EDITORIAL

The influence of opinion leaders

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Doctors and the general public believe that evidence should guide rational prescribing. In most Australian medical schools, students are taught evidence-based medicine to better equip them for critically appraising the evidence to guide their future management of patients. However, this is not always the mechanism by which doctors in practice seek solutions to clinical problems. A systematic review found that primary care physicians were more likely to seek answers to clinical questions from colleagues than from electronic resources.[1] Perhaps the most disappointing finding in this review was that the situation remained unchanged between 1992 and 2005, despite the digital revolution. It is very likely that most specialists also use colleagues as their main source of information to answer clinical problems.[2]

Doctors seek solutions from other doctors and due to the hierarchical relationship of this transfer of information, a relatively small number of doctors guide national and international prescribing patterns. These 'opinion leaders' have an influence far beyond their own prescribing patterns. The process and qualifications by which an individual becomes an opinion leader have never been defined and may be prone to manipulation by vested interests. This mechanism to disseminate information has risks as well as benefits.

Opinion leaders have several possible benefits. A small number of experts are very likely to achieve consensus in how to manage specific problems. This uniformity of approach allows patients to have relatively consistent treatment from primary care to specialist care, across ambulatory and inpatient settings.

Most doctors find it impossible to stay abreast of all the developments in their fields. Opinion leaders tend to have a very narrow focus within a subspecialty. This enables them to have a good working knowledge of the latest advances in their fields and facilitates the appraisal of the latest evidence and its influence on practice.

Opinion leaders are often involved in research. This gives them additional insights into the major advances within a specific field. They are frequent attendees and contributors at major international conferences and are aware of developments that may not even be published. A Cochrane systematic review has found that local opinion leaders (note – local rather than national) may successfully promote evidence-based practice.[3]

The major risk of opinion leaders seems to be related to the disproportionate influence that external agencies may bring to bear. Most concerns are about the influence of the pharmaceutical industry, but similar issues are apparent with companies manufacturing medical devices.

The pharmaceutical industry makes every attempt to contract opinion leaders, educate them about its products and seek their advice as to how to maximise sales. This is often through a mechanism such as drug-specific medical advisory boards. These contractual relationships are covert and unregulated, and the code of conduct of Medicines Australia is quite vague about these matters.[4] When does reimbursement for services rendered become coercion, and place an opinion leader under a sense of obligation?

Remuneration for an opinion leader may take multiple forms including payment for attendance at medical advisory board meetings, honoraria for giving lectures to specialists and general practitioners, and sponsorship to attend international meetings. Each component may seem relatively modest, but the totality can be significant. Opinion leaders would be unwise to foster relationships with only one company as major bias would result, and frequently enter into arrangements with multiple companies. Unfortunately, many opinion leaders pay scant attention to non-pharmacological strategies which typically do not provide the same incentives.

From the Editor

Although vaccination has been available since the 1950s, pertussis is still a problem in Australia. Philip Britton and Cheryl Jones explain the role of antibiotics in preventing further attacks.

Patients with asthma should know how to deal with acute attacks. Helen Reddel provides advice on how to write an asthma action plan for treating acute exacerbations.

Drug interactions may be acute or emerge over time. Ben Snyder, Thomas Polasek and Matt Doogue discuss how to look for likely interactions.

Loss of vision becomes more likely with ageing. Roland Bunting and Robyn Guymer tell us how the management of age-related macular degeneration has been improved by drugs aimed at vascular endothelial growth factor.

Detecting mutations of epidermal growth factor receptors is one indication for consulting a cytologist. Phillip Woodford and Rebecca Said give guidance on how cytology can help diagnosis.

The interests of pharmaceutical companies may coincide with the interests of patients. Novel drugs which dramatically improve the management of patients benefit all parties. The introduction of such drugs should rightly be facilitated by opinion leaders. However, a close relationship between industry and opinion leaders may have negative consequences. Examples include the creation of new diseases or the dramatising of relatively minor conditions. This medicalisation of ordinary life, for example male baldness, has been termed 'disease mongering'.[5]

The use of opinion leaders in such disease awareness campaigns is crucial. There is evidence that some opinion leaders have been successfully chosen and groomed by pharmaceutical companies. Individual doctors, who may not be well known or widely published, are chosen by a company because of their favourable views of a specific drug.[6] The promotion of these individuals as opinion leaders results in a distortion of the consensus process regarding the role of that drug.

A close relationship between companies and opinion leaders in research may also be problematic. The involvement of independent academics in research is one of the important safeguards in ensuring checks on companies. The inexplicable failure of a pharmaceutical company to report deaths in a large study of rofecoxib, and the subsequent defence of the drug's utility by some opinion leaders, raises questions regarding their independence.[7] Similarly, the involvement of opinion leaders does not seem helpful in convincing companies to publish the results of negative studies, particularly if there are other positive studies of the drug.

Most concerns are about the influence of the pharmaceutical industry

Pharmaceutical companies have a legitimate right to contract opinion leaders to help publicise their products and maximise their profits. Respected colleges[8] and medical associations have argued for greater transparency of the relationships between opinion leaders and companies. This would enable other health professionals to consider the putative financial gain when they weigh up the arguments of these opinion leaders. Such transparency has not been achieved, and how to monitor and deal with non-compliance with college and association guidelines remains a problem. Transparency would resolve many of the current tensions as to how opinion leaders are perceived. In the meantime, all opinions, including those contained in this editorial, should be treated with healthy scepticism. ◁

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Letters to the Editor

Management of polypharmacy: can we safely discontinue medications?

Editor, – The authors of the article on deprescribing (Aust Prescr 2011;34:182-5) remind us about the critical role all clinicians play in generating, and potentially mitigating, polypharmacy. There is a paucity of high quality evidence to guide when to discontinue medications, especially where the event to be avoided may not be experienced for years or decades.

Initiating any medication requires a framework to evaluate its continuing use and includes:

- explicitly categorising the level of prevention (primary, secondary or tertiary) that the new medication is addressing
- agreed, measurable and clinically relevant endpoints
- the time by which clinical benefits are likely to be experienced

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