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Ethics & Behavior

ISSN: 1050-8422 (Print) 1532-7019 (Online) Journal homepage: http://www.tandfonline.com/loi/hebh20

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To cite this article: Marisa de Andrade, Aamir Jafarey, Sualeha Siddiq Shekhani & Nikolina Angelova (2018): The Ethics of Pharma–Physician Relations in Pakistan: "When in Rome", Ethics & Behavior, DOI: 10.1080/10508422.2018.1481751

To link to this article: https://doi.org/10.1080/10508422.2018.1481751

Accepted author version posted online: 05 Jun 2018.
Published online: 06 Jul 2018.

ETHICS & BEHAVIOR, *00*(00), 1–17

ISSN: 1050-8422 print / 1532-7019 online
DOI: https://doi.org/10.1080/10508422.2018.1481751

The Ethics of Pharma–Physician Relations in Pakistan: "When in Rome"

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This article investigates the pervasive influence of the pharmaceutical industry in Pakistan and primarily the attitudes of the medical community toward such interactions. We used an inductive approach informed by grounded theory principles to analyze interviews and focus groups with consultants, residents, medical students, and a pharmaceutical industry representative in Karachi and Lahore (n = 27), and participant-observation data from two biomedical conferences. Data were then analyzed through a deontological and teleological ethical theoretical framework. Findings highlight the reasons leading to the continuation of norms including weak regulations, physicians' expectations of receiving favors, and limited exposure to bioethics education. Recommendations for practice, policy, and research are discussed.

Keywords: pharmaceutical industry, Pakistan, medical ethics, pharma–physician relationships, bioethics education

Reliance on the pharmaceutical industry for medical products is a necessary part of healthcare provision (Jawaid, Jafary, Khan, & Hashmi, 2010). However, the industry has become increasingly influential in not only how medicine is practiced and what medications are prescribed but also setting the research agenda (Vakani, Jafri, Amin, & Sheerani, 2011). Pharmaceutical industry influence is reflected in Continuing Medical Education (CME) activities and meetings, in the selection of topics to be discussed during these meetings, and in choosing speakers for topics of their choice (Jawaid & Jafary, 2004).

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Although these influences have been visible across the world, there is now evidence of actions to curtail this infiltration of industry into the medical care, clinical research, and academic domains. In Pakistan, however, linkages between the pharmaceutical industry and physicians are still the norm despite some visible efforts to tackle them (Mustafa, 2012).

There is a dearth of literature on pharma–physician interactions in Pakistan and their impact on practice, policy, research, and public health. There have been attempts to understand the attitudes and perceptions of physicians regarding the ethics of such behavior in several Western countries (Campbell et al., 2007; Riese et al., 2015), but the scenario in Pakistan is different. Most of the literature is in the form of opinion pieces and editorials (Dawn, 2008; Khan, 2006; Reza, 2006). These pieces tend to emphasize the dangers of such interactions and explain the values that come into conflict with each other when physicians "sell their souls" to pharmaceutical companies (Shamim & Shamim, 2011).

An article by Jawaid and Jafary (2004) sheds light on the overwhelming influence of pharmaceutical companies in numerous academic conferences in Pakistan to the extent of driving the entire agenda of such events. Moreover, a study conducted with physicians in general practice in the country also revealed that pharmaceutical representatives were the most common source of information about new drugs on the market. Pharmaceutical representatives were also listed as major influencers in the prescription of medications (Rohra et al., 2007).

Almost all studies were conducted within the medical profession except one by nonmedical professionals in Pakistan. Asif and Amin (2012) found that physicians expect monetary rewards from pharmaceutical companies in return for prescription of certain medications. A "cocktail" of medications is prescribed to patients in anticipation of quicker results, but this strategy fails because patients have to buy medications mostly out of their own pocket and may find the costs of such prescriptions prohibitive to their budgets (Jawaid et al., 2010). Important to note, physicians do not believe that "cocktail" prescription occurs due to a company's influence, even though research elsewhere indicates that prescription patterns are indeed influenced through gifts (Wazana, 2000).

Due to limited information available on pharma–physician behavior in Pakistan, it is important to conduct primary research on this subject. By engaging with various stakeholders including a pharmaceutical industry representative, this exploratory qualitative study explores Pakistani medical community members' motivations for accepting gifts from the pharmaceutical industry, their attitudes toward such interactions, and the associated regulations. The article concludes by considering the possibility of moving toward a model where pharma–physician interaction no longer remains the norm.

METHODS

Study Design

This study followed a cross-sectional exploratory research design using qualitative methods with a segment of Pakistani medical community members and a pharmaceutical industry representative in two cities (Karachi and Lahore). An exploratory research design was employed, considering the fact that there is little or no literature available on perspectives of Pakistani physicians' interactions with the pharmaceutical industry in the country. This method of

qualitative research design is utilized when there are fewer studies to refer to on a particular topic, and thus it aims to provide new insights (Cuthill, 2002).

Because our study was concerned with the behavior of the medical community with respect to the pharmaceutical industry, we drew upon normative ethical theories of deontology and teleology (Murphy & Laczniak, 1981). These theories were considered suitable to understand the thought process behind the medical community's interactions with the pharmaceutical industry.

Deontological theory is concerned with the inherent righteousness of behavior rather than its consequences (Hunt & Vitell, 1986). In other words, deontologists believe that "certain features of the act itself other than the value it brings into existence" determine its righteousness (Frankena, 1973, p. 14). Teleologists, on the other hand, are concerned with the morality of the particular decision in terms of its consequences rather than its motives (Hunt & Vitell, 1986). They suggest that a behavior is ethical if it produces a greater balance of good over evil than any other alternative behavior. Teleological theories, however, differ on the question of whose good it is that is being promoted. If individuals try to promote their own greatest good, they are ethical egoists, whereas ethical universalists consider an act to be right only if it produces the greatest good for all people. Ethical approval for the study was granted from the Ethical Review Committee at Sindh Institute of Urology and Transplantation (SIUT).

Participants

Purposive sampling was used to identify appropriate participants who would be willing "to talk as freely as possible" while the interviewer guided "the discussion through a set number of key points as unobtrusively as possible" (Calvert & Calvert, 1992, p. 36).

Twenty-six participants from the medical community were recruited to take part in the interviews and focus groups. Five were consultant physicians (two psychiatrists, two family physicians, and one gastroenterologist), 15 were physicians-in-training (residents) pursuing postgraduate medical education in various specialized fields, and six were students enrolled in undergraduate medical education. Keeping in mind that there is another side to the pharma–physician interaction, the study also sought to involve representatives from the pharmaceutical industry to obtain the viewpoint of the industry. We managed to recruit only one interviewee from the pharmaceutical industry, which we acknowledge as a limitation. We did not intend to capture the pharmaceutical industry's generalized position on these matters through this interview. However, the interviewee reflected on major issues from the industry's perspective, so these views were included to make for a more insightful analysis. Data were also gathered from members of the medical community at two biomedical conferences through participant observation.

Due to the sensitive nature of the topic under investigation, recruitment was facilitated through a gatekeeper who was well known and trusted by physicians. The gatekeeper also ensured that the participants were fully aware of the research design and study purpose and translated or conveyed particular messages when language became a barrier. Participants were informed that the purpose of the research was to learn about the perceptions of their colleagues in relation to interactions with the pharmaceutical industry and have the opportunity to share their views on the subject and consequently inform future research, practice, or policy. The

authors believe that the perspectives of participants, whether the medical community or industry representatives, cannot be generalized to portray perceptions across the country.

Data Collection

Three methods were employed to collect data in December 2013: in-depth interviews, focus group discussions, and participant observations at two medical conferences.

Six in-depth interviews were conducted: five included the consultant physicians, whereas one interview was conducted with a pharmaceutical industry representative. Each interview lasted for approximately 60 min. Four focus group discussions were also conducted; three of these discussions involved physicians-in-training, and one included medical students as participants. Each focus group discussion lasted approximately 90 min. The interviews and focus group discussions were recorded digitally to aid record keeping.

The first author participated in the medical conferences facilitated through the gatekeeper, who also made the introductions. The researcher conducted her observation by taking field notes during the panel discussion as well as during informal conversations with conference participants during breaks. As the researcher was one of the conference speakers, some of the participants approached her to discuss the topic presented, and as a result they agreed to be part of the research. Objectivity was maintained by informing participants about the aims of the field work and field-note taking (Angrosino & De Perez, 2000). During the process of data collection, the researcher became immersed in the community in order to study it from within (Yin, 1993). This allowed her to gain a clear insight into the sensitive issues that were being studied (Funder, 2005). In addition, this involved asking herself not only *what* people were doing but also *how* they were doing, and most important, it facilitated her questioning of her own ideas about the "what" and "how" (Richardson, 1996, p. 103). To avoid research bias in the fieldwork, the researcher maintained an "open mind" (Funder, 2005, p. 2). She assumed that she did not know enough about Pakistani pharma–physician relations a priori and allowed the context to influence her thinking.

DATA ANALYSIS

Data from interviews and focus group discussions was transcribed verbatim by a professional transcriber. All transcripts were then anonymized and assigned identification numbers. An inductive approach informed by the principles of grounded theory was used to analyze interview, focus group, and participant-observation data, which allowed for the development of categories and concepts and an understanding of the relationship between emergent categories and concepts (Pidgeon & Henwood, 1997). This "grounded theory-lite" approach using "a set of procedures for coding data very much akin to thematic analysis" was deemed appropriate, as we did not aim to produce a new theory from the data (this could only be achievable through a larger research study; Braun & Clarke, 2006, p. 8; Pidgeon & Henwood, 1997). Instead, we used inductive coding to establish themes, categories, or concepts that could then be analyzed through the deontological and teleological ethical theoretical framework.

Each transcript was first read in full and then assigned open codes manually. Open codes refer to labels provided to certain concepts within the text (Strauss & Corbin, 1990). After this,

comparisons were made between the transcripts, leading to the development of themes. These two steps were conducted by the first three authors of the paper. Overlapping data were analyzed concurrently with a degree of flexibility to facilitate the modification of emergent findings (Eisenhardt, 1989). Triangulation (a process that involves the use of various data sources or multiple methods to increase validity in qualitative research) was provided through the field notes taken during participant observations by the first author (Carter, Bryant-Lukosius, Di Censo, Blythe, & Neville, 2014; Richardson, 1996). The agreement on the final themes, which were categorized by the patterned responses or meanings within the data set (Braun & Clarke, 2006), was done by resolving differences among the research team. The final step, conducted by all four authors, involved analyzing each theme through the deontological and teleological ethical theoretical framework (Frankena, 1973; Hunt & Vitell, 1986).

Findings

Our findings revealed several interconnected themes reflecting the pervasive influence of the pharmaceutical industry in Pakistan and attitudes of physicians toward pharma–physician relationships.

Weak or Nonexistent Pharmaceutical Industry and Healthcare Regulation in Pakistan

Almost all physicians noted how weak or nonexistent regulation in Pakistan leads to the increasing influence of industry. A representative from the pharmaceutical industry added, “In this country, you have every law written down but none is implemented” (Interviewee [int] 1). This was echoed by consultants, who said an “incentivized or disciplined” (int 2) approach to regulation would make little difference “in a country like Pakistan, where regulation and accountability and polices” are “only on paper” and “not put into practice” (int 4). It was noted that “there is no culture of respecting what is the law, what is the policy, what is the guideline” (int 4). This view was shared by several physicians who highlighted that there are existing guidelines, such as the Karachi Bioethics Group guidelines, but no one follows them or there is a lack of awareness about them (ethnographic observations). Residents tended to agree: “A law is a law if it is enforced, otherwise it is not a law” (focus group [FG] 1). Another physician in training emphasized that “laws should be made, and get us [juniors] to follow them” (FG 3). The representative from the pharmaceutical industry agreed: “You have to implement the law if you want to make traffic move normally on the roads” (int 1).

Participants said that this trend was pervasive due to the government being unable to regulate the health sector. They mentioned a widely reported incident that led to 150 deaths due to contamination of a drug during its manufacturing process, resulting in the formation of the Drug Regulatory Authority of Pakistan. However, interviewees generally noted that the regulatory authority has “failed to deliver” and is “not functioning” (int 1). One reason mentioned for weak regulatory processes was the devolution of powers from the federal government to the provinces as a result of a constitutional amendment (18th constitutional amendment, 2010), which led to a “chaotic period” that is “still persisting” (int 1).

According to the pharmaceutical company interviewee, the industry is “begging” to be regulated (int 1). It was explained that in the absence of government regulation, pharmaceutical companies are left to regulate themselves, which they do by using international guidelines.

Although it was acknowledged that there are "dangers" and shortcomings with international codes of conduct implemented by multinational pharmaceutical companies, the industry stakeholder said that these are established and "effective ways of countering those dangers," as companies "have built certain parameters to minimize those [dangers]" (int 1). Reference was made to industry self-regulated codes of conduct and companies being signatories of the United Nations and antibribery codes, thus ensuring that noncompliance was considered a breach.

However, some medical students felt that codes of conduct should not be implemented by the pharmaceutical industry or physicians themselves but rather by a central body with regulatory power to sanction physicians using "disciplinary measures" for breaking rules, such as having "your license … cancelled" (FG 4).

In addition to penalizing physicians who do not abide by regulation, it was also suggested that "you incentivize" those who are following rules (int 2). A consultant added that at present "there are no carrots and there are no sticks. … You should give us some incentive to practice ethically" (int 2). It was noted that the reward does not necessarily need to be financial—"a small certificate," for example, would be acceptable (int 2). Alternatively, physicians could just be publicly recognized for being truthful: "Being called an honest doctor as opposed to a dishonest one would work in every culture" (int 2). A system of "naming and shaming" physicians who behave unethically was discouraged by the physician-in-training, as it would result in "negative publicity" (int 2). Some residents agreed that this would be "going to one extreme of it" and lead people to become "angered" and "instead of convincing them, infuriate them" (FG 1).

Many physicians, across all levels interviewed, revealed that their interactions with the industry were largely governed by the "individual choice" they make based on their "conscience" (FG 3). As one resident put it, "Rules and regulations are always there from different bodies but again I think it is on a personal level, what I follow [and] what you follow" (FG 1). Some medical students said they did not "mind either way" (FG 4) whether a code to monitor pharma–physician relations existed.

On the other hand, a consultant wanted "to go a little further" than guidelines by introducing "advocacy and activism," even though there were doubts that this would work "because our two motives [physicians and the pharmaceutical industry] are so different; they are diametrically opposite to each other" (int 4). Nonetheless, the need for role models, in the form of individuals and institutions implementing these guidelines, was highlighted "to show the wider society" that you can implement regulations even though "there isn't a culture of accountability and checks and balances" (int 4).

The industry representative suggested that "the first step is to regulate the doctors," as "there is no [effective] General Medical Council" and there are "a [large number] of unlicensed practitioners, [and] quacks in Pakistan" (int 1). Consultants agreed that there are "some doctors who are working in the community and they don't even realize what they are doing wrong" (int 2).

Interactions with Pharmaceutical Companies Will Not Influence Physicians' Behaviors

Some physicians said that interactions with pharmaceutical companies and accepting gifts are acceptable as "as long as you are not influenced by them to the extent that you are compromising patient care" (FG 3), or as long as physicians do not promote pharmaceutical companies or sell

their products (ethnographic observations). This was based on the conviction that it is the physician's opinion that matters and the belief that physicians are able to "regulate their own actions" (FG 4), uninfluenced by relations with industry. One physician explained that physicians' behavior cannot be influenced by small gifts from pharmaceutical representatives because, as doctors, they are the ones who decide what drugs are accepted (ethnographic observations). Such opinions were voiced from all levels in the medical community. One explained, "They are not forcing you to do stuff for them" (FG 4). Therefore, some participants believed that the relationship may not involve an element of reciprocity. Another medical student went on to add that the favor may be "expected" but not "imposed" since there is no "signing of a contract" (FG 4). Physicians-in-training also said that awareness of industry's intentions protected them as they "would never prescribe those [medications] which were not effective" (FG 3).

Some respondents said that the nature and amount of an industry favor defined its appropriateness. There was a distinction between small gifts as opposed to large favors, with a widely held notion that "little things … cannot influence prescription" (FG 1). As one resident explained, "I am not going to be influenced by a pen or a mug or a tissue box that somebody gives, I don't even read whatever is written [on it]" (FG 2).

The position of an individual in the medical hierarchy was also regarded as one of the factors guiding the actions of individual physicians. Experienced physicians stated that although they may receive funding for conferences and CMEs, this does not influence their behavior, as the "more senior you become, the more you realize that you don't have to be obliged by any of this because it is an activity that you did, and it is a professional relationship" (int 3). According to one consultant, experience teaches you "how to draw lines," so medical students can be influenced by industry gifts, "but to a consultant who is earning fortunes every month, they are petty things and they cannot influence you" (int 3). Commenting on funding received to organize or attend medical conferences, another consultant added that their work would not be prejudiced because "they are just giving us money; they are not going to give us a presentation to present … the content of the symposia is decided by us" (int 2).

Pharma–Physician Relations are Geared Toward Inducing Reciprocity

Conversely, other physicians held the firm notion that "nobody gives a product for free" (FG 2). A consultant explained, "There is nothing like [no such thing as] a free lunch, there is something attached to that. And in the case of this industry, it is to prescribe their [specific company's] medications" (int 4). Relations with the pharmaceutical industry were therefore expressed as a "serious conflict of interest" (int 4).

Some residents said that the "give and take" dynamic of the relationship between the industry and the physicians is just "wrong" (FG 3). One explained that the relationship works through the use of clever "marketing and advertising, which, even if you think is not affecting you, is actually affecting you and those around you [juniors and colleagues]" (FG 3). The phenomenon of positive bias was offered as a reason for industry influence. The intention of the pharmaceutical representative, according to this resident, is to "make sure that you remember them" (FG 3). Another added that they ask to meet on a regular basis to "give you another reminder" and then "it goes back into our memory. In the end, we are like, okay, so they gave us something; let's just put their names [medications] down there" (FG 1).

According to one consultant, physicians' obliviousness to this influencing is due to "a little bit of ignorance and lack of awareness" and "unconscious denial" (int 2). This view was supported by a surgeon who explained that during his industry-funded fellowship, he was provided with training on a medical device that was also manufactured by the pharmaceutical industry. The surgeon added that the pharmaceutical industry works on physicians' relationships slowly without them even realizing it: "Maybe you're nothing now, but in the future, you'll be someone that they'll work with closely—you'll be their next key opinion leader. But this isn't something you notice" (ethnographic notes).

Physicians Expect Favors from Pharmaceutical Industry

As one consultant put it, "There is a deliberate attempt [on the part of physicians] to get favors, to get more money, [driven by] either … need or simple greed" (int 4). Other consultants agreed that their colleagues are complicit as they "twist" contacts with representatives for their "personal gains" (int 2). In fact, physicians feel a sense of entitlement to receive these gifts—"They think it's their right!" (int 2). One physician added, "This is Pakistan. When in Rome, do as the Romans do. Everyone is on the take here" (ethnographic notes).

Some said that physicians all over the world accept gifts, not just in Pakistan and other developing nations. Most, however, listed several "bribes" or gifts that could be exchanged: "There can be so many examples, you know, endless" (FG 1). Items included "simple trinkets like ballpoint pens and pads and stethoscopes, to the medium size ones like laptops and personal computers, to the really, the big ones like, like a car for example" (int 4); bowling and pinballing; international and domestic travel; tours; "if you need a car, they will give you a car" (FG 1) in return for prescribing "a thousand, two thousand pills" (FG 1); branded materials, such as lab coats, pens, USBs, and stationery; "Sunday brunch for the family" (FG 1); and trips to international symposia for physicians and their families.

The drug company interviewee explained how physicians themselves have wish lists for pharmaceutical favors that cause problems for multinational companies, who have greater restrictions and regulations. According to the industry respondent, when unreasonable requests are declined, the response from the physician whose request has been turned down will often be: "Go to hell! There are two hundred reps sitting outside my clinic who will [comply with my demands and] sponsor me" (int 1).

This respondent added that although there are "hundreds of [academic] papers bashing the pharma industry" (int 1), there are very few that emphasize the role of the physician in this interaction. This occurs due to the "privilege' enjoyed by physicians and the reputation of drug company representatives as "bad people" who go around "bribing people" (int 1).

Necessity of Pharmaceutical Support

One resident explained,

> The problem in our setup, the kind of patients we deal with are very poor. They can't afford medications. So if I had a choice between giving them a sample of an antibiotic [that comes from pharmaceutical companies] versus giving them no medication at all since they cannot buy it, I [will] choose that [latter] option not because it is right, but because it is the better of the two. (FG 2)

The main reason quoted for this state of affairs is that the government has relinquished its responsibility toward its primary duty of providing healthcare.

The industry has thus emerged as a savior in a system plagued with financial troubles, with junior physicians earning low amounts, thus creating greater susceptibility among individuals who "work horrendous hours" (int 2). According to one consultant, such a culture therefore promotes greater reliance on the industry which serves to relieve those who are "really struggling" financially (int 2). Residents added that industry aids cash-strapped government hospitals as well as private hospitals and provides necessary items such as air conditioners, refrigerators, ward equipment, water dispensers, and books and journals for the library. One consultant explained, "They come here and they offer us free drug samples; I am begging them to open up a small [free] drug [outlet for] my patients who cannot afford [to buy drugs]" (int 2). A participant in the bioethics session added, "This is Pakistan—we don't have access to drugs, our patients need these samples. We have to get the money from somewhere" (ethnographic notes).

The necessity of dependence on the generosity of the industry support was described by some as "major problem" (int 2). Rationalizing this dependence on the industry, a consultant said, "This kind of culture [is justified] because we are poor country" (int 2).

Other residents stressed that "the context of the environment you are in" also needs to be considered, and "when you are in clinical practice, there is no ideal world" (FG 2), implying that compromises have to be made. A consultant gave this example: "If I get stationery from pharmaceutical companies, then I save about three or four thousand [rupees] per month, so I might as well get it from the pharmaceutical agency" (int 4). Another provided this justification for accepting favors: "I needed file covers for my patients [medical records], and I was not getting a lot of support from my institution, so I asked one of the companies, and they very happily complied" (int 6). In such an environment, physicians tend to become "complacent" (int 2).

The pharmaceutical industry was also described as the main source for funding for Continuous Professional Development (CPD) activities. One senior doctor explained that without industry, most academic work would "dry out because 80% to 90% of the academic budget and bursaries come from the pharmaceutical end" and "that if you want to do a conference then you start begging [from the industry]" (int 2). However, commenting on the sponsored CPD activities such as attending seminars abroad, a representative from the pharmaceutical industry noted that often physicians "are not even attending the sessions" but rather "enjoying different types of pleasure trips" (int 1). It was suggested that perhaps only approximately 20% of the attendees actually attend the scientific sessions at conferences.

The Omnipresence of the Pharmaceutical Representative

Physicians-in-training explained how pharmaceutical representatives "are just sitting there" between rotations and "come in and they try and alter [change] our minds" (FG 3). A consultant viewed the omnipresence of representatives as a way of "building relationships" and the fact that they are there "most of the time to remind us [of their products]" (int 6). A difference in the attitudes of representatives was noted between junior and senior physicians. Medical students said they were not targeted as they do not write prescriptions, but heard "stories" about drug representatives approaching "big doctors" so that they could "build reputations so that they [consultants] will use their products" (FG 4).

In the opinion of a medical student, there was "no harm" in this if it is recognized that the company and its representative has a "good name and makes good product." In such a situation,

when there are "fair dealings with the doctor," it becomes acceptable to prescribe that product, according to this respondent (FG 4). Some students, however, had acute awareness that pharma–physician interactions meant that "there is a relationship that is developing," which is designed to influence the prescribing behaviors of physicians (FG 4).

One senior doctor explained how pharmaceutical companies are on commission and "even track the prescriptions: like, if I write a certain brand they will come and tell me thank you for writing that brand" (int 2). Their pervasiveness, along with the "cultural thing of insistence" means that for some doctors "it becomes very difficult to say no" (int 4). Consultants explained how they fit pharmaceutical representatives into clinic schedules even though it is at their "discretion" (FG 1) almost as in an appointment system: "We usually explain to them [to] make sure that you are coming a week from next so that there is not a rush of these persons [pharmaceutical representatives] outside [the clinic]" (FG 1).

Defending the promotional efforts of the industry, a medical student stated that "everybody has a right to advertise their product and just make themselves known" (FG 4). This opinion was echoed by residents, who said that pharmaceutical companies have the legitimate right to market themselves "as they want to survive in the market, they want their name out there" (FG 3). A physician who justified the marketing strategies of the pharmaceutical industry noted, however, that it is up to physicians whether they will let themselves be influenced by advertisements directed at them (ethnographic observations).

Blurred Line between Pharmaceutical Marketing and Scientific Information

Several residents viewed pharmaceutical representatives as sources of information, who "give us [doctors] updates about the drugs" (FG 3), sometimes daily, rather than marketers working on behalf of commercial companies. Some doctors expressed the belief that reminders are not influencing materials. As one resident put it, "These things are just for reminders for the names of the products. You are not influencing them really … even as a reminder I don't think they can influence the outcome" (FG 1).

Very early establishment of the link between the pharmaceutical industry and CME support was evident in an example offered by medical students on "surgery skills," where "they had pharmaceutical reps there" supplying needles and teaching suturing (FG 4).

For the most part, all of the information presented in pharmaceutical-funded conferences was perceived to be scientifically rigorous and accurate. One consultant explained, "As far as the topics are concerned, they are unbiased by it; none of the talks or the research or anything has pharmaceutical [industry influence]" (int 2).

Some senior doctors made a clear distinction between information and promotion. For example, "A little logo on the information leaflet" provided to "general practitioners in the community" was deemed to be acceptable if the physician "just write[s] that s/he collaborated with a specific company" (FG 1). An awareness program on a mental health day, where industry arranges "tea for the general public," "give[s] them the pamphlets," and provides information about doctors' presentations was viewed as informative by some residents (FG 1).

There was some evidence of critical thinking by some medical students, who view information sessions as a way for drug companies to continue "advertising their products" (FG 4). As one student explained, "We still have the brand name in our hand; we are using that brand each time … you will obviously remember the name; so marketing is done for them" (FG 4).

Corporate Social Responsibility

Under the rubric of corporate social responsibility (CSR), industry often organizes public awareness programs for health topics, such as breast cancer, osteoporosis, and so on, which are viewed by some physicians as genuine efforts to help the public. For others, however, CSR is seen as an opportunity to create positive bias for industry and the marketing of their products: "a euphemism for corruption as far as industry is concerned" (int 4). One consultant compared CSR activities to a religious "pilgrimage"—an opportunity for the industry representatives to "wash off their sins" (int 2).

It was suggested by some residents that industry always has "its own agenda" and "it's not pure philanthropy because you don't see that altruism" (FG 2). A consultant provided the example that

> giving a water cooler to a unit of a poorly resourced public-sector hospital is CSR; we are doing good for these poor patients, but in return, you [the pharma company] are asking that physician to make sure that the drug gets into the hospital formulary. [This is something] they will never reveal. (int 4)

On the other hand, the drug industry representative stated that painting schools and orphanages and creating patient access programs does not suggest an "ulterior motive" (int 1). A consultant, however, did not agree: "We need to be careful about laying a garden or building a school for poor people or creating water sewage lines in slum areas" as they are "wiping away the bad things with the good things" (int 3).

Some participants also expressed that despite the industry doing it for their own good, CSR was viewed important for a developing country such as Pakistan, due to lack of alternatives. In a country where poverty is rife, this was seen by some medical students as an ethical trade-off, as industry is "actually feeding hungry people" (FG 4).

Constant Struggle in Negotiating Ethical Boundaries

In absence of laws and regulations governing physician behavior with respect to the pharmaceutical industry, people are left to negotiate their own ethical boundaries. Junior doctors noted that "there are some blacks and some whites," but ethics is all about the "larger proportion" which is "gray." It was therefore suggested that "there is no right and wrong" (FG 4). This consultant, however, did not agree: "Whether you are a doctor in a well-resourced institution or not so well-resourced, there are basic ethical principles that you have got to adhere to, otherwise you shouldn't come to this profession" (int 4).

For several, accepting favors and gifts was acceptable if it went to a patient who could not afford it. In such instances, for example, "free medical camps" where pharmaceutical samples provided by industry were made available, this support was considered acceptable (FG 2). Others used the size of the gift as a gauge of acceptability, so, for example, "If it is a pen it's helping us [junior doctors]" then it would be appropriate (FG 2). Being "sent on trips" was not seen as ethical by some (FG 2), whereas others felt that it is entirely appropriate for a pharmaceutical company to fund physicians' travel to an international conference where they can learn more to inform their practice (ethnographic observations). A consultant suggested that it would not be acceptable to "take a sweater," but "a tissue paper box for the clinic" would be acceptable (int 2). Others, however, thought that it was appropriate to accept and keep a gift for

personal use, such as pens and key chains (FG 4). A small prescription pad, however, was described by one junior doctor as problematic if it was branded as "You are using a prescription in your practice [so] everyone is going to see it" (FG 4). Some also perceived the gift to be acceptable "if you feel that it doesn't change your decision-making" (FG 4).

One consultant suggested that accepting gifts is considered permissible "because it is not being talked about very often; you are not being questioned about it very often, so you become sort of complacent" (int 2). According to this participant, doctors need to set some guidelines for themselves.

There was some evidence that some doctors are starting to challenge social norms by criticizing peers who accept gifts; however, there was a view that "nobody can do anything about that" other than "look down at it in a bad way" (FG 1). Reference was made to the "culture" that doctors have grown up in: "Nobody likes or dislikes it; it's just there" (int 4). Reflecting the discomfort in such liaisons, some respondents expressed a desire for the next generation to be different to consultants who accept industry gifts—to be pioneers for a more ethical system. Some physicians were hopeful that the "new generation" can obtain information from different places, such as the Internet, thereby becoming more critical of the system (ethnographic observations).

Importance of Bioethics Education

It was noted that although 10 to 15 years ago "people didn't even hear the word bioethics" in Pakistan, now there are venues for learning about the field (int 4). One physician shared that ethics was not taught at medical school, and often students were exposed to "unethical practices" without even realizing it: "…when they organize events at hotels you speak to your friends and you're like, 'hey, are you going to that party?', and you go, just because you're a student and you don't think about these things" (ethnographic notes).

The importance of bioethics education, according to one consultant, needs to be reinforced throughout doctors' careers—"at every level, absolutely"—and have a practical element so students can see consultants practicing policies (int 4).

This was particularly deemed to be necessary for medical students. Several doctors suggested it should "be mandatory at the grassroots level," when students "are starting to think about interaction with the population" and industry (int 2). There was also a view that students should be taught humanities to reinforce "moral and cultural values" (int 3).

This notion was shared by the representative from the pharmaceutical industry, who said that in his estimation, only approximately 5% of doctors were exposed to ethics education, whereas for representatives from multinational companies, it was mandatory to be exposed to their ethics code. According to him, an "ethical code of promotional practice is hammered, hammered, hammered [into medical reps]," ostensibly to ensure ethical conduct (int 1).

DISCUSSION

The pharmaceutical industry's influence on physicians, at healthcare institutions, in clinics, and in other related areas seems well entrenched in Pakistan. The industry was observed to have expertise in cultivating targeted relationships with physicians by providing unmet needs in medical care, in equipment or CPD activities, or in the form of perks and privileges for influential physicians. All

these go a long way in building relationships, which ultimately have the potential to induce reciprocity (Dawn, 2008).

In addition, the absence of governmental regulations in the health sector, or the weak application of the ones that do exist, has created space for industry to dictate its terms, which physicians find difficult to challenge. Gradually, academic institutions have also relinquished their space to the industry, as mentioned by our participants, because it is a willing source of funding with large resources. The extra effort required to mobilize support from one's own institution is deemed too formidable, and the industry is an easy alternative.

However, one alarming aspect that the study raises is that very few people seem to mind industry influence. This is considered as the norm—the way things are done in Pakistan—so there is hardly any challenge to these customs. As our participants also explained, some people remain uninformed or in denial about the existence of this problem and take it for granted. Indeed, those from our study also remained convinced that in a country such as Pakistan, pharmaceutical support was "necessary." The realization that physicians are not questioning how industry behavior impacts their practices and therefore their patients raises some serious ethical concerns. One of the ethical frameworks that this article adopts—teleological theory—argues that it is essential to determine the consequences of a certain behavior to evaluate the morality of a particular decision (Hunt & Vitell, 1986). One could argue that in the face of the numerous problems surrounding the health sector in the country and the vacuum left by government, pharmaceutical industries have stepped in and become the "savior" by funding numerous activities. As our study showed, physicians seem to justify their relationships with the pharmaceutical industry by considering that this was the better of the two options—for example, no medications for patients versus medications funded by industry. However, both the industry and the physicians seem to be ignoring the long-term consequences of their behavior, which may be placing patients at risk of harm.

In contrast to rationalizing linkages with industry, deontological theory notes that some choices cannot be justified by their effects no matter how good they might seem, as they are determined by their features (Hunt & Vitell, 1986). In principle, the relationship between the pharmaceutical industry and physician raises the potential of a serious conflict of interest. The behavior of Pakistani physicians might be considered as detracting from the profession's integrity because it allows certain pharmaceutical companies to impact physicians' decisions on what medications they prescribe to patients. This directly harms patients, as industry serves to maximize its profit by charging high prices for medications, which is particularly problematic in Pakistan, as 70% of the healthcare expenditures are paid out of pocket by the patient (Pakistan Bureau of Statistics, 2009).

Thus far, we have examined the teleological and deontological theories as separate systems of ethics. However, many moral philosophers recommend a mixed deontological-teleological system (Hunt & Vitell, 1986). Frankena (1973), for example, suggested that "the way to tell what rules we should live by is to see which rules best fulfil the joint requirements of utility and justice" (p. 44). If we are to decide the ethics of physicians' behavior and judgment, this theory suggests that we first determine the rules of behavior. This can exist in the form of regulation. However, there was broad skepticism with respect to regulation, both from physicians and from the industry representative.

The widespread apathy toward enforcement of regulations in Pakistan has its roots much deeper than the issue of pharma–physician relations; often, Pakistanis express the same skepticism toward

enforcement of rules and regulations in other spheres of life, from traffic laws to the penal code. However, there were views that some code of conduct must be there to provide guidance. Even those who spoke about the need for such a code did not seem to be aware of the existence of such a document in Pakistan. Whereas the multinational pharmaceutical industry has a code of ethics, most physicians were entirely unaware that any such document that was relevant to them. This too reflects the loosely regulated body that the medical community represents, compared to industry (especially the multinational companies), which has far greater internal monitoring (Thomas, 2005). Physicians have classically preached self-regulation and shied away from any external regulating body interfering in this closed club (Cruess & Cruess, 2005).

The Healthcare Ethics Committee of the National Bioethics Committee (NBC) of Pakistan, a federal government notified body, has recently published guidelines for teaching bioethics to medical and dental college students (NBC, 2010). Although they are available for use on the NBC website, they have not been enforced by the Pakistan Medical and Dental Council (PMDC). Currently, no medical professional has been censored for issues related to a conflict of interest.

In this context, internal ethics has more significance in Pakistan. As the system of accountability will take its time in evolving, it is important for individuals to take responsibility for their own actions. Despite the lack of accountability or enforcement of regulations, there are examples of institutions and departments that refuse to interact with pharmaceutical representatives or seek their help in CPD activities. There are also groups, such as the Karachi Bioethics Group, a collection of individuals from different medical institutions from Karachi, who get together and discuss ethical issues in healthcare. This particular group has proposed its own recommendations regarding pharma–physician interactions (Karachi Bioethics Group, 2011).

Bioethics education can be an additional approach for providing regulatory frameworks to protect public health. However, although bioethics is increasingly being taught in medical schools, it is important to stress the aspect of a "hidden curriculum" (Cribb & Bignold, 1999). There is often a significant difference between what is taught in textbooks and the practical application of the course material. The problem is compounded by the fact that Pakistan is a hierarchical society, where the "professor" assumes the mantle of the unassailable patriarch; therefore, his actions and words count much more than anything written in the textbook (Moazam, 2006). Therefore, it was alarming to note that junior doctors speak about how they have seen their seniors taking "large" favors from the industry and that some of the interviewed physicians-in-training did not see anything wrong in the principle of this practice. This is an area of great concern, and as one consultant in our study emphasized, bioethics ought to be taught from the undergraduate level to raise the young physicians' understanding regarding such matters. It is also important to have role models, which targets the problematic area of the "hidden curriculum." One recent development in this area has been the capacity development initiatives by the Center of Biomedical Ethics and Culture (at the Sindh Institute of Urology and Transplantation in Karachi, which has been training healthcare professionals in leadership positions from across the country through Postgraduate Diploma and Masters programs so that they can introduce formal bioethics education at their institutions (Jafarey, Khan, & Moazam, 2015; Jafarey & Moazam, 2010). This is just one initiative, but such efforts can help sensitize physicians toward understanding the ethical challenges in their relationships with the industry.

LIMITATIONS

As the study collected participants' views on ethical practices concerning their potential relations with the pharmaceutical industry, they may have found it challenging to explore the topic, or perhaps they may have adapted answers to make them more appropriate. We believe that our sample size was adequate with respect to the medical community since we reached data saturation, meaning that no new codes emerged with subsequent transcripts (Guest, Bunce, & Johnson, 2006). Our sample size for industry representatives could be extended, but due to the difficulty in engaging this particular population on this topic, we chose to include the perspective of one representative who was accessible to us and has been involved in conducting academic sessions, elaborating the role of the industry in physician-industry relations for several years. Although we acknowledge that this particular pharmaceutical voice does not represent the perspectives of the entire industry, their opinions do capture the essence of the conflicts within this relationship. However, this does represent one of the limitations of our study, and future studies can engage more stakeholders from this position to obtain a wider picture. Due to the sensitive nature of the topic and relatively small number of easily recognizable participants, we did not get ethical approval to directly ask physicians if they were in receipt of pharmaceutical support.

Furthermore, all researchers come from a bioethics background and as such may have an inherent bias on the subject matter. The gatekeeper has been involved in teaching ethical issues in pharma–physician relationships for several years and helped develop guidelines for this with the Karachi Bioethics Group. As such, it is possible that recruitment may have been partial to participants who shared similar values. Every effort was made to minimize this. Participants were assured that there was no right or wrong answer and that they would not be judged or expected to answer or respond in any particular way. Irrespective of what their position is on the subject, this would be respected, and the reasons for maintaining such a position would be explored throughout the interviewing process to inform further research and policy.

CONCLUSION

There is a compelling urgency for the implementation of ethical reform and the introduction of statutory powers and enforcement in the public health system in Pakistan. This research provided evidence of how behaviors deemed unethical in the biomedical literature with respect to pharma–physician interactions are not considered uniformly "wrong" by stakeholders in Pakistan: the pharmaceutical industry, medical institutions, and physicians. What is more, there are several tiers of beneficiaries who would be at risk of disenfranchisement if the "system" is changed. Upping the "bid" to lure prescriptions by pharmaceutical companies is much easier than finding scientific evidence palatable for the prescriber to promote their products. The entire cadre of pharmaceutical reps depends on their own livelihood for the system to be preserved. Hospitals and medical institutions tend to benefit by having industry relieve them of responsibilities that are actually theirs. Last, the physicians are accustomed to receiving gifts, perks, and privileges, which they perceive as a right.

Nevertheless, there are some from within the system who are uncomfortable with the prevailing norms and want to bring about a change. To challenge the system, a multipronged strategy at three levels—prevention, accountability, and sustainability—is required. Prevention

involves raising awareness at various levels, such as in medical schools and during postgraduate training programs. The bioethics education guidelines recently developed by the Healthcare Ethics Committee of the NBC, if ratified by the PMDC, will be a step in this direction. In addition, the importance of bioethics education cannot be downplayed because it can help sensitize young physicians and medical students, who are comparatively easier to educate than senior physicians firmly established in their practices. There is evidence that people are forced to think and change their practices because of their exposure to bioethics (Jafarey, 2014). Public awareness is also essential, and it can be achieved through write-ups in national newspapers and discussions through mass media. With respect to accountability, the role of regulating agencies, such as PMDC, becomes even more important because they have the power to not award any points for CPD activities if there is overt pharmaceutical influence. Moreover, pressure from within the medical community, advocacy and lobbying can support the enforcement of regulations, as was done in the case of organ trafficking in Pakistan (Moazam, 2013). Austerity measures, such as ensuring limited pharmaceutical presence near the conference areas by separating the academic arena from the advertising area, can also be enforced by the government. Finally, a successful ethical reform might require the cooperation of international organizations with local partnerships and practitioners to be able to respond to local challenges and improve existing practices in public health.

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