

Strategic MedComms Forum 2010

Reshaping the healthcare
conversation

A report of the main points discussed
by David Williams, 3C Strategy Limited

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www.medcommsforum.com



NetworkPharma

About the author

David Williams pursued a career in the pharmaceutical industry for 12 years before joining the medical communications sector in 1989 to deliver educational and training multimedia programmes to clinicians, nurses and other health professionals on behalf of the UK Department of Health and Central Office of Information. Subsequently, David developed a number of early intervention strategic solutions to support the commercialisation process within the international pharmaceutical sector.

David then progressed to collaborate with medical and clinical associations, societies, colleges and accreditation authorities internationally to develop and deliver fair, balanced, unbiased and independent accredited events and on-line programmes in support of medical continuing professional development. David is now owner and managing director of 3C Strategy Limited, an independent communications and CME consultancy. Since becoming a consultant to the industry, David has been engaged in reviewing the medical communications sector across the whole of Europe and, as a founding participant in the Good CME Practice Group (a European CME Forum initiative), is currently occupied developing models for the assessment of effectiveness of medical education (CME) and its impact on day-to-day medical practice.

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Strategic MedComms Forum 2010: Reshaping the healthcare conversation

30th September 2010, organised by NetworkPharma Ltd

Chairman and Inquisitor: Professor Trevor Jones CBE (Director of Allergan Inc (USA) and Sigma Tau S.p.A. (Italy). Chairman of the UK stem cell biotech company ReNeuron plc, the International CRO Synexus Ltd, a member of the Boards of NextPharma Technologies Ltd, SciClone Pharmaceuticals Inc (USA), VeronaPharma plc and Tecnogen S.p.A.)

Session 1: The changing landscape

Session Lead: Dr Leo Francis (President, Publicis Medical Education Group) together with Dr Richard Smith (Board member, Public Library of Science) and Dr Alex Wyke (CEO, PatientView)

Session 2: The continuing evolution of Medical Education and the place of CME

Session Lead Chris Stevenson (Senior Commercial Director Global CME, Haymarket) together with Dr Tim Ringrose (Director, Doctors.net.uk), Professor Robin Stevenson (past-President, European Board for Accreditation in Pneumology) and Dr Monica Shaw (Global Medical Affairs Director at Shire Pharmaceuticals)

Session 3: The paradigm shift; let's get social

Session Lead Dr Andrew Spong aka @andrewspong (Editorial Director, Nexus and Co-founder, Healthcare Social Media Europe #hcsmeu) together with Dr Annabel Bentley aka @doctorblogs (Medical Director at Bupa), Alex Butler aka @Alex__Butler (Digital Strategy & Social Media Manager, Janssen Cilag) and Neil Crump aka @aurorahealthpr (Managing Director, Aurora)

Session 4: Defining the legitimate role of scientific communications between industry and stakeholders

Session Lead Charlie Buckwell (CEO, Medical Communications, McCann Healthcare Worldwide) together with Emma D'Arcy (Founder, medpharmaconnect), Dr John Gonzalez (Global Skills Lead – Publications, Global Clinical Development Department, AstraZeneca) and Chris Graf (Associate Editorial Director, Wiley-Blackwell)

Introduction

Many activities are undertaken under the umbrella term of ‘medical communications’ – including clinical communications, medical education and continuing medical education (CME)/continuous professional development (CPD). Each interest group has its own assembly – the publications planning congress, the digital conference or the European CME forum (amongst others) – and their own separate concerns and considerations, but they all share many common themes, such as a foundation in the science, transparency and the challenge of perceived bias. Let us not forget that they mostly also share the same funding stream, i.e. that provided by pharmaceutical companies, although increasingly there are signs of collaboration with non-governmental organisations and other non-commercial institutions.

Although these services are often delivered alongside each other, in recent years there has been an increasing separation of their development, certainly from traditional promotional activities such as advertising and sales force support, often brought about by regulatory and legislative requirements or perceived conflicts of interest. So, it is especially interesting that these specialties have been brought back together under one roof to review and begin to ‘reshape the healthcare conversation’.

The stimulus for the programme for this meeting came from confusion over nomenclature, as exhibited by many within the client base and even some among the medical communications community itself:

- What is medical communications?
- How does it differ from clinical communications or medical education?
- Is medical education the same as CME?
- How are publications to be managed within each of these silos?
- Do medical public relations and medical advertising sit comfortably under this umbrella term of medical communications, or should they be regarded as something completely different?

As the programme developed, wider issues became apparent and so the content and format for this event began to take form. It was not expected that many answers would be found during this one-day meeting, but rather it was intended to open the conversation and to engage the widest possible audience. The event was broadcast live and is archived for future access, and tweeting in and out of the event was wide-ranging and far-reaching. Links to these outputs and others can be found at www.MedCommsForum.com.

It is hoped that the conversation will continue within the community, within individual organisations, at special interest events and in LinkedIn discussion groups, such as the MedComms Forum. It is hoped that this will be the first of many multidisciplinary forums, and ultimately that we will be able to put forward a clear and consistent point of view about the role of medical communications.

The event

Over one hundred specialists gathered in the magnificent and inspirational setting of the lecture theatre of the Oxford University Museum of Natural History. They included representatives not only from the groups already mentioned, but also from the wider set of stakeholders such as physicians, patients and industry.

Under the expert guidance of Professor Trevor Jones, who acted both as moderator and inquisitor, four sessions addressed topics, including the changing landscape, the evolution of medical education, the impact of social media and the legitimate role of scientific communications between industry and stakeholders.

By way of an introduction, Jones recalled the old world of pharmaceutical discovery, development and detailing, in which only one person had to be communicated with – the doctor. However, the image presented and the appalling way in which we have carried out direct-to-consumer advertising in the USA has meant that pharma's reputation has become tarnished. Jones expressed a view that there really is only one customer now and that is the payer. While this is a crude and utilitarian approach to life, this is the situation we find ourselves in; and now, suddenly, the patient has also emerged as an important contributor to this overall debate. Patient groups today are hugely strong and hugely powerful, and demand a different type of relationship with industry. Hence, the patient is very much at the centre of things, although the payer remains the primary customer.

Session 1: The changing landscape

Dr Leo Francis discussed the changing environment and the relationship between industry and physician. The medical communications community needs to have a better understanding of what influences the prescriber, and be much more sophisticated about how they go about that engagement. Increasingly, evidence is required to support the programming delivered and the outcomes achieved. No longer are medical communications agencies just the purveyors of programming, they are now in the business of creating value and demonstrating the evidence that supports what they do.

Healthcare provision is embracing a change from sickness management to a focus on wellness. Insurance companies and other healthcare systems are increasingly looking at the retention of health and improving health rather than managing sickness because of its inherent cost-effectiveness.

The patient voice is becoming a mandatory part of the mix, not least in being able to encourage adherence and persistence. In addition, we now have tools to be able to demonstrate very clearly how we can bring about behaviour change and how that behaviour change truly shows patient benefit.

The pharmaceutical industry is seen in a very negative light. Why are there never conversations about the lives saved and the benefits, including patient wellness and improving productivity, brought about by our industry? The medical communications community should not be a silent partner in this environment but should be more vocal in its support of the industry. Francis suggested that this could be achieved by developing different collaborations with physician and industry associations, and with healthcare organisations.

So, the questions that need to be addressed are:

1. What will pharmaceutical manufacturers (our clients) look like in the future?
2. Are we making the most of patient contributions to health and healthcare?
3. Which of the changes we are seeing in this unfavourable political environment are making a difference to the nature of what we do?
4. How is the role of medical communications to change in terms of creating value rather than our traditional role of adding value?

Our proposition can no longer be simply to push messaging, communication planning, etc., we have to show how we are really creating value.

Dr Richard Smith agreed that the focus should no longer be on doctors, although they do remain important players. In their dealings with doctors, the reputation of the pharmaceutical industry is going from bad to worse and, although he was uncertain of what the medical communications community is, he said that if these are the people that are supposed to be getting messages out

about the effectiveness of drugs, how they can be useful and how they add value, it seemed to him that they are doing a very poor job.

Dr Alex Wyke focused on patient communities. Doctors feel disenfranchised and patient groups are rising in response to this. The alignment between community groups and doctors is getting closer and closer. All community groups are keen to have a role and it was suggested by one contributor that an educational dialogue is now required at this level.

The medical communications community needs to move on from being agents of the pharmaceutical industry, and it was suggested that the new role of the medical communications agencies could be as advocates to build relationship between patients and pharma.

As the discussion was opened to the floor, two points were made with regard to this:

1. Who will pay if pharma do not? Government, healthcare providers?
2. Patients are divided into many small groups (national, local, ethnic minorities, older, carers, gender specific, etc.) – up to 1 million estimated in the UK alone – making access a huge task. How, then, do you get patients involved when some patient groups have their own innate prejudices?

The point of compliance was also addressed, with patient leaflets being judged to be legalistic and difficult to read in years gone by. This has improved, but other communication channels now exist such as social media. Medical communications companies have the opportunity to address this on behalf of their pharmaceutical clients, but patient groups are generally uncomfortable with medical communications agencies getting involved. Patients do not want pharma involvement.

As summarised by Jones, this session provided no answers and appeared to generate more questions than anticipated; but one thing was clear, the medical communications environment has changed and will continue to change, potentially radically.

The medical communications environment has changed and will continue to change, potentially radically

Session 2: The continuing evolution of medical education and the place of CME

Chris Stevenson opened the session with a short presentation on the current status of CME that set the scene for the ongoing discussion.

In Stevensons' view, CME/CPD is becoming increasingly important, but is under rising pressure from government, insurance companies and healthcare professionals.

There is a growing need for access to independent, unbiased materials that provide medical professionals with critical information to keep them current, improve their knowledge and skills, and maintain and improve patient care.

One way this could be viewed, is that the industry has moved from the era of direct promotion (sales), to the era of indirect promotion (medical communications), to the era of transparency (education and transparency).

This raises several questions, including:

- Is the role of independently developed content a growing part of the future of information provision to healthcare professionals (HCPs)?
- What are the critical issues facing this market?
- How will this be funded?
- How will the medical communications industry respond? Can it respond?
- How should medical societies, accrediting bodies and providers of independent content develop their capabilities?
- What is the future role of pharmaceutical manufacturers in supporting independent programmes?

Professor Robin Stevenson told the gathered delegates that CME needs to move toward formats that are most likely to improve clinical behaviour, and that probably means moving away from didactic presentation to small-group interactive sessions with facilitators – these are things that are difficult and expensive to organise.

Activity accreditation exists to ensure there are adequate procedures in place to ensure lack of bias, etc. Across Europe, this is administered by EACCME (the European Accreditation Council for Continuing Medical Education). The system will usually quickly identify if there is just one company behind a programme and, in future, a single-sponsored event or activity will not be accredited as the move to multisponsorship gathers pace.

Where activity accreditation fails, in Robin Stevenson's view, is in identifying good education. Discussions are ongoing to decide whether Europe should follow the USA and change from activity accreditation to provider accreditation.

In response, Dr Tim Ringrose believed that industry should continue to be involved in CME as long as its involvement is completely transparent. While accreditation will generally be regarded as a stamp-of-approval that demonstrates a lack of bias, there remain other factors that may incur perceptions of bias that multisponsorship will not necessarily overcome.

Dr Monica Shaw then spoke about the relationship between industry and CME. When asked by Jones if she saw CME supported by industry as a necessary part of awareness and as marketing, Shaw responded by saying that she truly believed that industry can be an equal partner in the delivery of quality education. With this in mind, Shaw has a concern about the use of the word 'independent', because that assumes everything that comes from pharma is bad and everything that does not come from pharma is good. Everybody has a vested interest in whether programmes are deemed independent or not, and educational programmes are better judged on the criteria of bias and quality rather than just independence.

Chris Stevenson returned to the topic of activity versus provider accreditation and asked the audience whether, if offered the opportunity to accredit their own work, they would approach organisations such as Robin Stevenson's European Board for Accreditation in Pneumology? Whilst many indicated they would, there was an immediate question as to what current activities would have to be given up by medical communications companies for this to be a viable option?

One possible answer to this is that no agency would be able to deliver promotional and educational activities, and still be given the stamp of an accredited provider. However, at the moment, this is not yet the case in Europe. Chris Stevenson said that, for the foreseeable future, medical communications agencies in Europe do not have to give anything up. The US situation is different, however – the debacle of CME in the USA was caused by people thinking that they could pass off promotional programmes as independent.

Francis interjected here from the floor to say that Europe must learn from US mistakes. The way forward is through partnership, joint working and transparency; and medical communications agencies in Europe need to acknowledge that the US model is not one to follow.

The way forward is through partnership, joint working and transparency

Separately, Shaw stated that being independent is no guarantee of quality. The pharmaceutical industry is beginning to recognise that good education is good business because it wants physicians to practice good medicine, which in turn leads to positive outcomes for all concerned.

Buckwell also commented from the floor that maybe we need to reassess the language of 'promotional' versus 'education', proposing that it is more important to ask if an activity is ethical, well-founded, accurate and likely to drive evidence-based practice, and whether the source is transparent.

There was a suggestion from the floor that one unintended effect was that the pharmaceutical industry used CME for off-label promotion. Whilst Francis agreed that pharma does need to be in the mix, he re-affirmed that in the USA it is all about regulation. Off-label promotion would not be allowed and this was supported by another contribution from the audience: Eugene Pozniak, Programme Director of the European CME Forum, asserted that CME is about improving clinical practice. It is not product-driven and so there would be no perceptible opportunity for off-label promotion.

The next question from the audience asked why are physicians passive recipients of CME? The answer provided was that pharma sponsors have defined needs up until now. However, Robin Stevenson stated that doctors are taking an active role in their education by attending what is a relatively new format in the UK – the multidisciplinary team meeting, in which about 20 people consisting of doctors, nurses, surgeons, pathologists, radiologists, etc., come together in a room. Such meetings provide a very good learning environment, and directly affect the way medicine is practiced in future. They also have the unintentional benefit of being very inexpensive to organise.

The session drew to a close by asking what direction is accreditation taking and who is driving the agenda? Delegates were encouraged to be part of the decision-making process and help to define best practice by continuing the discussion within initiatives such as the European CME Forum's Good CME Practice Group.

Session 3: The paradigm shift; let's get social

Dr Andrew Spong acted as chair for this session and presented and discussed the impact of social media on the world of medical communications.

The influence of social media is causing pharma, HCPs and patient interaction to evolve. New environments are emerging with diverse audiences manifesting new needs and new expectations, particularly with regards to full participation. What are medical communications, medical education and medical publishing groups doing to adapt?

Patients are reaching out to their peers on the web and in so doing have formed communities serving different disease states, different languages, etc. Patients themselves are not impressed with the medical communications world. The e-patient is well informed and empowered.

On the other hand, stated Spong, the medical communications community is noticeable by its absence from the web. The recent International Society for Medical Publication Professionals (ISMPP) conference is a good example – little came out of the conference on the social web. The message here is that if medical communications providers are not talking to their audience that audience will look for its information elsewhere. The voice of traditional medical communications stakeholders is not to be heard on the social web. Why?

Dr Annabel Bentley laid out the opportunities of the social web from her point of view. Social media is no longer trivial, it is mainstream, and not to understand how this impacts on people's lives is to miss a huge opportunity. However, where there are huge opportunities, there are of course many challenges, especially around ethical and regulatory issues.

Alex Butler agreed. The opportunities are massive, but with that come risks. The low reputation of pharmaceutical companies has already been discussed, but social media provides pharma with the opportunity of having an open and transparent dialogue with the public, to show that there is a human face behind the corporate façade, to share value in terms of high-quality information, and to provide tools and resources to help people manage their medications better.

In addition, pharma wants to hear what people have to say. However, Jones immediately picked up on this point by saying that pharma is not allowed to get involved in a one-to-one discussion with patients. Pharma cannot promote its products to patients or encourage patients to ask specific questions about medication. Butler responded by saying that it is OK to engage people (who are not necessarily patients) in general discussions about their health.

This still unnerved many, but was countered by the results of a survey, carried out on the Janssen corporate twitter account, which showed that of respondents who said they were from the general public (60% of all respondents) over half said they did not trust information from pharma (despite following that twitter account). However, 98% said they did trust the links provided by Janssen on the UK twitter account @JanssenUK – the suggestion being that pharma can be a valued provider of quality content. This was corroborated by the number of requests from followers asking for more links to Janssen content and more information on drugs and clinical trials, and enquiries regarding Janssen's Facebook presence.

It does seem that this twitter account is enabling Janssen to speak to a slightly different demographic than previously. Interestingly, none of the twitter account users has yet declared an adverse event, and no-one has asked directly about a medication.

Neil Crump was next to comment and supported Bentley's assertion that social media is now mainstream, citing television news programmes that now turn to twitter to find out what the public thinks about an issue. Every other sector, whilst not as highly regulated, is engaging in social media. While the dialogue about health, about medicines and about disease is on-going, the pharmaceutical industry and the medical communications community is in danger of being left behind.

Jones then asked Bentley to discuss how she, as a medical professional, manages the burden in terms of the time she allocates to social media. Is there a danger of overload and what advice is there available on what Bupa can do with the information received?

Bentley explained that if you switch from a medium where the sender is in control to one where the recipient is in control, then overload is manageable. Social media offers this and allows people to manage their messages in a different way. The other thing that has changed is that you no longer have to be tied to your desk to manage your messages. So there is a definite shift in how information overload can be managed.

Spong went on to say that there is nothing to fear from social media and that it is just another channel that needs to be incorporated into the overall communications strategy. He encouraged all present to start to participate in the twitter community, #hcsmeu, where this is discussed all the time.

At this point the conversation was opened up to the audience and the first to comment was Dr Thomas Kellner from Merck, where communication with patients via social environment is considered to be high risk. He contended that to have a real impact requires a huge investment with unclear benefits and asked the panel to comment on this.

Another delegate made the point that pharmaceutical companies spend tens of thousands of dollars on static websites that never attract the number of visitors hoped for, whereas social media is fully engaging. However, the regulatory hurdles can be prohibitive when trying to conduct such a dialogue.

The answer from the panel was that regulation is not a good enough reason to not share with and support the public. There is a responsibility that goes beyond just selling drugs. Patients do not want promotion, they want information and conversation; patients do not want to be marketed at, they want to be talked to.

Janssen is developing its own charter of engagement on social media, and the medical communications community should develop its own rules of engagement soon, or a regulator will.

The view was expressed that it is a great excuse for industry to sit on the sidelines and say 'we need guidelines' when such guidelines might be regarded in some quarters as irrelevant. The focus needs to be on the fact that the pharmaceutical industry is inaudible to the patient. In a passionate statement, Spong said that the industry is invisible to the patient and is therefore irrelevant to the patient. The patient is not hearing pharma and pharma is not listening to the patient. Where is the patient in pharma strategy?

Ken Sutor, an independent consultant to the industry, stressed that traditional medical communications goes through a long process of approvals before it reaches publication, whereas social media is all about instant reaction and immediate response. It is quite difficult for the pharmaceutical industry and medical communications agencies to make that transition.

Other delegates emphasised the point that social media is simply a part of digital strategy. It is an evolving landscape that is currently generating more questions than answers but should be regarded as one component of the shift to better communication with the patient.

Social media should be regarded as one component of the shift to better communication with the patient

Session 4: Defining the legitimate role of scientific communications between industry and stakeholders

This session was chaired by Charlie Buckwell, who described the responsibility of the medical communications community as being to provide a foundation for well-informed, rational debate between all stakeholders – not to steer or control the debate, but to ensure that there are accurate and well-founded principles for that debate – and scientific communication needs to encompass not only clinical value, but also economic value.

Buckwell quoted Larry Hirsch, past President of the ISMPP, in asserting that physicians and medical scientists can provide objective, evidence-based reasoning, even if supported by industry.¹

To provide food for thought and for future discussion, Buckwell proposed a more balanced, up-to-date, evidence-based critique of pharmaceutical industry practices. Perhaps even a systematic review of what the industry is now doing in terms of transparency, fair balance and good publication practice, with improved health being a common goal.

In answer to a question from Jones on who should carry this out/pay for such a review, Buckwell replied that each of the stakeholders should have a part in its development. Its development would rely on the industry opening up its doors to its practices and on the academic community dropping some of the prejudice that it has about commercial interests. Such a review would also demand significant courage from all sides.

Jones then made the point that there have been groups in the past from academia who have objectively looked at these practices and set the record straight only to then be accused by the *BMJ*, *Lancet* and others of being in industry's pocket because of advertising. Nevertheless, this does need to be done.

Emma D'Arcy was then asked how legitimate it is for HCPs and the industry to be involved in this debate. D'Arcy turned this question on its head to ask whether scientific information from industry can legitimately be withheld from its stakeholders? We talk about the pharmaceutical industry having the right to publish and to communicate, but it is more than that. It is a necessity and responsibility of the pharmaceutical industry to demonstrate how it is performing to its stakeholders.

The perception/reputation of industry is exasperating. D'Arcy believes we are living in a McCarthy-esque era where everything that is touched by pharma is tarnished – every single day there is a negative communication about industry published somewhere. This is completely inappropriate, but overall the data tell us that the scientific community does trust industry and D'Arcy was of the opinion that the idea that patients do not want their doctors to interact with industry is generally not upheld.

Dr John Gonzalez commented upon the development of platforms where the science shows through. AstraZeneca is committed to good publication practice, but one of the problems it faces today is that the industry is judged on activities of 10 years ago; practices are very different now. Industry is these days transparent about its policies and transparent about its data. Investigators and journal editors have access to data; and independent auditors can investigate publication practices, such as the money spent with key opinion leaders, the money provided as grants, sales and marketing practices. Despite the fact that all these practices are in place, the industry's reputation still appears to be going from bad to worse.

Good corporate governance is not a message that the public want to hear.

A member of the audience stated that transgressions are still happening, especially in the area of authorship of papers. This was discussed by Chris Graf who wants to encourage authors to behave in an appropriate manner. Wiley-Blackwell has something in excess of 250 medical journals that each have their own policies and processes in place to encourage authors to get their manuscripts in order, and to include all the relevant information about authorship, funding, conflicts of interest, etc.

Jones put a question to the audience on just this subject: "How many people feel that the major medical journals operate a well-balanced editorial comment on publication strategy?"

¹Hirsch LJ. Conflicts of interest, authorship, and disclosures in industry-related scientific publications: the tort bar and editorial oversight of medical journals. *Mayo Clin Proc* 2009;84(9):811–21.

Just two or three responded positively and Jones supported this view by saying that he believes certain journals to be highly biased.

Returning to Graf, the subject of open access was raised. The growing tendency of pharma to post research results on its own websites will not replace 'proper' publishing. The pharmaceutical industry wants a certain journal brand and whatever that brand means to a community to impact on its clinical results; hence, peer review and author/expert interpretation of the data will remain important.

Wyke declared that patients feel annoyed about their limited access to medical journals, as they are unable to afford the necessary access fees. Graf responded by saying that patients can go to the library free of charge. Nonetheless, publishers are currently being challenged to find a business model that will make access for the public more equal. Big publishers are beginning to embrace the world of open access and more developments are likely.

There was some disagreement in the audience over this issue. Whereas some were of the opinion that is morally indefensible for patients to be asked to pay for this information, others could not understand this argument when patients pay for their computer to get online, they pay for prescriptions, etc.

Jones summed up the session by saying that huge significance lies in getting the message out there and letting patients express their views in a way that is influential is becoming important to them and vital to the industry in terms of the National Institute for Health and Clinical Excellence and other governmental bodies.

We are advocating communication founded on and driven by the science; alongside a more balanced, up to date, evidence-based critique of industry practices

Conclusion

As stated in the introduction, this meeting was not expected to create solutions but simply to act as a catalyst for future discussion.

Jones summarised by saying that the Forum had covered an incredible variety of topics. By allowing different parties in the medical communications community, industry and patient groups to get together to deal with the changing and changed nature of the links between all the stakeholders, the Forum has provided a really important starting point.

The data that are being generated from clinical studies need communicating in a rational way to both payers and to the public, and that is a vital role for all. But, perhaps most importantly, the patient must not be forgotten. Jones declared "If we forget the patient, we're dead!"

Developing the partnership between the professionals who research and develop the drugs, the professionals who sell the product and the professionals who communicate is the way in which the medical communications community can be successful for the patient and for the shareholder.

If the drug industry is to address its problem of always being portrayed in a negative light it needs to show the value of its drugs in new and innovative ways. The medical communications community can play a critical role in enabling fair balance, focused on the evidence and on partnership between stakeholders.

More information about future developments and links to the outputs of this meeting can be found at www.MedCommsForum.com

