizer spokesperson Christine Antoniou says the promotion of off-label use of drugs “is not standard practice and our representatives receive a lot of training and regular reminders that off-label promotion is not at all something that we want to do. We hope it's an isolated incident and we're looking into it.”

Tejani says off-label promotion is common and described a number of similar pitches, including ones for off-label use of Recombinant Factor 7 for stroke patients, and moxifloxacin eyedrops for people undergoing cataract surgery. Pharmacy representatives have even urged FHA staff to lobby regulators to approve a drug for off-label indications, Tejani adds.

In 2005, the FHA invited drug company representatives to a forum, where expectations regarding the accuracy and quality of clinical evidence presented by drug detailers were spelled out. “We told them: ‘This is what we feel is appropriate, and this is where we think you will be crossing the line.’”

Tejani says such incidents demonstrate the value of optimal prescribing initiatives like therapeutics letters or academic detailing visits. “It [does away] with clinical opinion and bias. Instead, it simply states what we know and what we don't know about the evidence... [and] this is the kind of fact-based information clinicians and patients need to make informed decisions.” — Wayne Kondro, *CMAJ*

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for 10 to 15 minutes, or as long as they want, get the distillation, ask the questions that they want and have someone be able to provide them with answers to the clinical problems that they're running across in their practice, in a relatively short amount of time, from someone whose job isn't to sell them a product."

Along with the BC Community Drug Utilization Program, the 4 aforementioned programs have also attempted to jointly produce reviews under the rubric of an informal umbrella called the Canadian Academic Detailing Collaboration. They cooperated on a review of statins for cardiovascular disease, and ultimately hope COMPUS will aid their cause by producing reviews they can disseminate within their respective provincial borders.

In turn, Vice President Barb Shea says embryonic COMPUS itself hopes to eventually build a publicly accessible electronic database collating all evidence-based reviews, including those undertaken by academic detailers; as well as undertake research and then create a pair of databases about the relative merits of evidence-based interventions like academic detailing, therapeutics letters and e-detailing. "One [database] would be about what works with health professionals. And the second is what works with consumers and patients."

Therapeutics Initiative Program Coordinator Ciprian Jauca says therapeutic newsletters have already proven their effectiveness. Under UBC's program, established in 1994, findings are essentially disseminated as a randomized control trial, with the letters being mailed out to doctors.

Prescribing profiles are subsequently examined. "Thus far, we've found that you can't see an impact of any one letter by itself. There were trends but none of it was statistically significant," Jauca says. "But when you combined the effects of the letters over time, there are highly statistically significant effects in terms of actually prescribing changing in the expected direction."

Allen says Nova Scotia recently surveyed its doctors to ascertain the effectiveness of academic detailing as a continuing medical education (CME) tool. While some physicians found office visits inconvenient and weren't thrilled by having CME provided by non-physicians (Nova

Scotia uses 2 pharmacists and a nurse as detailers), others found it "invaluable."

The primary knock has been cost, Allen says. "But if you think education is expensive, try ignorance. You don't have to save many prescriptions to cover the costs of academic detailing." — Wayne Kondro, *CMAJ*

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Canada's new toxic hit list called "inadequate"

Is it a toxic hit list or toxic miss list? That's the question many in the medical and scientific community are asking about the federal government's new Chemicals Management Plan — a multi-million dollar program that imposes strict new regulations on about 4000 "legacy chemicals" used in industrial and consumer products.

The so-called "toxic hit list," unveiled by Prime Minister Stephen Harper on Dec. 7, targets substances such as benzene, sulfuric acid and Bisphenol A that were grandfathered onto the market in 1994 when tougher new environmental rules took effect. Phase 1 of the 4-year \$300-million plan will begin in February when Environment Canada launches a review of 200 chemicals, which it categorizes as "high-priority" and a potential risk to human health. Once every 3 months the department will release the names of chemicals in small groups, after which industry will have to provide information that proves the substances



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Critics say the government ought to adopt the precautionary principle when dealing with toxic substances.

are safe. If they fail, the chemicals will face stringent controls or be banned.

While the plan has been endorsed by several high profile environmental groups including Pollution Probe and Environmental Defence, it has been met with skepticism by some scientists and medical doctors.

Scientists for a Healthy Environment has garnered nearly 800 signatures from scientists in a letter that criticizes the Tory's new strategy

"I suspect it's an inadequate plan," says Dr. David Schindler the Killam Memorial professor of ecology at the University of Alberta and the driving force behind Scientists for a Healthy Environment. "I think the expense of doing a thorough review and evaluation of these things is beyond the budgets that we see in these departments these days, and I think the onus if not for doing them, then funding them, should be thrust back on industry."

The group's letter criticizes the government for not moving fast enough and for not using the "precautionary principle" when dealing with the chemical industry. Also called "reverse onus," the principle would shift the responsibility to industry to prove its products are safe. Under the current system, it's up to the government to prove that substances are dangerous. Schindler says he believes such a legislative shift is crucial, especially when you consider the severe budget cuts the department has faced over the past 30 years.

"I just don't think those departments have the capacity anymore," he says. "Of these thousands of chemicals there might be 4 or 5 people in Environment Canada who are knowledgeable enough to wade through them."

George Enei, Environment Canada's point man on legacy chemicals, says that there is currently no plan to adopt reverse onus. Rather, his department has moved towards a "shared" responsibility between government and industry.

"Historically, when you take a look at the legacy substances it's always been on the shoulders of the government to collect the data, analyze the data and make a decision. Now what we're saying is 'no, we're not going to take that full responsibility. We want others to do some of that work for us,'"