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Title page

'There are ways…drug companies will get into DTC decisions'- How Australian Drug and Therapeutics Committees address pharmaceutical industry influence

Short running title: Drug and Therapeutics Committees and industry influence

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What is already known

- Pharmaceutical industry marketing can negatively affect appropriateness of medicines prescribing and increases costs
- Drug and Therapeutics Committees have a role in protecting patients and hospitals from harms and costs of company marketing

What this study adds

- Drug and Therapeutics Committee oversight of formulary, off-label use and medicines access programs is vulnerable to industry influence
- Drug and Therapeutics Committee members are aware of pharmaceutical industry influence over local prescribers but may consider it outside their responsibility or feel powerless to intervene
- DTCs and hospitals should collaborate on implementing tighter restrictions on disclosure processes and on industry marketing in hospitals

Abstract

Aims

One tool for protecting quality use of medicines in hospitals is a drug and therapeutics committee (DTC) that oversees medicines availability. Pharmaceutical industry marketing to prescribers is associated with less appropriate prescribing and increased costs. There is little data on decision-making practices of DTCs so it is unknown whether or how they might be vulnerable to pharmaceutical industry influence. This project explores DTC decision-making with a focus on how pharmaceutical industry influence on access and use of medicines is identified and managed.

Methods

We used a qualitative methodology with individual interviews of 29 participants who were current or recent members of public hospital DTCs across New South Wales, Australia. Participants included medical, pharmacy and nursing staff and one citizen. Committees were linked to specific hospitals or regions, and some were affiliated with paediatric, neonatal, rural or mental health services.

Results

Drug committee processes for oversight of medicines in public hospitals are vulnerable to pharmaceutical industry influence at several points. Applications for formulary additions are sometimes initiated and completed by company representatives. Conflict of interest disclosures among applicants and committee members may be incomplete. In some institutions, medicines are available from pharmaceutical companies without committee review, including through free samples and industry-supported medicines access programs. Participants noticed the presence and impact of pharmaceutical company marketing activities to local clinicians, resulting in increased prescriber demand for products.

Conclusions

Improved DTC practices and review of hospital policies concerning pharmaceutical marketing activities might preserve the independence of evidence-based decision-making for safe, cost-effective prescribing.

Main text

1 INTRODUCTION

Pharmaceutical industry marketing is seen by many healthcare professionals as an important source of medicines information. However it is associated with less appropriate and judicious prescribing and it increases costs, thereby reducing rather than improving prescribing quality.[1 2] Many doctors remain in denial about the negative impact of pharmaceutical industry marketing and continue to engage with the industry [3 4] despite the abundant evidence that the effects are real and corrosive. Industry-funded gifts to doctors, including low-value gifts such as lunch at meetings, alter prescribing habits in favour of brand name products over cheaper generic alternatives with established safety records.[5 6] Doctors who rely on free medicine samples in public hospitals are more likely to prescribe medicines that differ from their preferred choice [7] and practice guidelines.[8] One important tool for optimising quality use of medicines is a drug and therapeutics committee (DTC), also called a medicines committee, a quality use of medicines committee, a prescribing and medicines committee or similar.[9 10] These committees oversee access and use of medicines in their local institutions. They evaluate the efficacy and safety of medicines and create hospital formularies, which are lists of permitted medicines that suit the local patient cohort and institutional budget.[11 12] They protect patients and hospitals from the health and financial harms associated with use of medicines, particularly heavily promoted medicines.[10]

All public hospitals in Australia have a local, regional or state/territory based DTC that has governance over the formulary medicines that clinicians can prescribe for specified purposes.[10] DTCs review applications for new formulary medicines and applications to prescribe medicines for individual patients in exceptional circumstances –so-called 'individual patient use' applications. Individual use applications request access to a formulary medicine outside the approved formulary use, or use of a medicine that is not on formulary, which are often high cost medicines. This might apply for new drugs or in rare diseases, where there is limited or no evidence from randomised control trials. DTCs also

have responsibility for the oversight of medicines that may enter their institutions in other ways, including free samples and pharmaceutical company access programs where individual companies provide discretionary access to medicines at reduced or no cost, usually within a formal, company-administered framework.[12] Access programs are often run alongside company applications for national regulatory approval and/or subsidy of medicines, and inclusion criteria for access programs are generally aligned with the indication for which approval and subsidy are being sought. Companies may also provide access to free or reduced cost medicines on an informal basis, upon request from individual prescribers or patients.[12 13]

DTC membership is typically multi-disciplinary; membership is sometimes tied to specific professional roles; alternatively, members are selected from volunteers or recruited by the Chair. DTCs are supported at a state and national level by independent organisations that provide guidance and practical advice, including guidance on how to identify and mitigate the harm from pharmaceutical industry influence.[14] For example, the New South Wales Therapeutics Advisory Group (NSW TAG) advises all DTCs to include a section on the formulary application form where applicants must report past or future receipt of pharmaceutical company funds. However, there is little empirical data on the decision-making practices of Australian DTCs around which medicines are put on formulary or approved for individual patient use [15] so it is not known whether or how those processes might be vulnerable to pharmaceutical industry influence. There is also a lack of data on what strategies DTCs use to address industry influence within committees and their local institutions.

This project was prompted by ongoing concerns within NSW TAG about the potential for industry influence in public hospitals and an interest in identifying strategies to mitigate such influence. Our aim was to identify and analyse current DTC practices in order to

recognise potential points of vulnerability to pharmaceutical industry influence. Our research questions were:

- How do DTCs oversee access and use of medicines in public hospitals?
- What are the potential points of pharmaceutical industry influence on medicine availability and use in public hospitals?
- What strategies do DTCs use to detect and/or reduce the likelihood of pharmaceutical industry influence over DTC decision-making?

2 METHODS

We used the 'Consolidated Criteria for Reporting Qualitative Research' (COREQ) checklist to guide our reporting of the methods and findings.[16] Ethics approval was obtained through The University of Sydney Human Research Ethics Committee [2018/765] and St Vincent's Hospital Ethics Committee [2018/ETH00701].

2.1 Design

We used a qualitative methodology for our empirical research, well suited to researching processes and issues where there is little existing empirical data.[17] We conducted individual interviews using sampling, recruitment and data collection methods informed by grounded theory as practiced by Charmaz.[18] We drew on the emerging discipline of empirical ethics, whereby empirical research and theoretical reflection on ethics concepts are combined to inform ethical guidance on a specific topic.[19 20]

The research team included academic experts in commercial influences in health and pharmaceutical policy, health professionals in pharmacy, nursing, and medicine, and experienced qualitative researchers. One of the researchers (AB) is the Executive Officer of NSW TAG and has extensive experience with DTC practice and policy. Another researcher (LP) attended two NSW TAG meetings and three different DTC meetings as an observer in

order to gain background knowledge of their responsibilities and practices. No data was collected during these attendances.

2.2 Sampling and context

We used New South Wales (NSW), Australia as our geographic case study. The state is divided into 15 geographic districts and 2 other networks for health administrative and budgetary purposes.[21] NSW government policies set out the governance processes for medicines in the districts/networks, with DTCs having the primary role and responsibility, including oversight over approval of medicines on formulary. Districts may contain more than one major hospital and more than one hospital-based DTC, or have a centralised district DTC with subsidiary committees in local hospitals having defined responsibilities about medicines access and use within that institution. For example, hospital DTCs or subsidiary committees commonly review the individual patient use applications for non-formulary use of medicines in specific patient situations. NSW TAG estimates there are 50 DTCs across NSW, and the group's support for committees includes collating and sharing decisions from major DTCs in order to reduce duplication of effort and identify emerging formulary issues.[22]

Our study sample consisted of current or recent past members of NSW DTCs. As per widely used qualitative research methods,[17] we aimed to capture a wide range of experiences and perspectives. We used a purposive strategy,[23] recruiting people working across diverse DTCs (centralised district, hospital-based, paediatric, neonatal, mental health), different geographic locations (metropolitan, rural) and with a range of backgrounds (medical, pharmacy, nursing, citizen). Participants were recruited through NSW TAG newsletters, NSW TAG and DTC meetings and recruitment emails to selected individuals using contact details known to the researchers or in the public domain. We carried out sampling, data collection and analysis iteratively, and our sampling strategy evolved as the study

progressed in order to obtain diversity of participants and variation in data. We continued sampling until we were no longer hearing new information (thematic saturation).[24]

2.3 Data collection

LP conducted semi-structured interviews[25] between May and October 2019, either face to face (n =19) in the workplace or over the telephone (n = 10). Using telephone interviews meant we could include participants from rural districts. There was no appreciable difference in the length or quality of interview between the different modalities. Potential participants were sent an Information Sheet and Consent Form prior to the interview. Consent was obtained in writing before and/or orally at the time of interview and before recording. LP introduced herself as a researcher and medical practitioner, partnering with NSW TAG to interview DTC members about decision-making practices and pharmaceutical industry influence. LP asked about participants' local DTC policies and practices around pharmaceutical industry interactions and about their individual experiences and perspectives on industry interactions including risks and possible mechanisms of industry influence (see supplementary file). Interviews were audio recorded, professionally transcribed and de-identified. All participants were given pseudonyms for the quotes used in this paper. LP wrote field notes after interviews to record contextual information, initial thoughts and reflexive ideas.

2.4 Analysis

Analysis and data collection occurred iteratively so that each could inform the other.[18] LP read interview transcripts repeatedly to identify salient topics and concepts. Three early interviews were shared and discussed with the rest of the research team. LP used the emergent data, these discussions and the team's a priori research questions to create a set of thematic and descriptive codes, which she edited according to feedback from the team. LP imported transcripts and field notes into NVivo software and organised portions of text according to these initial codes. Data from later interviews were compared against earlier

analytic interpretations, and codes were adjusted to accommodate new concepts and understandings. Earlier interviews were re-coded where necessary. Coded interviews were discussed in regular team meetings to check interpretations and any discrepancies were resolved by consensus. Once data collection was complete LP drafted overarching categories that organised and explained the data, which were refined after further discussion with the team.

3 RESULTS

We interviewed 29 people: 12 women, 17 men. Participants were currently or recently affiliated with 19 different DTCs and all but one were active members of a DTC. Twelve were current or previous DTC Chairs (see **Table 1** for characteristics of participants and current or recent DTC affiliations). The mean duration of interviews was 60 minutes (range 28-107 minutes).

As described by participants, the processes for DTC oversight of formulary and Individual Patient Use medicines (see **Table 2**) were clear and routinely adhered to by local staff: [1] clinicians made a formal application with supporting clinical trial studies; [2] the application, including supporting evidence, was reviewed by the DTC executive and/or full committee and was [3] approved or rejected or returned to the applicant for additional information. The processes for DTC oversight of industry-provided free samples and medicines access programs (see **Table 3**) were less clear, and many participants were aware of situations where free samples or access program medicines had been used in their local institutions without going through DTC review. DTC strategies to detect and reduce the likelihood of pharmaceutical industry influence over their decision-making processes included: policies requiring committee members to make regular declarations about conflicts of interest; and a requirement that applications for formulary or IPU medications be initiated and signed by senior medical staff. Most DTCs did not take responsibility for regulating pharmaceutical company presence in hospitals or their relationships with hospital staff. Participants

generally did not see this as the role of the DTC or felt the DTC had no capacity to influence policy around, for example, pharmaceutical sales representative presence in the hospital. Participants were aware of the risk of pharmaceutical industry influence over the use of medicines in their institutions, including vulnerabilities in DTC processes and external to the DTC. These are discussed in more detail below and in **Table 4**.

3.1 Industry could influence hospital formulary and Individual Patient Use processes

Participants described direct company involvement in applications and a lack of clarity around financial conflicts of interests amongst clinician applicants and DTC members.

3.1.1 There was direct industry involvement in formulary and Individual Patient Use applications

Although DTC policy required formulary applications to come from senior medical staff (see **Table 2**) this did not always happen. Some participants spoke of applications being routinely initiated and/or completed by company staff, with a clinical champion providing the necessary signature and company assistance remaining undisclosed even when prompted by the application form (see **Table 4)**. Some applications were preceded by a request from the company representatives to the DTC pharmacist:

> '[They] contact you and say, "Dr so-and-so wants to add this. Can you send me the form?"' (Pem, pharmacist)

Participants voiced concern that this kind of company involvement in the application process might result in greater use of medicines from companies with a bigger marketing budget, rather than using the most appropriate medicines:

> 'Does that mean that it's the drug companies that jump up and down the most and get the clinicians to submit those formulary applications that get [their products] on our formulary?' (Rosa, pharmacist)

Others were concerned that company input might mean the application form was more complete and more likely to succeed, despite relying on biased and potentially misleading evidence compiled by sales representatives. Participants from well-resourced DTCs had the time and expertise to notice when applicants were being selective about the evidence they provided to back up the application. For example, they conducted literature searches or had enough content expertise to recognise when 'major, major bits of evidence have been omitted.' (Arthur, doctor). However, for other participants, the time-consuming nature of an independent evaluation of the evidence meant they relied on the applicant's literature submission despite recognising that might be incomplete:

> 'To go through the literature is very difficult so you have to rely on … those papers [that] are submitted by the person who's making the request, [and] there's that issue that they're the ones submitting what they want you to see.' (Vince, doctor)

3.1.2 Formulary and Individual Patient Use applications could be initiated by doctors with financial ties to industry

The current NSW TAG-endorsed templates for formulary and Individual Patient Use application forms include a section for applicants to declare conflicts of interest with pharmaceutical companies. However, this might be left blank, and even if was completed, participants noted the declaration might not accurately capture all relevant information about financial relationships between applicants and pharmaceutical companies (see **Table 4**).

A few participants said they sometimes actively sought additional information about financial links between applicants and pharmaceutical companies using institutional or publicly accessible databases of industry payments to doctors. Applicant links with industry might be particularly important in circumstances where local hospital politics could affect DTC decision-making processes. Greg (doctor) talked about 'animosity between DTC and the clinicians' which could potentially affect formulary or Individual Patient Use applications,

and Tom (doctor) said that the DTCs might feel pressured to accept applications from some local clinicians:

> 'Certain sub-specialty groups within hospitals … get a disproportionate amount of influence and leverage on the DTC … some specialists may or may not be leaning on particular individuals within their … DTC.'

3.1.3 DTC decision-makers could have conflicts of interest with industry

None of the participants had a policy precluding members with conflicts of interest from attending. Most participants said that members were expected to declare any financial conflicts of interest through annual written forms and verbally prior to each meeting, but implementation was incomplete (see **Table 4**). For example, there was not always enough time for the usual verbal or written conflicts of interest to be completed. Other participants said that verbal and/or written declarations about conflict of interest were not part of their committee's normal practice. There was little or no discussion about what constitutes a conflict of interest, for example it was left up to individuals to decide whether or not any financial relationships they might have with pharmaceutical companies were relevant to the current agenda. Similarly, no reporting thresholds (in monetary amounts) were mentioned.

DTCs dealt with declared conflicts of interest in different ways. Some participants said that any members with self-identified conflicts 'abstained from any comment' (Matthew, doctor) or 'would leave the room' (Cherylene, nurse) but others said that a declared conflict 'just gets noted.'(Brinda, pharmacist) One participant said that asking a conflicted person to leave the room would be received as an insult and others suggested that it would be undesirable to recuse members with financial conflicts of interest because it would mean missing out on the expert views of one or more highly regarded clinicians. This could be particularly problematic in smaller institutions:

> It becomes very tricky where all the doctors in an area benefit from money flowing … into their clinical trial fund, directly or indirectly. So … you need the expertise to

make a balanced decision about what is the value and worth of this. (Justin, pharmacist)

A minority of participants said that disclosures around conflicts of interest were not routinely requested at their DTC meetings.

3.2 Industry could bypass DTC oversight via free samples and medicines access programs

DTCs did not necessarily have oversight over the availability and use of medicines that were prescribed by hospital doctors and provided in outpatient clinics through free samples and access programs such as compassionate access and patient familiarisation programs (see **Table 3**). Most participants said that DTC policy was that free samples must be stored in pharmacy and only dispensed via prescription. However, most were also aware that free samples were sometimes given directly by pharmaceutical sales representatives to doctors or nurses, kept in clinic areas and given out without DTC knowledge or oversight (see **Table 4).**

Many participants said that their DTC also required all medicines supplied under medicines access programs to go through formal committee review. For example, clinicians were required to submit formal Individual Patient Use applications even for medicines provided freely or at reduced cost on compassionate access and must apply to the DTC for approval to participate in product familiarisation programs. However again, such policies were not always followed (see **Table 4**). Participants said that access programs might influence hospital use of medicines in ways that extended beyond the life of the program. For example, they might lead to clinicians acting favourably towards pharmaceutical representatives in order to maintain open channels of access. They also acknowledged that access programs might influence DTC decision-making, since committees that regularly reviewed Individual Patient Use applications for compassionate access could become more familiar with the use of a new product and more likely to approve it for new indications.

A minority of participants said their DTC allowed clinicians to engage directly with companies about access programs without any oversight. For example, Justin (pharmacist), said that 'As a drug committee it wasn't our role to ask' about compassionate access and explained that in his experience, 'Companies usually required, and we supported, the clinician to go to [Company A], for example, and say, "We have someone here who would like to use this medicine."' Another participant agreed that responsibility for use of medicines from free samples or medicines access programs should rest with the doctors and was, in their view, outside the remit of the DTC:

> I have heard of some specialists, like in haematology and oncology, potentially getting some starter packs for certain patients but not through pharmacy … I guess it's one of those things where it's just the clinicians use their own professional and ethical judgement to handle whatever interactions that they have with the pharmaceutical's rep, and it's not really the purpose of the DTC telling them how to be a professional. (Tristan, pharmacist)

3.3 Industry could influence medicine prescribing through marketing and relationship-building with hospital clinicians

Participants talked at length about the potential for pharmaceutical industry influence on the use of medicines in public hospitals through company marketing (see **Table 4**). They described direct marketing activities occurring in hospital grounds, including personal meetings between sales representatives and DTC members and clinicians, and industry sponsorship of lunches for staff educational meetings, sometimes preceded by brief marketing presentations. They also talked about marketing activities outside of the hospital including company funding for staff conference travel and registration, payment for dinner meetings at local restaurants, and promotional stalls at conferences. Participants recognised the immediate impact of these kinds of activities, noticing increase in prescriptions of relevant medicines or applications for putting new medicines on hospital formularies:

> I can tell when there is a dinner in town from a particular drug company who's doing education for the medical staff. I can tell you when the dinners are on because there'll be a renewed interest in certain items. (Leanne, pharmacist)

Many participants spoke about clinical trials as possible sources of influence of hospital medicine use. Trials were beyond the scope of responsibility for most DTCs, although some did review trial protocols when their institution was taking a leading role in the trial. Participants were generally positive about the opportunities that opened up for patients when their clinicians signed up to trials, but also discussed concerns about ways in which industry-funded research might lead to company influence over medicine use. They knew, for example, that hospitals with strong research agendas might build up well-established research teams, where salaries were funded by pharmaceutical industry money, and that this might create a level of institutional dependence on the industry. Some also spoke about the possibility that 'longer term relationships' between clinicians and drug companies might create 'a risk that that can establish a bias in prescribing and a bias in preference.' (Matthew, doctor)

3.4 Strategies and solutions

We employed semi-structured interviews, a strength of which is to allow participants to define their interest in a topic and to share information they find most relevant. Many participants initiated discussion about how to mitigate against risks of pharmaceutical industry influence over medicine use within their local institutions, thus we developed this line of conversation into the analyses presented here (see **Table 5**). Their suggestions were aimed at all stakeholders, including local and regional DTCs, hospitals, departments, individual doctors and governments. Dominant ideas were: improved conflict of interest declarations in formulary and Individual Patient Use application processes; more sharing of evidence evaluation and decisions between local DTCs particularly around new and uncertain products; and strengthened hospital policies to limit presence and activities of

pharmaceutical sales representatives in local institutions. No participants suggested having a policy that DTC members must be free of industry relationships.

4 DISCUSSION

The DTC members that we spoke with described standardised and well-defined DTC processes for oversight of availability and use of medicines through formulary and Individual Patient Use mechanisms within the NSW public hospital setting. However, their descriptions also highlighted that points along the decision-making pathway are vulnerable to pharmaceutical industry influence, particularly the application process, which is commonly instigated and completed by company representatives rather than clinicians. Some DTCs are under-resourced and others may feel pressure to accept requests from local clinicians; industry generated submissions may be particularly problematic in those situations. Current conflicts of interest disclosure practices amongst applicants and DTC members are incomplete, lagging behind policies for national and international bodies that assess drugs and medical devices [26] and behind standards for guideline development [27 28] and there is scope for improvement and tightening up of current policies. Despite clear guidance from the national Council of Australian Therapeutic Advisory Groups (CATAG) that DTCs should oversee all free samples and Medicines Access Programs,[12] there is variation in practice, with some committees delegating responsibilities to individual clinicians, and some clinicians assuming responsibility against the expressed policy of the DTC. This means that there may be an underregulated pathway for pharmaceutical companies to provide prescription medicines in some institutions. Pharmaceutical companies engage in multiple types of marketing activities to public hospital staff within and beyond the confines of the workplace. In DTC members' experiences, prescriber demand for products closely followed marketing events. Improved DTC practices and review of hospital policies around pharmaceutical marketing activities might reduce the risk of negative industry influence over prescribing quality.

The dominant concern raised by participants around pharmaceutical company marketing to DTCs and hospital staff leading increased use of new and branded company medicines echoes the recent medical literature. New medications are often no more beneficial than older products [29-31], are more likely to result in unforeseen serious adverse effects [32] and generally incur higher costs. In particular, the emergent field of so-called high-cost medicines places significant financial demands on healthcare institutions.[33] Pharmaceutical companies cultivate demand for new products amongst clinicians, encouraging them to use new products and/or apply to DTCs for formulary inclusion. They familiarise local clinicians with new medicines by offering them at no cost as samples or on compassionate access schemes. They indirectly promote new indications for old medicines by encouraging off-label use in public hospitals prior to, or instead of, submission for approval by national drug regulators, although this is in breach of Australian legislation.[22 34 35] Access programs appear generous but several problems have been identified: they may raise false expectations amongst patients given that there is often a lack of robust evidence for efficacy; they do not contribute to research on real world use since data on benefits and harms is not routinely collected; and they contribute to higher health expenditure since the costs are recouped by companies from future sales of medicines when access programs end.[10] Sales representatives encourage doctors to prescribe branded products instead of generics or biosimilars, as a way of showing support for their company's research and development activity, claiming that they need high revenue to support this important work. However there is already a generous system of patents to protect company profit margins, and income from sale of products is just as, if not more likely to go to marketing than to new research.[36]

This is the first interview study in Australia on interactions between DTCs and the pharmaceutical industry. Our identification of extensive drug company staff involvement in medicines application processes, which echoes findings about widespread industry influence over medical device purchasing in US hospitals [37], raises concern that medicines availability and use is shaped by industry interests. These may not match the interests of the public or of institutional budgets. DTC decision-making in Australia has been criticised in the past for

inconsistent outcomes and deficient processes [22 34], including inadequate evaluation of the quality and bias of supporting evidence, and insufficient transparency about conflicts of interest. Our results show that some of these concerns are ongoing. In addition, DTCs have limited oversight regarding marketing to hospital staff, and many did not see this as part of their remit, despite it being a clearly identified responsibility of DTCs by the World Health Organization (WHO).[38]

We suggest a multi-pronged approach to change (see **Table 5**). We urge DTCs to adopt additional decision-making processes similar to that used for the WHO Essential Medicines list[39], with key features being: strict conflict of interest rules for committee members and clear disclosures for all applications; an independent search for evidence; critical evaluation of the evidence by the committee; and open access to all applications and evidence evaluations so that committees can share resources. These practices should also apply to DTC oversight of medicines access programs. Hospitals and government health departments will need to allocate funds for this, but costs could be recouped through reduced medicines expenditure.[40] We advocate for banning pharmaceutical sales representative presence in hospitals in favour of academic detailing [41], and for Medicines Australia, the pharmaceutical industry trade association, to revise their Code of Conduct accordingly.

4.1 Strengths and Limitations

The strengths of this study are its empirical nature and the depth and breadth of interview responses received. We drew on the views and experiences of a diverse sample of committee members, and continued sampling until we were no longer hearing new information. We were able to provide a comprehensive picture of DTC oversight of medicines access and use in public hospitals, and how those processes might be vulnerable to industry influence. The study was confined to NSW, where DTCs operate at local and regional levels. In other countries and other Australian jurisdictions, the hierarchy of decision-making bodies is different, meaning that the responsibilities and roles of

committees will vary across different locations. The costs and benefits of the proposals in Table 5 are unknown.

Conclusion

Drug and Therapeutics Committee oversight of formulary, off-label use and medicines access programs is vulnerable to industry influence and while DTC members are aware of pharmaceutical industry influence over local prescribers at least some consider it outside their responsibility or feel powerless to intervene. Minimising pharmaceutical industry influence and promoting rational, cost-effective prescribing is important for reducing safety risks associated with new medicines and limiting the costs associated with new medicines, including high cost medicines. DTCs have been described in this journal as the 'guardians of safe and rational medicines use.'[10] In order to allow them to fulfil this role, DTC practices and hospital policies around pharmaceutical company marketing should be revised and strengthened. We urge DTC members and hospital administrators to work together on matters such as implementing tighter restrictions on disclosure processes and on industry marketing in hospitals, in order to preserve the independence of evidence-based decision-making for safe, cost-effective prescribing.

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