LETTERS

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Drug information and the general practitioner

Sir,

The pharmaceutical industry is said to devote 45% of its promotional budget to financing the activities of representatives, a total of over £5000 per year for each general practitioner in this country.[1] Two questions arise: (1) What do general practitioners think of the quality of information supplied by representatives, in comparison with other sources of drug information? (2) How much are general practitioners' prescribing habits influenced by the activities of representatives?

We recently circulated a questionnaire on these subjects to general practitioners working in Greenwich and Guildford. The size and characteristics of the two populations were sufficiently similar for us to combine the results, giving a total of 156 responses from a population of 229 general practitioners (response rate 68%).

Eighty-four per cent of responders regularly saw drug company representatives; 26% of responders saw two to four per week and 4% saw four or more per week. Single-handed practitioners tended to see more representatives than doctors in group practices. A clear majority (70–80%) of these general practitioners were happy with the accuracy of information supplied to them by representatives as regards the efficacy of the drugs discussed and the indications for their use. However, on cost and contraindications, 47% felt that the information supplied was unreliable.

Drug company representatives ranked highly (together with advertisements in medical journals) as sources of information about the existence of new products. However, for information about the usefulness of new products, the general practitioners said they turned to non-industry sources such as the *Prescribers' Journal,* articles in medical journals, the *British national formulary* and contact with other doctors. The *Drugs and Therapeutics Bulletin* scored very highly for finding out about both the existence and usefulness of new products.

The 16% of responders who as a rule saw no representatives said that they doubted the impartiality of employees whose job it is to promote their firm's product, and they saw this promotional aspect as in conflict with the provision of reliable information.

In response to a direct question on whether they felt their prescribing was influenced by drug company representatives, 63% felt that they were influenced 'slightly' or 'not at all', the rest saying that they were influenced to a 'moderate' or 'large degree'. Oddly, of those saying they were 'not at all' influenced, half saw at least one representative per week.

Doctors do not have to bear the financial costs or the possible adverse effects of their prescriptions. This places on them the responsibility to develop critical self-awareness of the ways in which they are influenced in prescribing decisions. Conversely, by demonstrating that they can assess the evidence critically and independently, doctors can have a positive impact on the quality of drug information made available to them.

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Reference

1. Smith R. Doctors and the drug industry: too close for comfort. *Br Med J* 1986; **293:** 905-906.

Training practice nurses for prevention

Sir,

In 1985 Harrow health district appointed a facilitator, called the GP screening coordinator, to organize a basic screening programme to be undertaken in individual practices by practice nurses. It was recognized at this stage that there were no training programmes for nurses interested in screening in general practice and this had led to the setting up of a course in preventive medicine for practice nurses within Harrow health district.

The initial programme included lectures and workshops relevant to the practice nurses' prevention programme in general practice. Essential ingredients of the course were: an epidemiological overview of hypertension and cervical and breast cancers, information on practical aspects of blood pressure measurement, cervical and breast cancer screening methods, diabetes in general practice, and health education, including advice on healthy eating and prevention of alcoholism.

A pilot two-day course was run in February 1986, and was attended by 16 practice nurses employed in practices within the Harrow health district, two from the health authority's well person clinics, and two from practices outside the health district but in overlapping areas. Following publicity through local and national press and radio networks, the course was subsequently offered to practice prevention nurses throughout the country, and two further courses were run in June and September 1986. These courses were oversubscribed, and we currently have a waiting list of 30 applicants for the next proposed course in June 1987.

The participants provided written feedback about the course. Each member asked for more time to be spent on all the subjects covered, and the course has subsequently been extended to three days. The evaluation of the course demonstrated to us, however, that practice nurses are concerned about their lack of formal training for their posts and are clearly asking for more information on topics outside the sphere of preventive medicine. This in itself presents many difficulties, since a training course is impossible if the role of the practice nurse is not clearly defined. One definition of the practice nurse[1] is more concerned with the place of employment and the employer than with the role of the nurse.

There were problems with the financ-