THE NETWORK'S
# NEWS LETTER
(a quarterly publication)
ASSOCIATION FOR RATIONAL USE OF MEDICATION IN PAKISTAN
(a company limited by guarantee not having a share capital)
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# Drug Research Fund

*Medical Research in Pakistan has always taken a back seat and most often the excuse given is that there are financial constraints in promoting research. In this situation, it is amazing that the Ministry of Health is sitting on millions of rupees collected over the last 16 years from the Pharmaceutical industry in the name of drug research but not a rupee has been spent on research.*

*It was in July 1978 that the Federal Government created a Central Research Fund to be maintained by the Ministry of Health. The fund consists of 1% of the gross profit of the pharmaceutical industry. By now, this fund should be in the range of hundreds of millions of rupees. The fund was to be utilized for clinical trials and research on drugs.*

*The Federal Government was also supposed to constitute a committee of experts to advise on the utilization of this research fund. The committee consisting of D.G. Health, Executive Director NIH, Chairman of PMRC, Chairman of PCSIR, Chairman of Pharmacy Department, Dean of Faculty of Pharmacy, Professor of Pharmacology, Representative of Pakistan Pharmaceutical Manufacturers Association, and Drug Controller. In the last 16 years, although, millions of rupees were collected under this head not a single grant has been given from the fund for conducting research and neither the Government ever asked for applications for such grants. As a matter of fact, the Committee could not even meet! The first meeting, after a lapse of 16 years, was held a few days back. It is most unfortunate that in spite of the fact that the Ministry of Health has a large sum of money reserved specifically for research, it has failed in its duty to encourage medical research.*

*It is suggested that the Ministry of Health should utilize this large amount to improve pharmaceutical research and should involve those institutions,*

*organizations and individuals who are working in this field. In this regard the Ministry should get in touch with College of Physicians & Surgeons, Pakistan which has recently started a discipline of Clinical Pharmacology and is now establishing a National Adverse Drugs Reaction (ADR) Monitoring Centre. The Network for the Rational Use of Medication also has been providing objective information about drugs to doctors and the general public and can make use of funding from the Ministry to improve it's services. Besides that the Ministry should get in touch with those individuals who are interested in this field and provide necessary facilities in the field of drug research and related areas.*

# Essential Drug List

*Recently, the MoH convened a meeting of experts from all medical disciplines to formulate a new List of Essential Drugs. The Committee, after thorough discussions, recommended 471 drugs to be included in the National Essential Drugs List. This time the committee, along with the medical specialists representing their respective professional groups, also included health administrators from all the four provinces and AJK governments, Armed Forces, and private sector. A relatively liberal list, can cater to the needs of not only the teaching hospitals but also that of the district hospitals, rural health centers and basic health units. This is a welcome step. But an important point to remember is that this list needs to be implemented in all the Government Health Facilities. Otherwise, like previous lists, it will also meet the same fate and would gradually become dead and forgotten.*

*The supply of these drugs should be assured in all the facilities. The list should be widely circulated and publicized and doctors should be encouraged to prescribe these drugs not only in the Government Hospitals but also in their private practices. Doctors should not prescribe the drugs from outside the list without full justification.*

*The next logical step would be to limit the number of non-essential drugs registered with the MoH*

## *Corrigendum:*

The following typographic mistakes appeared in our March '94 issue. On page 5, line 24, please read "ingested" instead of "indigested". On page 10 under "Thiazides", line 8, please read "Cerebrovascular" instead of "Cardiovascular", On page 11, para 3, line 16, please read "Periactin BC" instead of "Beriactin BC".

We regret the oversight.

## * EXPERT DRUG COMMITTEE UPDATE:

The last issue of our newsletter contained an announcement *(page 12)* about the formation of an "Expert Committee on Drugs" by ministry of health, four members of which were from the Network.

During first sitting of the Committee on 17th January 1994 it was unanimously agreed that the Committee should not only deal with the issue of drug prices, but should also dwell upon other drug regulatory issues. Consequently, the working group within the committee, headed by Lt. Gen. (Retd.) Mahmud Ahmad Akhtar has already submitted three comprehensive reports to the ministry. First two reports, as was required, were pertaining to drug prices and the third report dealt with six different drug regulatory issues; namely re-registration of de-registered drugs, practically absent national essential drug list, unscientific drug registration and inadequate drug registration board, non-availability of essential drugs versus availability of irrational drugs, availability of essential drugs that are not available in the countries of origin and other countries and lack of quality control on drugs. Each issue in all the three reports has been dealt with thoroughly with a resultant explanation of the issue and a suggested action. The working group, which is mainly composed of people from Network, using the best expertise at hand put forth the universally acceptable principles for drug regulation.

To date, the Committee has met thrice and discussed different issues including the above mentioned reports. Ministry of health has taken some measures in the light of these recommendations but the situation demands much more firm handling. Firm, serious, and sustainable measures with a view to make rational and longer reforms is the actual need of the hour.

## * WORKSHOP ON TEACHING OF CLINICAL PHARMACOLOGY AT UNDER GRADUATE & POST GRADUATE LEVELS:

Recently established first faculty of Clinical Pharmacology (CP) at the College of Physicians & Surgeons, Pakistan (CPSP), just after its inception, arranged a three day workshop on Clinical Pharmacology Teaching on 26-30 March at the CPSP. Headed by Professor Akhlaq-Un-Nabi, the Faculty has taken a long over due initiative towards planning and restructuring of CP teaching in Pakistan, where a clinical pharmacologist is still a rarity.

Attended by almost all the heads of pharmacology departments in the country and by Dr. F. R. W. Moulds from Australia, the workshop was supported by WHO/EMRO and regional office of IOCU for Asia and Pacific. Experts invited from some other countries were unable to arrive in time.

After three days' deliberations the workshop ended with the development of a very useful set of recommendations both for undergraduate and post-graduate teaching in clinical pharmacology in Pakistan. A few of the most important points from recommendations are as follows;

**For undergraduate education:**

- The teaching of pharmacology should be continued in the fourth and final year classes.
- Teaching should be a collaborated effort of pharmacologists and clinicians.
- The core curriculum should be based on WHO and/or Pakistan Essential Drug List. It should also include core knowledge, skills and attitudes related to important aspects of clinical pharmacology.
- Pharmacy practicals should be discontinued and instead more emphasis should be given to prescription writing, ADR monitoring and assessment of the therapeutic status of a drug.
- Students in the final year should be examined specifically for clinical pharmacology and therapeutics.

**For post-graduate education:**

- Training programmes leading to MCPS and FCPS should be started.
- Eligibility requirements, approval of institutions, recognition of teachers etc. for such programmes should be done.
- Out of country training and continuing education programmes in clinical pharmacology should be planned on ongoing basis.
- The status and responsibilities of clinical pharmacologists in teaching institutions and in the health delivery system in general should be clearly defined.

## * WORKSHOP ON CONSUMER PROTECTION IN PAKISTAN:

On 31 March 1994, with the collaboration of International Organization of Consumers Unions (I.O.C.U.), Regional Office for Asia and Pacific (R.O.A.P), The Network conducted a one day "Workshop on Consumer Protection in Pakistan". This was the first initiative of its kind in the country. In the absence of a recognizable consumer association, consumer exploitation is rampant and such an initiative was long overdue.

Two representatives of IOCU, Ms. Shanthi Ramanathan and Ms. Shila Rani Kour came all the way from Penang, Malaysia to facilitate the workshop.

Many socially active, potentially useful and publically known professionals were contacted. About forty actually participated, primarily from Karachi, Lahore and Islamabad. They included doctors, social workers, lawyers, educationists, representatives of NGOs and representatives from relevant divisions of public

sector. The venue was College of Physicians and Surgeons, Karachi.

As an orientation workshop it was found to be very useful by the participants. A representative from Corporate Law Authority and Consumer Watch, a consumer group from Lahore, made informative presentations. Shanthi Ramanathan acted as resource person and introduced different aspects of consumer work.

During the first group work, participants identified ten priority consumer issues in Pakistan which were short listed to six in the following plenary. Afternoon group work was distinct in that each group had participants from one city. After agreeing to work in future in their cities on these six issues they tried to formulate an action plan for one year. At the end a slide presentation about IOCU-ROAP was made by Shila.

Over all, it was a very useful and unique workshop about the wider issue of consumer protection in Pakistan. Three core groups in three cities are now engaged in following their action plans. Those who want to know more about these initiatives must contact the following in Karachi and Lahore.

Dr. Tanveer Sheikh,
A-52, Block 17,
Federal B-Area,
Karachi.
Ph : 021-677500 (Res.)

Dr. Yasmin Rashid,
146, opposite Lahore College,
Shadman colony,
Lahore.
Ph : 0342-353850 (Mobile)

In Islamabad, the Network office can be contacted for further information.

IOCU formally announced that the Network office would act as a focal point for these core groups. Shanthi Ramanathan presented about 30 useful books on consumer work for the Network library. Interested individuals or organisation can contact the Network office for the list of these books.

The workshop ended with a promising announcement about a follow-up workshop next year.

## * SEMINAR ON CONSUMER & HEALTH CARE

The Lahore consumer protection core group took the lead by arranging a very well attended seminar on "Consumer and Health Care." As a follow-up event of the workshop on "Consumer Protection in Pakistan" the seminar was very well taken by the activists as well as by the media. Dr. Yasmin Rashid, President of the Lahore Pakistan Medical Association and the moving spirit of Lahore core group, worked tirelessly for the seminar.

It was a unique gathering, participants included, doctors, engineers, housewives, journalists, representatives of industry etc. Mr. Rana Ikram Rabani, provincial Minister of Health was the chief guest.

Speakers made excellent presentations. A detailed report of the seminar is available with us for those interested. The Lahore core group has made a very impressive start. With the first event they have made a dent in the system when the Minister announced that he would like to meet with a delegation formed by PMA Lahore and formally discuss the drug issues in particular.

The Network also collaborated with PMA Lahore to make this seminar successful.

Congratulations! Lahore group.

## * PARTICIPATION IN 47TH WORLD HEALTH ASSEMBLY:

The Network Coordinator was invited by Health Action International (HAI) to take part in the recently held (2-12 May 1994) WHO's 47th World Health Assembly (WHA) at Geneva as part of an international lobby team for better resolutions on drugs. The lobby team consisted of health activists from The Netherlands, Peru, Latvia, Thailand, France, Switzerland, Bangladesh, Uganda, Pakistan and Egypt. This year WHA approved five resolutions on various aspects of drugs. Final approval of each resolution involved lot of lobbying with delegates from different countries. After more than a week's hectic running around, analyzing, strategizing, arguing, and convincing, it finally resulted in a set of very strong and useful resolutions on drugs. Following are the titles of the resolutions on drugs approved in this WHA.

1. WHO ethical criteria for medicinal drug promotion (WHA 47.16).

2. Implementation of WHO's revised drug strategy; Rational use of drugs; and WHO's Action Programme on Essential drugs(WHA 47.13).

3. Implementation of WHO's Revised Drug Strategy, Safety, Efficacy and Quality of Pharmaceuticals (WHA 47.17).

4. Implementation of WHO's revised drug strategy: Revision and amendment of WHO's Good Manufacturing Practices for Pharmaceutical Products (WHA 47.11).

5. Role of the pharmacist in support of the WHO revised drug strategy (WHA 47.12).

Unanimous adoption of all these resolutions by WHA means recognizing the need for action, giving WHO a clean role in the work towards the control of drug promotion and reaffirming WHO's leadership and coordination in the area of drug policy development.

Pakistan showed a determined support to all these resolutions and DG Health made certain very positive remarks while speaking in favour of the resolutions. We hope that this strong bias in favour would also be reflected in our decision making back home.

Thanks to IOCU-ROAP and HAI for making it possible for the Network to participate in the WHA.

# ANTIBIOTICS IN CLINICAL PRACTICE

**Dr. Naseem Salahuddin**
*Consultant Physician, Liaquat National Hospital, Karachi*

When the first antibiotic, Penicillin, was discovered in the 1940s, it was a historical event in the treatment of infections. Its production was limited, so much so that during World War II the urine of patients treated with penicillin was carefully collected, and the precious antibiotic extracted and reused. Over the years many bacteria originally sensitive to this potent antibiotic, have become totally resistant, necessitating a change to newer and exorbitantly priced ones. As newer and newer antibiotics come on the scene, the older ones are being relegated to history. Improper exposure of pathogens to antibiotics, either by wrong selection, inadequate dosing or prolonged use produces natural selection and acquisition of drug resistance. Resistant bacteria, when transferred to another host, will, therefore cause infection that is difficult, if not impossible to treat.

There is at this time in Pakistan, a crisis arising from drug resistant bacteria. Millions of doses of all kinds of antibiotics (mostly unnecessary) are dispensed each day by ignorant, gullible practitioners whose knowledge of pharmacology is gathered from bits of information doled out by uncanny salesmen. The patient, unsuspecting victim of the grand designer, the multinational, pays for it by having his/her normal, natural healthy flora destroyed, suffers minor side effects like diarrhoea, vomiting, skin rash or at worst serious toxic effects such as the bone marrow being suppressed or wiped out, kidneys damaged or skin and mucosa exfoliated. All too often continued use of an antibiotic can itself be the cause of fever. The clever little bacteria has learnt to develop resistance and make it difficult for true infection to be eradicated with conventional drugs and all this for a hefty price of Rs.50/- to Rs.500/- per dose.

There are in actual fact, very limited indications for prescribing antibiotics. Sudden, acute fevers are usually due to viruses in the upper respiratory tract, self-limiting gastrointestinal infection, hepatitis, require support and symptomatic treatment; malaria requires antimalarials; trauma to skin requires local cleansing. Certainly, deep-seated or parenchymal infection in the lungs, kidney, bones, joints, heart valve (endocarditis), central nervous system, animal or human bite and septicemia deserve careful selection of an antimicrobial with due consideration to the causative organism in the involved organ or tissue. Abscesses must be drained surgically.

Any person unfamiliar with the basics of microbiology and pharmacology should not prescribe antibiotics. This includes many doctors, quacks, chemist shop dispensers and friends and family of the patient.

A few fundamentals in practice must be followed;

1. Antibiotics must be used only against known or suspected bacterial infections.
2. Local sensitivity patterns of pathogens versus antibiotics should be known through antibiograms from efficient laboratories.
3. Appropriate dosage must be selected according to body weight, disease condition, immune status and functioning of liver and kidneys. Higher dosage must be prescribed in severe infection, larger body mass and in diabetics. Liver and renal dysfunction may need dose modification.
4. Duration of therapy must be finite, depending upon severity of disease, and clinical response. Generally, most infections are to be treated for three to five days after full clinical response, but many times the duration has to be individualized. Under treatment results in drug resistance and relapse, while over treatment will result in side effects and superinfection.
5. If there is no response within 24-72 hours, there is no point in continuing the drug or changing to another drug in the same generic series. The disease must be re-evaluated.
6. 2 antibiotics in the same capsule or tablet, eg. ampicillin and cloxacillin, or cough syrups containing antibiotics must not be prescribed. They carry the risk of underdosing, and hence encouraging resistance. Two or more antibiotics may be used separately only if there is likelihood of two or more concomitant types of bacteria, or there is known potentiating effect.
7. If two antibiotics have equal efficacy and safety profiles, select the older and less expensive one. Cost must be considered.
8. There is no substitute for time spent with the patient. No patient wants to be drugged unnecessarily. The claim that antibiotics give "psychological" benefit is the argument of the feeble-minded.
9. Pre-operative prophylaxis must be used for no longer than 48 hours.
10. Study of disease and treatment from non-commercial medical literature or lectures must be continual.
11. All drugs, including antibiotics, are chemical poisons. Use them with utmost caution.

# Pakistan Needs Legislation to Control Marketing of Breastmilk Substitutes

***Anees Jillani***

Hundreds of thousands of children die each year in Pakistan due to diarrhoeal dehydration. Modern researchers believe that many of these deaths can be avoided by relying on the age-old practice of breastfeeding. It is an irony that while information about the breastmilk's superiority is leading to a change back to breastfeeding in the West, the Third World is going for the bottle.

In 1966, more than 87% of the children were breast-fed for 21 months or more in Pakistan. Now more than 50% of the infants are bottle-fed, and few, if any, are exclusively breast-fed. Breast-feeding is continuing to decline in our society. The decrease is also proven by the fact that in 1981 in Pakistan, Rs.150 million were spent on import of breastmilk substitutes as opposed to only Rs.1.5 million in 1975.

This development is unfortunate. It is now an accepted fact that breastmilk has all the proteins, vitamins and minerals a baby needs for the first few months of life. Even among malnourished mothers, breastfed babies are twice as likely to achieve normal weight for age. Mother's milk also immunizes the infant against common ailments, reducing by as much as 50% the risk of diarrhoea and respiratory illness. Breast feeding is one of the few natural methods to achieve contraceptive effect: it is perhaps nature's protective method from over-burdening mothers with already young children.

As opposed to advantages of breast feeding, breastmilk substitutes can boast of few advantages. Also there are a number of dangers associated with feeding with the bottle which obviously are not present in mother's milk. For instance, infants are more likely to be exposed to infections due to contamination of bottles, teats and baby-food. Illiterate mothers can hardly be expected to follow the instructions labelled on breastmilk substitutes. Baby-milk is obviously expensive. Bottle-feeding can also lead to malnutrition if the mother uses less than the recommended amount of milk-powder in preparation of feed. And most of the poor mothers hardly have a provision at home to keep bottle milk cool and to properly and regularly sterilize the bottles.

The question then is why are so many mothers in the Third World, including Pakistan, switching to breastmilk substitutes? One obvious reason is urbanization which results in less time available to mothers to breastfeed their children. This is all the more difficult for working women who are not provided with any facilities to be with their infants while working. Secondly, associated with the first reason is the changing family structure.

Thirdly, the desire of some females to modernize; and bottle feeding is seen by them as a sign of progress. And last but perhaps the most important is the aggressive marketing and distribution of breastmilk substitutes.

In order to control the menace of aggressive marketing and distribution, the World Health Assembly convened by the World Health Organization in May 1981, adopted the International Code of Marketing of Breast-milk Substitutes ("the Code") Pakistan was one of the countries that had recommended the adoption at the Assembly. But few positive steps have been taken since then for the Code's proper implementation here.

The aim of the Code is "to contribute to the provision of safe and adequate nutrition for infants by the protection and promotion of breast feeding, and by ensuring the proper use of breastmilk substitutes, when they are necessary, on the basis of adequate information and through appropriate marketing and distribution" It is a comprehensive code covering products like breastmilk substitutes, milk products, food and beaverges including bottle-fed complementary foods where marketed; and feeding bottles and teats .

Despite being comprehensive, the Code is practical. Instead of making every violation of the Code an offense like failure of the doctor to promote breast feeding, it endeavors to inspire him to promote it. At the same time, however, it makes it an offense for a doctor to promote breastmilk substitutes by displaying, advertising or distributing them in his clinic. On the other hand, it contain lots of recommendations for the governments to follow in relation to its responsibility for controlling the marketing of breastmilk substitutes.

The lack of implementation of the Code in Pakistan is not surprising for the following reasons:

- The commercial companies involved in the marketing and distribution of breastmilk substitutes are least interested in voluntarily complying with the Code's provisions.

- These commercial interests representing some of the biggest multinationals in the world have become immensely powerful in Pakistan over a period of time.

- The public generally is insufficiently aware of the principles of good infant feeding practices.

- Children have no constituency and no political power to check the menace.

- Women in our society, unlike in the West, are usually suppressed and have a low status.

- Almost all breastmilk substitutes are imported. This entails economic and political constraints on the Government of Pakistan to adopt the Code.

these circumstances, what can be done for the adoption of the Code in Pakistan? If the political will is present and e Government has the will to handle multinationals' opposition, the Code can easily be implemented; it has already en adopted through legislation in India, Nepal and Sri Lanka.

is natural that intense opposition and lobbying against the adoption of such legislation would take place by the mmercial interests likely to be affected by it. But the choice is that of the Government. On the one hand are ousands of children dying each day due to aggressive marketing of breastmilk substitutes. On the other hand are the crative multinational companies with their commercial interests. It is about time that the Government makes its oice in favour of Pakistan and its children, realize the urgency of the situation and take action to discourage eastmilk substitutes. Delay in this regard is resulting in thousands of children dying each day. And these deaths are eventable.

## Lets Hear From You:

We would like to invite our readers to write to us and comment about: (a) The Network and its activities, (b) any drug promotional activity in your area which you find objectionable or commendable and would like us to include it in "Our Correspondence" section, (c) suggestions and ideas on "Rational Use of Drugs" (RUD), (d) any media coverage in your area on RUD related issues (include cuttings etc.). You may send us a letter on RUD and the situation prevailing in the country and we would forward it for you to national dailies for their "Letters to the Editor" section as the Network supporter.

# Sponsored Symposia: science or veiled promotion?

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**WHO Drug Information Vol. 7, No.1, 1993.**

The relationship between research-based pharmaceutical companies and departments of academic medicine is inevitably symbiotic since the drug development process is dependent upon the active collaboration of practicing physicians. To avoid inadmissible conflicts of interest the relationship needs to be controlled in so far that it may influence medical teaching and the process of drug regulation.

Drug regulatory authorities are as dependent upon the collaboration and judgement of practicing clinicians as are the research based companies. Members of official advisory committees are also commonly advisers to these companies. A conflict of interest arises when there is a financial relationship and when the judgement or opinion of the person involved are liable to be biased or distorted by that relationship. Most highly-evolved regulatory authorities now require members of advisory committees to declare all relevant financial interests and to withdraw from discussion of any issues that are connected with these interests.

Within the USA a study group of the Institute of Medicine has recently been commissioned to study the operation of the 41 committees that provide technical and scientific advice to the Food and Drug Administration. The report had been interpreted as reaffirming the integrity of the committee process[1], but it also recommends changes. Central to the issue is the need to codify the criteria applied in granting waivers to prospective committee members who declare a financial interest. The report, however, provides no concrete guidance on how this might be accomplished.

More problematic is the conflict of interest that arises from the extent to which postgraduate medical education had become reliant upon support from pharmaceutical companies. In most settings, it is probable that sufficient distinction is made between the educational content of the programme and any associated promotional activities to assure objective presentation and coverage of the subject. There is concern, however, that this distinction is often obscured in the publication of sponsored symposia and "consensus conferences" [2-5]. It has been estimated that the annual investment of US-based companies in this form of sponsorship approached US$ 90 million in 1988[6] and this total may since have increased considerably.

A recent survey of 625 symposia published within 11 peer-reviewed medical journals[7] has confirmed that these publications often escape the review processes applied by the parent journal. Almost one-third of the publications included in the sample were sponsored by a single pharmaceutical company. Of these, many focused on a single drug -- which only exceptionally was classified by the Food and Drug Administration as offering important therapeutic gain - and half were concerned with unapproved indications.

Attention has also recently been drawn to the reticence of many authors to acknowledge funding of research by pharmaceutical companies in published reports[8,9]. A questionnaire sent to the corresponding authors of all clinical trials dealing with the medical therapy of angina pectoris published over a three-year period during the early 1980s in 8 major journals of cardiology and internal medicine revealed that pharmaceutical companies were primary or secondary source of funding in over 70% of instances. However, in less than one-third of these was this source of funding declared in the publication. Omission of this information apparently increased the probability that the reviewer would classify the study as adequately controlled and designed, and regard the conclusions as upheld by the data. Almost half the industry-supported studies were published in symposia. In many instances these comprised duplicate publications, few independently reviewed, and on no occasion was the source of funding cited in the article itself.

The conclusions drawn by the authors of each of these surveys are inevitable. They call for complete disclosure of financial arrangements between the contributors to symposia, the organizers, the sponsors and the publishers: for clear identification of symposia in published reports: and for editorial control to be applied in full to all contributions. These are offered coincidentally with draft policy guidelines issued by the US Food and Drug Administration which extend beyond a requirement for financial transparency[10]. They set our proposed requirements intended to assure, from the planning stage, the independence of industry-supported scientific and educational activities from the influence of the commercial sponsor.

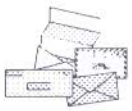
The challenge for regulators is to establish reasonable and effective controls that will not constitute an important disincentive to serious commercial sponsors of medical education.

References : Available on request.

## *Drug Information Service:*

We announced availability of this service at The Network in our September 93 issue (vol.2, No.3). Since then, we have been receiving queries (mostly written) on all sorts of drug related issues from our readers. In order for us to respond to queries promptly and objectively, we would request our readers to: (a) ask only one question at a time, (b) be specific and direct, (c) in case of a written query, please also give brief information about your professional/educational background and your contact number and postal address, Thank you.

# OUR CORRESPONDENCE



## A FEW SUGGESTIONS ON RATIONAL USE OF MEDICATION:

*The job being done by Network is really commendable! As a family physician, I do realize that there are glaring gaps between ideal and existing therapeutic practices. In my opinion following fronts have to be attacked very aggressively.*

1. ***DETAILING LITERATURE ABOUT PHARMACEUTICALS:***

   *Conceding the point that level of knowledge of doctors provides chances to commercial exploitation, companies keep on inventing, propagating and advertising quite wrong, far from truth, sales pitch. It is outrightly criminal. Two suggestions:*

   a. *There should be a centre where all ill-conceived literature can be referred to. The centre should then take steps to have it corrected or removed from circulation.*
   b. *Each and every piece of paper brought into the market, should bear the approval and name of a recognized subject specialist. To keep the cost low a list of willing but voluntary workers can be arranged by NGOs, like Network or PMA or sub-specialty organizations.*

2. ***PRESCRIBING PRACTICES OF LEADERS:***

   *Specialists and teachers are role-models for family physicians. If prescribing practices of these leaders are looked into, especially what comes out of their private consultations, it is really quite far from the principles of rational therapeutics. We, the family physicians, even when proper case referrals are made by us find in the majority of cases that:*

   a. *No diagnosis is committed.*
   b. *Prescriptions contain all nonsense which we ourselves are quite competent to commit.*
   c. *No communication exists between referring doctors and consultants.*

*My suggestion is that these leaders of profession should be made conscious of their responsibility to society at large and to referring doctors particularly.*

3. ***FORUMS IN CITIES ON PERMANENT BASIS:***

*NGOs like Network, should establish forums, where debate on drugs and related issues can be initiated and perpetuated. Doctors are quite eager for an independent source of information. Until now they are targets of sponsored and tactfully engineered clinical meetings.*

4. ***WHY IRRATIONAL PRESCRIPTIONS:***

*Apart from lack of knowledge, do the offenders stand to benefit themselves in anyway? This must be looked into. Wrong concepts and motives should be defined and eradicated.*

5. ***CONSUMER ORGANIZATIONS:***

*NGO should be setup with two objectives:-*

*i. To keep Ministry of Health under check & balance.*

*ii. To challenge the superior claims of commercial concerns in the court of law such as Federal Ombudsman.*

6. ***REPLACING ENGLISH WITH URDU:***

*As a doctor who has wide experience of communicating with doctors through written word, I have a feeling that there does exist a practical illiteracy towards English language among doctors. Theoretically this idea looks absurd, but on the ground, there is a loss of impact of message through this medium of expression. Should we study this aspect?*

***Dr. Saleem Akhtar Rana***
Family Physician, Gujranwala.

## UPJOHN'S UNHEALTHY PRACTICES

*Due to mushroom growth of pharmaceutical companies and their products there is intense competition in the market. So, every executive in the pharmaceutical industry is trying his best to grab as much share as possible. No doubt, it has become a cut throat competition but drugs deal directly with human life so there are some ethical and moral obligations for every one in the industry.*

*Multinationals are always complaining about the local industry's lower standards and their low cost basic materials and most of the times give this as the only reason for the superiority of their brand than the generic one. Off and on we also do hear boast of ethical practice or ethical business from them.*

*But one is dismayed when one sees that these big companies are themselves engaged in such practices that are highly immoral and unethical.*

*Sometime back Messrs Upjohn started a scheme to boost up its dwindling share of Lincocin. But this time it has not kept itself to the highlighting of superior quality of its drug but instead it asked different GPs to prescribe 500-1000 patients with Lincocin (lincomycin) and give the copy of prescription back to the company. (Obviously for the proof). Company claims that they are doing some "research". But this research is on the expense of the patient as he has to buy these medicines from the market, where Lincocin is quite expensive even when compared to other multinational products. Clearly, those doctors who are going to prescribe 500-1000 lincocin will be compensated by the company. When this scheme was being introduced some doctors objected to its immoral and unethical procedure but the company went ahead with it and just dropped the doctors who objected.*

*I think this is one of the worst examples of corrupting the noble profession. As not only to waste patients money on so called "research" is wrong (in any research company should and always provide medicines) it is also highly unethical to provide carbon copies of prescription to any one without taking the informed consent from the patient before. As no body is serious in this "research" anyway this is only a scheme by the company which is comparable to "Rocco" ice-cream promotional scheme of last year where dealers were awarded very lucrative prizes according to there sales. It is a pity that Upjohn now considers doctors as shopkeepers and tries to increase its sales by these crude methods. I am sure that Upjohn can never even dream of this scheme in the western world as it can lose its license or have to pay heavy multimillion dollars fine if foolishly it ever tried the same there.*

*As Upjohn is always telling us that they are importing this drug or that drug from abroad I do hope that they also import some pharmaceutical ethics from abroad. I am not demanding much, a little will also do.*

***Dr. Rana Jawad Asghar***
Family Physician, Lahore.

# MaLAM Announcement

*"In recognition of the high quality of the work already achieved by the Association for Rational Use of Medication in Pakistan we have great pleasure in appointing The Network to be MaLAM Centre in Pakistan.*

*Yours sincerely,*
***Dr. Peter Mansfield***
*Founder and Secretary,*
*Medical Lobby for Appreciate Marketing Incorporated".*

## What is MaLAM?

MaLAM International was established in 1982. It is a non-profit organization providing:

⇒ Dialogue between health professionals and pharmaceutical companies.
⇒ Support for quality scientific medical care.
⇒ Encouragement for reliable pharmaceutical promotion.

MaLAM is funded primarily from subscription to ensure it remains controlled by health professionals.

## Is MaLAM Effective?

Reports of MaLAM's impact have been published in the Lancet on five occasions and elsewhere. Improvements gained following MaLAM letters included withdrawal of

⇒ arsenic, strychnine, glucose, alcohol for psychological stress.
⇒ nikethamide for neonatal respiratory stress.
⇒ phenobarbitone, ephedrine, theophylline for acute asthma.

## How does MaLAM work?

Every month, MaLAM subscribers receive a copy of a letter addressed to a pharmaceutical manufacturer. The letter quotes a questionable promotional claim, provides a summary of the scientific literature for comparison and asks the manufacturer for evidence to support the claim

No pharmaceutical company can ignore questions from large numbers of health professionals.

## As a MaLAM subscriber you will:

⇒ Receive MaLAM letters each month.
⇒ Have the opportunity to influence drug marketing.
⇒ Receive MaLAM News monthly which reports on correspondence between MaLAM and manufacturer.

Joining MaLAM is a fascinating way to keep up with important facts about therapeutics which are not emphasized by manufacturers and which are not easily available elsewhere, MaLAM helps you select better therapy.

Please send us examples of unethical drug promotion so that we can coordinate action througn MaLAM head quarters in Australia.

For more information about MaLAM please contact the Network office which is now also acting for MaLAM in Pakistan.