NUMBER 98 November 2017

CODE OF PRACTICE REVIEW

PMCPA | Prescription Medicines Code of Practice Authority

The Prescription Medicines Code of Practice Authority (PMCPA) was established by The Association of the British Pharmaceutical Industry (ABPI) to operate the ABPI Code of Practice for the Pharmaceutical Industry independently of the ABPI. The PMCPA is a division of the ABPI which is a company limited by guarantee registered in England & Wales no 09826787, registered office 7th Floor, Southside, 105 Victoria Street, London SW1E 6QT.

ANNUAL REPORT PUBLISHED

The Annual Report of the Prescription Medicines Code of Practice Authority for 2016 was recently published. The increased number of complaints (76 compared with 54 in 2015) led to 100 cases in 2016, compared with 66 in 2015. The number of individual allegations (matters) considered in 2016 was 420, compared with 198 in 2015. Of the 420 rulings made by the Code of Practice Panel in 2016, 387 (92%) were accepted by the parties, 28 (7%) were unsuccessfully appealed and 5 (1%) were successfully appealed.

Continued overleaf...

DISCLOSURE TIMELINE 2018

Pharmaceutical companies with 2017 data to be disclosed need to be registered to use Disclosure UK well before the **29 March 2018** deadline for submission.

The ABPI Code requires the annual submission of company data detailing 'Transfers of value' – payments and benefits in kind made to UK health professionals and health care organisations (Clause 24 and others). The publication of this data on *Disclosure UK* is part of a Europe-wide transparency initiative spanning 33 countries. Further information can be found on www.disclosure.uk.org.uk and to register please email disclosure@abpi.org.uk

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PUBLIC REPRIMAND FOR SUNOVION

Sunovion Pharmaceuticals Europe Ltd has been publicly reprimanded by the Code of Practice Appeal Board for providing inaccurate and misleading information to the Panel and Appeal Board (Case AUTH/2935/2/17).

In Case AUTH/2935/2/17, the Panel ruled breaches of the Code as a Sunovion regional business manager (RBM) had encouraged staff at its February 2017 sales meeting to suggest to health professionals that if they did not consider Latuda (lurasidone) as part of a patient review there might be legal consequences. Latuda was indicated for the treatment of schizophrenia in adults aged 18 years and over. Sunovion accepted the Panel's rulings and provided the requisite undertaking.

During its consideration of this case, the Panel was concerned to note that in its initial response Sunovion did not provide an accurate summary of the interviews carried out regarding the February sales meeting which was only discovered when the Panel requested copies of the interviews conducted. The Panel queried why anonymised copies of these interviews had not been provided in the first instance. The Panel was disappointed by the conduct of Sunovion. Self-regulation relied, *inter alia*, upon the provision of complete and accurate information to the Panel.

On receipt of the case report as set out in Paragraph 13.4 of the Constitution and Procedure, the Appeal Board considered that the company's initial response was misleading and that the imposition of additional sanctions under Paragraph 11.1 should be contemplated. At its subsequent consideration of the matter the Appeal Board noted that in response to questioning the Sunovion representatives stated that the interviews were solely conducted by a senior UK director whose findings were that although the picture was mixed and unclear there was a strong probability that the RBM had done something wrong and that, on the balance of probabilities, this was in breach of the Code. According to the company representatives, this was included in the initial draft of the company's response to the complaint. However, the draft was altered by the US parent company based on external legal advice and it denied breaches of the Code stating that the interviews provided a mixed and somewhat unclear impression of the verbal direction provided. The Appeal Board considered that the responses of the company representatives to its questions were entirely contrary to Sunovion's written submissions to both the Panel and the Appeal Board and to the company's presentation at the consideration of this matter.

The Appeal Board was extremely concerned about the company's explanation. It considered that such a deliberately inaccurate, misleading and disingenuous response brought discredit upon and reduced confidence in the pharmaceutical industry. It was the respondent company's responsibility to provide accurate information. Self-regulation relied, *inter alia*, upon the provision of complete and accurate information from pharmaceutical companies. The Appeal Board noted the submissions from the Sunovion representatives and it considered that the company's conduct in altering its response, contrary to that of the investigator and the clear evidence from the interviews, raised very serious concerns about system failure and company culture.

The Appeal Board decided to require an audit of Sunovion's procedures in relation to the Code and on receipt of the report the Appeal Board would consider whether further sanctions were necessary.

Full details of Case AUTH/2935/2/17 can be found on the PMCPA website.

CODE OF PRACTICE TRAINING

Training seminars on the Code of Practice, run by the Prescription Medicines Code of Practice Authority and open to all comers, are held on a regular basis in central London.

These full day seminars offer lectures on the Code and the procedures under which complaints are considered, discussion of case studies in syndicate groups and the opportunity to put questions to the Code of Practice Authority.

For dates of the Code of Practice Seminars in 2018 please see the PMCPA website.

Short training sessions on the Code or full day seminars can be arranged for individual companies, including advertising and public relations agencies and member and non member companies of the ABPI. Training sessions can be tailored to the requirements of the individual company.

For further information regarding any of the above, please contact Nora Alexander for details (020 7747 1443 or nalexander@pmcpa.org.uk).

HOW TO CONTACT THE AUTHORITY

Our address is:
Prescription Medicines Code of Practice Authority
7th Floor, Southside, 105 Victoria Street, London SW1E 6QT

www.pmcpa.org.uk

Telephone: 020 7747 8880

Copies of the Code of Practice for the Pharmaceutical Industry and of this Review can be obtained from Lisa Matthews (020 7747 8885 or lmatthews@pmcpa.org.uk).

Direct lines can be used to contact members of the Authority.

Heather Simmonds: 020 7747 1438
Etta Logan: 020 7747 1405
Tannyth Cox: 020 7747 8883
The above are available to give informal advice on the application of the Code of Practice.

The Authority rather than the ABPI is the contact point for information on the application of the Code.

ANNUAL REPORT PUBLISHED

(Continued from cover)

The 76 complaints gave rise to 100 cases in 2016, higher than the number considered in 2015 (66 cases) or 2014 (49 cases). The number of cases differed from the number of complaints because some complaints involved more than one respondent company, and some complaints do not become cases at all, because they are withdrawn.

The percentage of cases ruled in breach in 2016 at 57% (57/100) was an increase compared with 2015, at 53% (35/66). However, if this is looked at on the basis of individual rulings 43% (182/420) were ruled in breach in 2016 and 2015 (85/198).

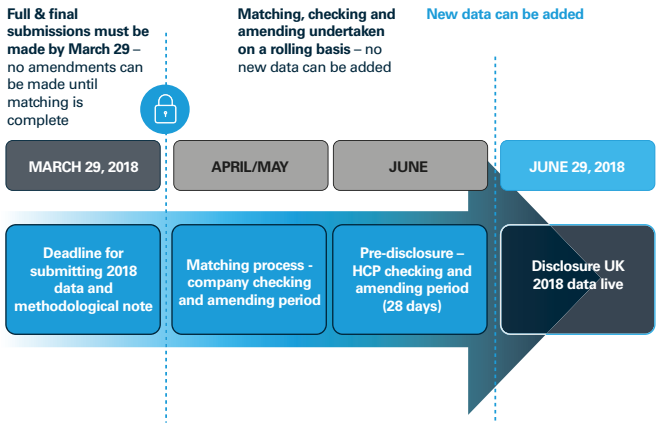
The average time to deal with all cases in 2016 was 11.9 weeks (9.8 weeks in 2015). The time taken to complete cases settled at Panel level in 2016 was 10.4 weeks, an increase compared with 2015, at 8.5 weeks. There was also an increase in time taken for cases which were appealed, 24.8 weeks in 2016 (19.2 weeks in 2015). The PMCPA is extremely conscious of the need to deal with cases as quickly and efficiently as possible. Many cases, however, required additional information before the Panel could make a ruling and in a few cases this was difficult to obtain. Three appeals were deferred due to procedural matters and a fourth following a request from the respondent company.

Each quarter the Authority advertises brief details of cases completed in the previous three months where companies were ruled in breach of Clause 2 of the Code, were required to issue a corrective statement, or were the subject of a public reprimand. These advertisements are published on the PMCPA website and placed in the BMJ, The Pharmaceutical Journal and the Nursing Standard and act as a sanction to highlight what constitutes a serious breach of the Code.

DISCLOSURE TIMELINE 2018

(Continued from cover)

Disclosure Timeline 2018 For 2017 Transfers of Value



Further details can be found in the ABPI Code (see Clause 24 and others) and on the ABPI website. The ABPI Disclosure template and Guidance on methodological notes can be found on the PMCPA website.

CASE AUTH/2783/7/15

THE DAILY TELEGRAPH/DIRECTOR v STIRLING ANGLIAN

Arrangements for a meeting

The Daily Telegraph of Friday, 24 July 2015 carried a number of articles critical of the activities of pharmaceutical companies in relation to payments to senior NHS staff. An article in The Daily Telegraph on 25 July named Stirling Anglian in relation to a meeting held in Germany. In accordance with Paragraph 6.1 of the Constitution and Procedure the matter was taken up as a complaint under the Code.

When notified of the complaint Stirling Anglian was provided with a copy of two articles ('The NHS officials paid, wined and dined on spa trip', and 'Doctors may have to declare links to drug companies') and an editorial ('Health Worries') which were all published in The Daily Telegraph 25 July 2015. These articles formed the basis of the complaint.

When informed by the PMCPA case preparation manager that the article 'The NHS officials paid, wined and dined on spa trip' would be taken up under the Code, one of the authors confirmed that the reports spoke for themselves. The journalist was willing to be involved to the extent of considering any questions from the PMCPA.

The Daily Telegraph articles of 24 July stated that senior health officials who helped decide which medicines were used by GPs and hospitals were '… being paid to work as consultants to pharmaceutical companies that want the NHS to "switch" to medicines they produce'. The articles headed 'NHS bosses paid by drug firms' and 'Lavish trips laid on by drugs firms to "sway" NHS staff' referred to an undercover reporter's findings. One article named two pharmacists one of whom was head of medicines management at a named clinical commissioning group (CCG) who attended a meeting in Germany at which a company took 12 'payors' to 'one of the top 10 hotels in the world'.

One of the articles reported that the named pharmacist who was head of medicines management claimed that each delegate was paid £500 a day to attend and all of those invited 'switched' to the company's product after the trip. The named pharmacist was reported as stating the attendees were treated to dinner at a 'flashy' restaurant and up to '£1,000 worth of champagne'. The report stated that the named pharmacist did not consider the ABPI Code applied once 'you're outside the country'. The savings to the NHS and that there was a clinical benefit were also mentioned.

The Daily Telegraph of 25 July, which named Stirling Anglian in an article headed 'The NHS officials paid, wined and dined on spa trip', included details about the arrangements; it stated that health officials attended a luxury trip hosted by a pharmaceutical company lobbying to get its products used by the NHS. It referred to a dozen senior staff, some of whom were named, who were taken to Baden-Baden, Germany. In the article a named pharmacist described the event as 'superb' and 'all the delegates came back with a glow'. They were paid £500 per day to attend and 'all the guests switched to the pharmaceutical company's products following the trip'. Three of the attendees were quoted as stating that 'no switches were made as a result of the meeting and decisions were made because drugs were cost effective or benefited the patient'. The article included photographs of the hotel which the named pharmacist described as 'one of the top 10 hotels'. The article stated that the PMCPA would be examining whether '… the trip had breached the rules' and that the Code stated that 'lavish, extravagant or deluxe venues must not be used'.

The second article 'Doctors may have to declare links to drug companies' and the editorial 'Health worries' referred to the meeting but discussed broader issues of NHS culture and disclosure of payments.

The detailed response from Stirling Anglian is given below.

The Panel noted that it was a well established principle under the Code that a pharmaceutical company was responsible for the actions of third party agents acting on behalf of that company. Stirling Anglian was responsible under the Code for the activities of its agents these being the third party named in the article and the manufacturer in relation to all the arrangements for the meeting in question.

The Panel noted that it was acceptable for companies to pay health professionals and others for relevant advice. Nonetheless, the arrangements for such meetings had to comply with the Code, particularly Clause 23. To be considered a legitimate advisory board the choice and number of participants should stand up to independent scrutiny; each should be chosen according to their expertise such that they would be able to contribute meaningfully to the purpose and expected outcomes of the advisory board. The number of participants should be limited so as to allow active participation by all. The agenda should allow adequate time for discussion. The number of meetings and the number of participants should be driven by need and not the invitees' willingness to attend. Invitations to participate should state the purpose of the advisory board meeting, the expected advisory role and the amount of work to be undertaken. If an honorarium was offered it should be made clear that it was a payment for such work and advice. Honoraria must be reasonable and reflect the fair market value of the time and effort involved.

As stated in the supplementary information to Clause 22, Meetings and Hospitality, there had to be valid and cogent reasons for holding meetings at venues outside the UK.

The Panel noted Stirling Anglian's conflicting submissions regarding the selection criteria. Stirling Anglian submitted that selected delegates included those who, *inter alia*, had questions about its manufacturing facilities and supply chain and that the meeting gave attendees the opportunity to conduct due diligence on the supply chain and manufacturing partners. The Panel noted that those were not valid selection criteria for advisory boards which should address *bona fide* questions of the company, not of the attendees.

The Panel examined the agenda. The meeting appeared to have two distinct parts; the morning lasted 2 hours plus an hour for lunch. It started with an hour on 'Operating and Company History'. This was followed by an hour on 'Presentation SAP' by Stirling Anglian. Half the group then toured the 'Production and Laboratory' with 'Highlight Macrogol filling lines' followed by lunch and the remainder of the group had lunch then the tour.

The afternoon meeting started at 13.30 with 'Questions and discussions on what you have seen today'. This was followed by two group discussions each of 45 minutes on CosmoCol and theiCal-D3. 'The Pipeline: Innovation, Tackling specials, new products and technology' was discussed for 15 minutes. The last session was 30 minutes on 'What have we learned today?', 'What action will you undertake on your return to the UK as a consequence of this event?' and 'If I were SAP I would …. Please complete the sentence'. All the discussions were group discussions other than the last session which was 'delegates in turn' and all discussion were 'facilitated by [the third party]'. The meeting closed at 16:00.

The Panel noted that the dedicated time on the agenda for the attendees to provide advice was not clear and allowing time for group discussions did not appear to be sufficient. Even if it were, this amounted to less than 2 hours (13:45 – 15:30).

The Panel noted that the description of the accommodation and evening meal in The Daily Telegraph article was different to that submitted by Stirling Anglian. The Panel noted that a letter drafted by Stirling Anglian's lawyers and signed by the named pharmacist retracted comments in relation to certain elements of hospitality referred to in the article. The letter stated that the comments made to the undercover reporter 'were false or grossly exaggerated' and he wished to correct the public record. The letter referred to the role of the third party in identifying various health professionals and experts in medicines management to provide advice to Stirling Anglian about how best to raise awareness of the company, its manufacturing/supply chain credentials and its medicinal products. It referred to Stirling Anglian paying economy airfare and £500 per day for attending. Hotel accommodation, dinner entertainment and ground transportation were paid by the manufacturer. The statement explained that delegates stayed in a straightforward business hotel near to Stirling Anglian's manufacturer's factory and a room at the hotel cost approximately £130 a night. He stated that he had grossly exaggerated when stating that the hotel was "probably the best in Baden Baden", that in the rooms "the waste bins were gold plated" and that the rooms of any delegate had a jacuzzi. There was no factual basis to state that the hotel "was top 10 in the world". The statement that a £1,000 was paid for champagne during the dinner entertainment on 2 July 2015 was inaccurate. The cost of the dinner (including any drinks) was approximately £70 per person. The statement concluded that the author had no reason to believe Stirling Anglian had breached the ABPI Code.

The Panel noted with concern Stirling Anglian's submission that advisory boards were a 'necessary and indeed entirely appropriate mechanism to engage with our customers and build awareness of our products'. Further that questions about the supply chain was a '*bona fide* reason for holding an advisory board in Germany'. The Panel noted that advisory boards were not an appropriate way to engage with customers and build awareness of products. The purpose must be for the company to obtain advice on *bona fide* questions.

The Panel examined the report on the meeting and was concerned that it, in parts, treated the entire meeting as an advisory board.

The meeting report noted that delegates all agreed that the trip was well executed, enjoyable and sociable. They did not feel, however, that the level of hospitality was in any way excessive. They appreciated the hospitality and enjoyed the presentations and factory tour. Some remarked that they were highly delighted to have been invited. There was unanimous agreement that every delegate would attend another advisory board of this type, if invited! The meeting report noted that the format of the advisory board was similar to the boards which were very successful. The manufacturer presented the history of the business, factory capacity and quality which produced a number of questions and comments. There was acknowledgement of good capacity for manufacturer and supply. There was a good degree of interest around twin dosing and resulting improved efficiency. One delegate mentioned use of calcium and vitamin D3 in caplet form, but stated the problem due to the total number of caplets per day. A third delegate stated at this point CosmoCol would be a particularly easy switch to make offering cost savings, improved flavour and improved range of flavours. Discussion around shelf life of CosmoCol was very positive.

The meeting report noted that a presentation was given by Stirling Anglian detailing pricing, product range and pipeline. Samples of theiCal-D3 were handed out. This prompted discussion round cost, savings and the advantage of once daily dosing. Discussion moved onto other pipeline products and

returned to Macrogol pricing. It was acknowledged that Stirling Anglian had driven down Macrogol prices in the UK. Certain other specific questions were raised at this point including on price, supply guarantee and questions on communications around pipeline products.

The factory tour of the plant was thought to be interesting and useful by all delegates.

The advisory board commenced after a buffet lunch and delegates were invited to respond to various questions including:

> **'What do you think about the meeting so far?'**
>
> **'How important do you feel it is to visit the factory in Germany? Could this be achieved by an advisory board in the UK?'**
>
> **'Prior to this meeting had you heard of Cosmocol?' and 'What are your thoughts on action on return?'**

The Panel was concerned that the questions and responses received indicated that this was not a *bona fide* advisory board. Responses referred to generous hospitality, that the visit to the factory in Germany was essential and switching to CosmoCol. Two of the delegates were not aware of CosmoCol prior to the meeting.

The discussion then switched the theiCal-D3. Questions included: 'What are your thoughts on theiCal-D3?' and 'What are your barriers to change?'

The Panel noted that responses included comments about the benefit of the once daily dosage regime and palatability. In general, delegates preferred this option to multiple doses of caplets. Comments around the favourable price point were received and widely acknowledged. Some delegates requested personal information around savings for their CCG, which Stirling Anglian agreed to provide.

The report then referred to a specific question from a delegate around future pipeline products from Stirling Anglian and their proposed costings. Stirling Anglian replied by giving approximate dates for proposed products which were desired by the delegates and their proposed costs were warmly anticipated.

The Panel noted that the question 'What will your general actions be on return?' was put to each delegate individually and according to the meeting report most of the answers included favourable comments about CosmoCol and switching and/or amending guidelines. There were also references to the theiCal-D3 switch programme. There was only one negative comment in relation to the prohibitive cost of a switch to CosmoCol.

The Panel noted the details of the presentations and discussions in the meeting report. The report appeared in parts to treat the whole meeting as an advisory board.

The Panel noted the company's submission that the meeting arrangements combined a factory visit with an advisory board and that the payment was for the advice received. It appeared to the Panel that according to the report, more emphasis was placed on the visit to the manufacturers and building confidence in Stirling Anglian and its products and understanding what the attendees' actions were on returning from the meeting rather than a genuine advisory board. Further, it was difficult to understand what advice was sought and would be obtained from the attendees, two of whom had attended another advisory board in another German city.

The Panel noted Stirling Anglian's submission that this was the fifth such meeting held at the manufacturing site and five other advisory boards had been held. The Panel did not have the agendas or other information about these other meetings but considered that if there was any similarity in the agendas it was difficult to see how this number of meetings could be justified. In addition, the Panel queried whether there was a *bona fide* need for advice such as to justify the advisory board meeting in question.

The Panel noted that the meeting for UK health professionals was held outside the UK and, as noted above, there had to be valid and cogent reasons for holding such meetings outside the UK. The Panel was concerned that the primary justification for holding the meeting outside the UK was the need for NHS staff to conduct due diligence on Stirling Anglian's manufacturing facilities and supply chain. The Panel noted the tour of the manufacturing facilities lasted an hour and queried whether in the particular circumstances of this case it was really necessary for the health professionals to travel to Germany to be reassured about the products and their supply. It would have been preferable for the manufacturers to come to the UK or to present using remote technology.

The Panel considered that overall the arrangements were not a valid advisory board: It was of concern that payment was received for 2 days at £500 per day rather than just for that part of the meeting (one afternoon) that Stirling Anglian described as the advisory board element. On the material before the Panel there did not appear to be a clear unequivocal issue upon which Stirling Anglian had sought advice which necessitated an advisory board; nor had the role of the participants in relation to the advisory board been made clear in the email invitation and elsewhere. The Panel noted its general comments above about the arrangements for the meeting. The Panel was especially concerned that at the end of the advisory board participants addressed what they would do differently as a result of the meeting which, in the Panel's view, demonstrated that the primary focus of the day was in providing information to and influencing participants rather than the provision of advice to the company. The time spent obtaining advice appeared to be extremely limited and further no preparation was needed. Taking all the factors into account the Panel did not consider that the arrangements either

for the whole day or just the afternoon were such that the UK health professionals had attended a genuine advisory board meeting. It therefore ruled a breach of the Code.

The Panel considered that, as it had ruled the arrangements did not meet the criteria for advisory boards, UK health professionals had been paid to attend a meeting where medicines were promoted including pipeline products. This was unacceptable. In addition, the payment was for two days and not limited to what Stirling Anglian described as the advisory body element. Further, it appeared that as a result of attending the meeting, health professionals' general actions indicated that switches to Stirling Anglian's products would be instigated. The Panel considered that the meeting was an inducement to recommend Stirling Anglian's medicines. A breach of the Code was ruled.

The Panel noted that the third party was providing services on behalf of Stirling Anglian. The Panel noted that under Clause 21 contracts under which institutions, organisations, or associations provided any type of service were only allowed if such services or other funding were, *inter alia*, not an inducement to prescribe, supply, administer, recommend, buy or sell any medicine. The Panel noted its ruling above of a breach and thus considered that the service amounted to an inducement. The Panel noted that Stirling Anglian had not exercised due diligence over the service. A breach of the Code was ruled.

The Panel then considered the level of hospitality. It was concerned that irrespective of whether it was justifiable to visit the manufacturer, the arrangements were unacceptable. There was no need for the delegates to stay in Baden-Baden. Accommodation nearer to the manufacturer should have been used. The hotel used was not appropriate, it appeared to be a lavish and deluxe venue. The location and facilities were still more akin to leisure travel than business purposes. The Panel was also concerned about the cost of dinner. Stirling Anglian's submission was inconsistent in this regard. The Panel noted the receipts for the pre-dinner drinks at the hotel which cost €447. Stirling Anglian submitted that this was not for the UK invitees but for staff from Stirling Anglian, the manufacturers and the third party. The Panel noted that the latter submission appeared to be inconsistent with an earlier submission which clearly stated on an agenda '18.30 meet at the Hotel… welcome drink 19.30 Dinner at the Restaurant…'. Overnight accommodation cost €199.

The Panel noted that the bill for the evening meal, twenty four people attended the dinner at a cost per head (excluding tax and gratuities) of £71.43.

The Panel did not consider that the hospitality was secondary to the main purpose of the event ie subsistence only. The level was not appropriate and was out of proportion to the occasion. Further, the costs exceeded the level that recipients would normally adopt when paying for themselves. A breach of the Code was ruled.

The Panel noted the supplementary information to the code Maximum Cost of a Meal which included the financial limit did not apply when a meeting was held outside UK in a European country where the national association was a member of EFPIA and thus covered by EFPIA Codes. In such circumstances the limits in the host country code would apply.

The Panel noted the limits in the German Code were relevant. The Panel noted the German limit of €60 and that around €100 or £71.43 was spent per head for dinner (excluding tax and gratuities). This was in excess of the local limit for a meal and therefore a breach of the Code was ruled.

The Panel considered that, overall, high standards had not been maintained and a breach of the Code was ruled.

The Panel noted that Clause 2 was reserved for use as a sign of particular censure. The health professionals that attended the meeting had received a payment for two days at £500 per day in connection with the promotion of medicines including pipeline products. The Panel noted that unacceptable payments was listed in the supplementary information to Clause 2 as an example of an activity likely to be in breach of that Clause. The Panel was extremely concerned that the role of the participants had not been made clear in the invitation or elsewhere. The Panel was also extremely concerned about the poor impression given by all of the arrangements. It noted its rulings above regarding the hospitality. Given Stirling Anglian's ultimate responsibility for all of the arrangements including those parts organised by the third party and its manufacturing partner, the company did not appear to have exercised due diligence and ensured that third party activities met the requirements of the Code. The Panel considered that the arrangements brought discredit upon and reduced confidence in the pharmaceutical industry. A breach of Clause 2 was ruled.

The Panel noted its comments and rulings above and considered that its concerns about the arrangements and the company's procedures warranted consideration by the Appeal Board. The Panel thus reported Stirling Anglian to the Appeal Board in accordance with Paragraph 8.2 of the Constitution and Procedure.

The Appeal Board was very concerned about the profound lack of Code expertise and oversight within Stirling Anglian that had allowed the meeting to go ahead. In the Appeal Board's view the arrangements for the meeting had been shambolic.

The Appeal Board noted that the company had accepted the rulings of breaches of the Code including a breach of Clause 2 and that it had stopped organising advisory boards until it was confident that it had appropriate oversight. The Appeal Board further noted the company's genuine contrition and that it had commissioned an external agency to audit its processes. Further the company had appointed a new general manager, was updating its procedures, training staff and considering employing compliance expertise.

Nonetheless, the Appeal Board was extremely concerned that UK health professionals had attended the meeting on the false understanding that it was an advisory board and had been paid to do so. This was unacceptable. Consequently, the Appeal Board decided, in accordance with Paragraph 11.3 of the Constitution and Procedure, to require Stirling Anglian to issue a corrective statement to all the UK attendees at the meeting. The corrective statement should refer to the case report. Under Paragraph 11.3 details of the proposed content and mode and timing of dissemination of the corrective statement must be provided to the Appeal Board for approval prior to use. [The corrective statement, which was agreed by the Appeal Board prior to use, appears at the end of this report].

The Appeal Board also decided, given its serious concerns about the conduct of Stirling Anglian as set out above, to require, in accordance with Paragraph 11.3 of the Constitution and Procedure, an audit of the company's procedures in relation to the Code, to take place in January 2016. On receipt of the audit report, the Appeal Board would consider whether further sanctions were necessary.

On receipt of the report of the audit and the company's comments in February 2016, the Appeal Board was encouraged by Stirling Anglian's willingness to improve its procedures and processes to comply with the Code, but noted from the report that significant progress was needed.

The Appeal Board was extremely concerned that despite a report that highlighted deficiencies in the company's knowledge and understanding of the Code and its failures with respect to compliance, Stirling Anglian had not provided any detail on when and how it would address those matters.

Stirling Anglian subsequently provided a further detailed response as requested. The Appeal Board was concerned that in an action plan some actions were marked as active with no indication of the expected date of completion. The Appeal Board decided that the company should be re-audited in June 2016 at which point it would be expected to demonstrate significant improvement.

Stirling Anglian was audited in June 2016 and although the Appeal Board was encouraged that the audit highlighted that Stirling Anglian had made meaningful improvements in compliance and that much work had been done, it also noted that there was still more to do. Stirling Anglian needed to ensure that its progress to date was maintained and built upon.

The Appeal Board decided that Stirling Anglian should be re-audited in April/May 2017 at which point the Appeal Board expected it to be able to demonstrate further and sustained improvement.

At its meeting in June the Appeal Board considered the report of the May 2017 re-audit and noted that the company's standard operating procedures (SOPs) were due to be reviewed and updated by August and it decided that Stirling Anglian should provide the PMCPA with the outcome of its review, evidence of training and any new SOPs by early September.

On receipt of Stirling Anglian's response the Appeal Board considered that the PMCPA should ask Stirling Anglian to further amend its SOPs in light of certain concerns. On the basis that this work was completed promptly, the progress shown to date was continued and a company-wide commitment to compliance was maintained, the Appeal Board decided that, on balance, no further action was required.

The Daily Telegraph of Friday, 24 July 2015 carried a number of articles critical of the activities of pharmaceutical companies in relation to payments to senior NHS staff. An article in The Daily Telegraph on 25 July named Stirling Anglian in relation to a meeting held in Germany. In accordance with Paragraph 6.1 of the Constitution and Procedure the matter was taken up as a complaint under the Code.

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One of the articles reported that the named pharmacist who was head of medicines management claimed that each delegate was paid £500 a day to attend and all of those invited 'switched' to the company's product after the trip. The Daily Telegraph reported that it had the names of the 12 attendees. The named pharmacist was reported as stating the attendees were treated to dinner at a 'flashy' restaurant and up to '£1,000 worth of champagne'. The report stated that the named pharmacist did not consider the ABPI Code applied once 'you're outside the country'. The savings to the NHS and that there was a clinical benefits were also mentioned.

A Daily Telegraph article of 1 August referred to 'Watchdog wants NHS whistleblowers to highlight fears over payments from drugs firms' and that the Director of the PMCPA called on 'industry figures to pass on complaints to help it "deal with these issues"'.

COMPLAINT

The Daily Telegraph of 25 July named the pharmaceutical company involved, Stirling Anglian, in an article headed 'The NHS officials paid, wined and dined on spa trip'. The article included details about the arrangements; it stated that health officials from across England attended a luxury trip hosted by a pharmaceutical company lobbying to get its products used by the NHS. It referred to a dozen senior staff, some of whom were named, who were taken to Baden-Baden, Germany. In the article a named pharmacist described the event as 'superb' and 'all the delegates came back with a glow'. They were paid £500 per day to attend and 'all the guests switched to the pharmaceutical company's products following the trip'. Three of the attendees were quoted as stating that 'no switches were made as a result of the meeting and decisions were made because drugs were cost effective or benefited the patient'. The article included photographs of the hotel which the named pharmacist described as 'one of the top 10 hotels'. The article stated that the PMCPA would be examining whether '… the trip had breached the rules' and that the Code stated that 'lavish, extravagant or deluxe venues must not be used'.

The second article 'Doctors may have to declare links to drug companies' and the editorial 'Health worries' referred to the meeting but discussed broader issues of NHS culture and disclosure of payments.

When writing to Stirling Anglian the Authority asked it to respond in relation to Clauses 2, 9.1, 18.1, 21, 22.1, 22.2 and 23.1 of the Code.

RESPONSE

Stirling Anglian stated that it took the issues raised very seriously and was disappointed that it had been associated with unfair, exaggerated and inaccurate reporting as depicted in The Daily Telegraph articles on 23 and 24 July 2015. It engaged external counsel and its manufacturer was also considering its legal position. The company was very surprised to see the comments of the Director of the PMCPA in an article on The Daily Telegraph website on 31 July which made specific reference to this case. Stirling Anglian submitted that such comments compounded the damage to its reputation.

As a recently formed small pharmaceutical company which aimed to grow in the face of fierce competition, Stirling Anglian submitted that conducting advisory boards in Germany was an entirely appropriate way to engage with health professionals, raise awareness of its products and build confidence in the supply chain. Stirling Anglian refuted any allegation that its actions were in breach of the Code. In particular, it could not be held accountable under Clause 2 for bringing the pharmaceutical industry into disrepute on the basis of unfounded comments made by a third party. Under the principle established by the European Court of Justice in the Damgaard case (Case C-421/07), the third party was responsible under medicine advertising rules for its comments and respectfully suggested that the PMCPA took this specific matter up with the third party. Stirling Anglian did not see where its actions or those of its manufacturers had been such as to bring discredit upon, or reduce confidence in, the pharmaceutical industry; it acted appropriately at all times and it was the subject of unfair, exaggerated and inaccurate reporting. This matter was taken up with the applicable editors and journalists of the journals that had reported this issue.

Stirling Anglian submitted it had no case to answer and therefore was not in breach of Clause 2. A recent email from the named pharmacist of the third party explaining his actions was provided.

Clause 9.1

Stirling Anglian submitted that it had conducted itself in accordance with the highest standards of professional conduct and had complied with the Code in all aspects of its advisory board meeting, factory visit and payments of honoraria to NHS personnel attending the event and providing expert advice.

The company was disappointed to be named in reports which it considered were unfair, exaggerated and inaccurate. Advisory board meetings were standard practice within the industry. The Code expressly allowed such meetings and factory visits to take place.

Furthermore, given that one of the manufacturing sites for CosmoCol was in Germany, it had valid and cogent reasons for holding such advisory boards in Germany. As a recently formed company, and in light of other companies failing to ensure continuity of supply at considerable cost to the NHS, potential customers continually asked its representatives about the supply chain arrangements including manufacturing partners, product quality and security of supply. For this reason, it arranged advisory boards at its manufacturing partner's factory, allowing customers to conduct due diligence as appropriate. This was a *bona fide* reason for holding an advisory board in Germany and allowable under the Code.

Stirling Anglian provided honoraria in line with advice on customary industry practice and economy class air fares. Again, these payments were within the Code and as far as it was aware, properly declared by delegates.

The German manufacturing partner provided hotel accommodation and an evening meal nearby together with ground transportation in Germany and meeting room facilities at its factory. Stirling Anglian was fully aware of its responsibilities under the Code. It discussed its obligations under the Code

with the German manufacturers, including the level and nature of the hospitality that was permitted and the details of the programme. Stirling Anglian and the German manufacturers understood that the hospitality provided was within both that guidance and the applicable German rules.

Clause 18.1

Stirling Anglian stated unequivocally that no gifts, pecuniary advantage or benefit was supplied, offered or promised to attendees at the advisory board, in connection with the promotion of medicines or as an inducement to prescribe, supply, administer, recommend, buy or sell any medicine. Stirling Anglian strongly denied any such suggestion or allegation and further, there was no evidence whatsoever of such practices.

Hospitality was provided by its German manufacturer as explained above but there was never any expectation that this was in return for a recommendation to prescribe its medicines (as clearly stated in contracts with the attendees). The honoraria paid were in line with industry standards in recognition of delegates' expertise and advice provided during the advisory board. These payments were of course then subject to each individual providing a declaration of interest to their employing authority, a matter over which the company had no control.

Clause 21

Stirling Anglian submitted that in the context of the advisory board at issue, held on 3 July, it did not engage with any 'institutions, organisations or associations of health professionals under which such institutions, organisations or associations provide any type of services' on its behalf.

Stirling Anglian engaged only with a named third party (a private company which provided advisory board services) and 12 individual health professionals. Further details of these arrangements were given elsewhere, however, the modest honoraria paid was purely for the advice received and did not in any way constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine. Stirling Anglian strongly refuted any such suggestion.

Clause 22.1

Stirling Anglian submitted that one of the primary reasons for the meeting was to provide delegates the opportunity to conduct due diligence as appropriate on Stirling Anglian's manufacturing facilities and supply chain. As the manufacturer's plants were in Germany, the advisory board had to be held there and given journey times from the UK, it was necessary to provide attendees with one night's hotel accommodation.

Accommodation, breakfast and an evening meal were provided and paid for by its manufacturer. The hotel in Baden-Baden was near to the factory and where the manufacturer usually hosted guests to the facilities. The hotel was relatively small and did not have in-house leisure facilities, although facilities were available from third party providers nearby. Neither Stirling Anglian nor its manufacturer were aware of delegates' use of any such leisure facilities and did not pay for any. Further, due to the very tight timeline and the focus of the advisory board meeting and the factory visit, it would have been virtually impossible for the delegates to have engaged in leisure activities.

Stirling Anglian understood the costs incurred by its manufacturer were reasonable and within the Code. It was told that the accommodation cost was around £130 per room per night.

The manufacturer provided meeting room facilities at the plant (where the advisory board was held), together with a tour of the factory.

Twelve UK health professionals attended the advisory board, along with staff of Stirling Anglian (two), manufacturer's staff (eight for part of the meeting) and third party organisers (two). The names of the delegates and other attendees were provided.

Clause 22.2

Stirling Anglian did not host or pay for any meals or accommodation during the advisory board. Rather, it was hosted by its manufacturer which provided and paid for all meals and accommodation during the visit.

The manufacturer paid for modest drinks, which were ordered individually and dinner at a restaurant in Baden-Baden on 2 July 2015, ahead of the factory tour on 3 July 2015. The guests were provided with a preselected reduced menu with a main course price range of £13 – 24. The average overall costs of the dinner for the whole party including starters, main courses, desserts and all drinks amounted to approximately €70. Further details and a breakdown were provided.

Clause 23.1

Stirling Anglian submitted that a group of health professionals was invited to Germany to:

- give the attendees the opportunity to conduct due diligence on Stirling Anglian's supply chain and manufacturing partners;
- provide advice on how best to raise awareness of Stirling Anglian and its medicinal products within the NHS; and
- provide advice in identifying other medicine needs within the NHS which Stirling Anglian might help address, in line with its vision of driving down costs, reducing waste and improving patient experience.

Delegates were selected on the basis of their interest in Stirling Anglian medicines and questions raised in relation to its manufacturing facilities. The third party invited the delegates from various NHS regions. The number of invitees was set at 12 to ensure a useful

discussion during the advisory board, but also to facilitate factory tours where numbers were limited. Stirling Anglian entered into a consulting agreement with each delegate which was specifically designed to reflect Code requirements. For example, it clearly stated that:

> 'Consultant shall carry out the Services to the best of the Consultant's ability in a professional manner and in compliance with all applicable laws, rules and regulations including all applicable anti-bribery and anti-corruption laws, the [ABPI Code of Practice for the Pharmaceutical Industry (the "Code")], the British Healthcare Business Intelligence Association ("BHBIA") Legal and Ethical Guidelines for Healthcare Market Research and/or any other codes of practice applicable in the country where the Services are being carried out.
>
> Consultant shall provide the Services for the ultimate benefit of Stirling Anglian Pharmaceuticals Ltd., (the "Company"). Consultant agrees that he/she shall declare that he/she is a consultant of the Company whenever he/she writes or speaks in public about a matter that is the subject of this Agreement or any other issue relating to the Company.'

and

> 'Stirling Anglian Pharmaceuticals Ltd. shall reimburse Consultant for travel and out-of-pocket expenses incurred by Consultant in performing the Services provided such expenses are reasonable and necessary in connection with the Services and have been approved in advance by Stirling Anglian Pharmaceuticals Ltd. The Parties acknowledge and agree that fees payable under this Agreement are intended to represent fair market value for the Services to be provided hereunder. For the avoidance of doubt the payment of fees under this Agreement shall impose no obligation upon Consultant to promote or otherwise encourage the prescription, recommendation, purchase, supply, sale or administration of the products of the Company nor is it intended to reward past practices.'

Stirling Anglian stated that where a CCG added Stirling Anglian products to its formulary, this was done entirely on an arm's length basis and purely on considerations of cost/benefit and in particular of patient care. Reports in the press to the contrary were inaccurate and without foundation.

Stirling Anglian engaged a third party private company to organise advisory boards on its behalf. Its services were limited to:

- recruitment of attendees;
- logistical support;
- chairing of advisory board meetings and
- provision of post-meeting review and summary of discussions.

In consideration for these services, Stirling Anglian paid a fee per advisory board. The letter confirming the terms of the engagement was provided.

Stirling Anglian stated that the third party invited a range of delegates from various NHS regions who expressed an interest in its products and had questions on its manufacturing facilities, supply chain etc, given it was a recently-formed company.

Stirling Anglian submitted that it was wholly legitimate for Stirling Anglian to raise its profile and seek guidance from health professionals on how best to raise awareness of its products with key staff. It was important that cost-effective and quality medicines were brought to the attention of key staff to allow decisions to be made to benefit patients.

It was also important to demonstrate to key NHS personnel the reliability of manufacturers and distributors of medicines provided by Stirling Anglian, so that there could be confidence in the continuity of the supply chain ie confidence that a patient prescribed one of Stirling Anglian's medicines would not experience any difficulty in obtaining a supply. Stirling Anglian also took advice from these advisory boards on the sorts of products to be developed and how existing products might be improved.

Copies of correspondence between Stirling Anglian and the third party were provided and copies of contracts that Stirling Anglian had with the third party and with each delegate. In spite of reminders signed contracts were not received back from three of the delegates.

The meeting was initiated by Stirling Anglian in response to feedback and questions from customers and potential customers. The delegates were identified (based on the selection criteria above) and invited by the third party. The advisory board setting allowed Stirling Anglian to gather together a number of key NHS medicines management personnel in a single venue. As such this was seen as efficient time management as opposed to organising a number of separate meetings with individuals.

Stirling Anglian submitted this format was perfectly acceptable to the ABPI and it was common practice within the pharmaceutical industry and the NHS. The setting also allowed an open and frank discussion and sharing of ideas amongst NHS colleagues. As a result Stirling Anglian gained a much better insight into the needs of the NHS and patients which would be put to use in developing its product portfolio.

One of the sites where CosmoCol was manufactured was in Germany. As such it was appropriate to hold advisory board meetings in Germany at the plant where customers could conduct due diligence as appropriate. For NHS colleagues the factory visit and the chance to meet key people from the manufacturer and from Stirling Anglian were all viewed as being crucial in providing reassurance about the continuity of the supply chain for Stirling Anglian's medicines.

In response to a question, Stirling Anglian stated that no materials were provided to the delegates during the meeting or afterwards. The only presentation slides used were those of the manufacturer, which comprised a company overview, details of its

capabilities and a description of the manufacturing process. A copy of the manufacturer's presentation was provided.

Stirling Anglian provided detailed account of the two day programme to include leisure time

2 July:
Travel from UK to Baden-Baden
18.30 Meet at the hotel in Baden-Baden. Welcome drink
19.30 Dinner at the restaurant

3 July:
09:00 Travel to manufacturer plant
09:30 Introduction and presentation by manufacturer
10:30 Presentation by Stirling Anglian
11:30 Group 1: Production & Laboratory Tour
11:30 Group 2: Lunch
12:30 Group 2: Production & Laboratory Tour
12:30 Group 1: Lunch
13:30 Advisory board discussion and questions
16:00 Shuttle back to the airport

It was an approximately two hour drive between Frankfurt Airport and the meeting venue and so it was impossible to schedule the event and travel into one day. The advisory board was held in a meeting room at Stirling Anglian's manufacturer's factory at Appenweier with lunch in a separate room.

In response to a question about certification, Stirling Anglian submitted that there were no materials which required certification.

In response to the request for a complete and comprehensive breakdown of all the hospitality provided to include incidental costs together with a copy of the receipted invoices and credit card receipts to show where bills were settled, Stirling Anglian submitted that as it did not provide the accommodation or sustenance it was unable to provide receipts. However, it was told by the manufacturer which met these costs that the hotel was €199 (around £130) per person per night and that the meal including starters, desserts, coffee and all drinks did not exceed £70 per guest. The meal was selected from a restricted menu with a main course price range of €13 -24 and given the heat and the long journey to reach the venue most guests retired early having mainly consumed soft drinks. Regarding the drinks, 26 bottles of mineral water, 32 aperitifs, 1 Coke, 4 bottles of red wine, 9 bottles of white wine, 1 glass of beer and 3 digestivs were consumed by the group as a whole only half of whom were members of the advisory board, the rest of the group being representatives of the manufacturer, Stirling Anglian and the third party.

In response to a question about fees and travelling expenses an honoraria of £500 per day was paid by Stirling Anglian to each delegate in recognition of their expertise and advice provided during the advisory board.

Stirling Anglian also paid for economy class air travel between the UK and Frankfurt together with out-of-pocket expenses. Details of the cost of each delegate's airfare and expenses were provided.

Stirling Anglian stated that it had held ten advisory boards since June 2013, five of which had been at the manufacturing site in Appenweier/Baden-Baden.

FURTHER INFORMATION FROM STIRLING ANGLIAN

In response to a request for further information Stirling Anglian reiterated that it took its compliance obligations very seriously. The company submitted that it had complied with the letter and spirit of the Code (as interpreted by various PMCPA cases on these matters) in relation to the advisory board meeting itself and this was reflected in the documents between participants and the third party. However, the company was infuriated by the untrue comments made by the named pharmacist about the arrangements and rationale for the meeting. The company referred to his email dated 13 August 2015 in which a retraction was made stating that 'a number of over enthusiastic and exaggerated comments' had been made.

Stirling Anglian also understood from the press reports that the relevant CCGs were checking to see whether the NHS officials who attended the meeting had complied with NHS standards of business conduct. Stirling Anglian submitted that the primary responsibility for ensuring that the delegates made the appropriate disclosures and obtained the right consents to work with Stirling Anglian rested with the individual delegates. Each CCG had its own guidance. The delegates represented and warranted to Stirling Anglian that they had complied with their NHS and other professional obligations.

Procedural comments/observations

Stirling Anglian asked that a number of procedural queries were addressed prior to the final determination. These included confirmation of the context in which the PMCPA provided comments to The Daily Telegraph in relation to the newspaper's article on 31 July 2015 ('Medicines watchdog calls for whistleblowers') whether The Daily Telegraph had provided a copy of the full video of the applicable interview with the named pharmacist and/or whether the PMCPA would be asking for a submission from the journalist responsible for the story. If so, it asked for a copy of the correspondence so that it had an opportunity to respond. Stirling Anglian stated it was seeking a retraction/clarification from The Daily Telegraph.

Stirling Anglian submitted that it (and no doubt other pharmaceutical companies using the third party's services) had been very badly let down by the untrue comments reported in The Daily Telegraph.

Stirling Anglian was fully aware of the PMCPA's position 'that a company was responsible for the actions of third parties employed on the company's behalf even if that third party acted outside the instructions from the pharmaceutical company'. However, without shirking its compliance obligations for the meeting itself, this principle could not

extend to situations where the agent/third party was genuinely 'off on a frolic of their own'. In this regard, Stirling Anglian referred to two reasons. Firstly, in making untrue comments to The Daily Telegraph (or anyone for that matter) the third party acted outside the terms of its engagement with Stirling Anglian. The company did not endorse the comments and nor did it authorize them. Secondly, nothing Stirling Anglian had seen from the reporting suggested that the comments were made to meet contractual obligations. Rather, Stirling Anglian understood that the comments were made to a journalist who pretended to represent an Indian pharmaceutical company which wanted to organize an advisory board on the Greek islands. This had nothing remotely to do with Stirling Anglian and the comments were not made to potential delegates attending Stirling Anglian advisory boards.

Stirling Anglian submitted that the second point above was a key issue from a vicarious liability perspective and it wanted to ensure that the PMCPA was aware of this nuance since it reflected the legal case law on this principle and therefore a body like the PMCPA exercising a public function must adhere to it during its decision-making process. Also, extending liability to situations where a third party was off on a frolic (as defined by the two factors above) was neither fair nor just and would result in an unreasonable interpretation of the Code.

For this reason, Stirling Anglian respectively suggested that the PMCPA also wrote to the third party in relation to the untrue comments made. There was a clear basis for the PMCPA to do this under the principle established in Damgaard and Stirling Anglian did not see any reason why the PMCPA could not invoke it (separately or in parallel to this complaint). However, the PMCPA might decide that the evidence provided to date to demonstrate that the comments were untrue was sufficient.

In response to additional questions from the Panel, Stirling Anglian accepted responsibility for the arrangements of the meeting but it could not be held liable or responsible under Clause 2 for the subsequent comments made by the named pharmacist and reported in The Daily Telegraph. It submitted that it had been very badly let down in this matter as had anyone using the third party to assist with advisory boards.

Stirling Anglian stated that the third party identified and proposed potential candidates who would be willing in principle to work with Stirling Anglian based on its knowledge and experience and in particular its healthcare contacts across the UK. As stated above, delegates were selected if they expressed an interest in Stirling Anglian's products and had questions about the company's manufacturing facilities, supply chain and so forth since Stirling Anglian was a recently formed company. The third party confirmed the delegates.

Stirling Anglian then invited delegates to the meeting enclosing a copy of the consultancy agreement and requesting certain information to make travel reservations. Copies of expense reports and invoice of the delegates, which were filled out and sent to the third party were also provided. Copies were then emailed or posted to Stirling Anglian for reimbursement.

Stirling Anglian was not aware of any other communications between Stirling Anglian and the delegates or between the third party and the delegates.

Stirling Anglian stated that it emailed travel details and a copy of the two-day agenda to the delegates. This was followed up by two emails with further advice on weather conditions and dress code. A more detailed agenda was later provided to delegates by the third party. There was no pre-reading.

Stirling Anglian stated that the consultancy agreement was drawn up by the company to ensure all its engagements with consultants were properly regulated. The services were defined in paragraph 1 to describe the advisory board meeting, which included a tour of the manufacturing facility, presentations on the manufacturing issues as well as the products and how Stirling Anglian planned on positioning them, before group discussion, questioning and the rendering of advice. The agenda for the meeting set out the scope of the meeting in more detail.

As previously stated, the consultants were engaged for their experience and expertise in medicines management. The services provided included:

- advice on how best to raise awareness of Stirling Anglian, its manufacturing/supply chain credentials (hence the factory tour and presentation by Stirling Anglian's manufacturer on the various manufacturing techniques), and Stirling Anglian's medicinal products within the NHS; and
- advice in identifying other medicine needs within the NHS which Stirling Anglian might help address, in line with its vision of driving down costs, ensuring supply chain integrity and manufacturing excellence, reducing waste and improving patient experience.

Copies of the contracts had already been provided to the PMCPA. Stirling Anglian had also included certain provisions regarding compliance with the Code that it wished to highlight. However, additional provisions that Stirling Anglian submitted were important in light of apparent investigations by the NHS into transparency and declarations, could be found in clause 6 which made it clear that the delegates confirmed that their attendance and services complied with applicable NHS and professional rules governing outside employment.

There was no obligation on any participant to conduct market research within any other role on behalf of Stirling Anglian.

Stirling Anglian provided a copy of the final meeting report. As stated previously, no slides were used at the afternoon meeting. The objectives for the meeting as a whole were clearly stated previously.

There were no separate objectives for each separate session. The format of the report reflected the objectives. The report constituted the final record of the meeting as produced by the third party. Stirling Anglian held no further records of the discussion.

The report gave a detailed account of the meeting including comments on the hospitality, presentations in the morning, including the visit to the factory and the afternoon advisory board meeting. It detailed the delegates' opinions on Stirling Anglian, its products both licensed and pipeline and what attendees would do on their return. The report also referred to discussion about switches. The report concluded that '… this was a useful and fruitful event. Many positive actions should result directly from the discussions'. Attendees would all 'attend another advisory board of this type if invited'.

Stirling Anglian submitted that given its longstanding relationship with the manufacturer, Stirling Anglian handled interactions with it on behalf of the third party, including, for example, provision of delegates' names and other details (eg arrival times). The manufacturer then arranged local logistics, accommodation and meals. A detailed breakdown of the costs for the hotel and dinner was provided previously and receipts were now provided. The lunch was a light buffet with soft drinks (primarily water) and was hosted in the main office of the manufacturing facility. According to the manufacturer, the cost of the lunch per head was €20.80.

In relation to Stirling Anglian's policies and procedures prior to the company joining the list of non members that comply with the Code and accept the jurisdiction of the PMCPA in May 2015 Stirling Anglian submitted that it had interacted with colleagues in a manner compatible with the Code and would always endeavour to do so. Material and meetings were co-approved by senior members of Stirling Anglian's staff. Advisory boards were documented as complying with the Code and the company expected delegates and third parties also to comply with the Code (the company referred to the contract with the third party and also the consultancy agreement with delegates) as well as their own NHS codes and professional codes of conduct. Stirling Anglian reviewed a number of PMCPA rulings on various advisory boards over the last several years and firmly believed that its approach was consistent with the letter and spirit of those rulings. In that connection, Stirling Anglian cited three cases where the PMCPA found no breach; Case AUTH/2527/8/12, Case AUTH/2454/11/11 and Case AUTH/2113/3/08.

Stirling Anglian also cited one example of advisory boards that the PMCPA considered on balance did not stand up to scrutiny, eg because delegates were being promoted to more than advice being sought; Case AUTH/2290/12/09. Stirling Anglian believed that the manner in which it conducted its meeting was far removed from such examples and delegates had not complained in this regard. Any suggestion or impression that the purpose of the meeting was promotional could only be the result of the untrue reporting.

Stirling Anglian provided a copy of a letter signed by the named pharmacist who wished to correct the public record.

In response to a second request for further information Stirling Anglian submitted that its response detailed below was based on its recollection of events at the time and this did not always fit with the particulars of the restaurant bill because the bill was mixed with beverages enjoyed by representatives from the manufacturer after the UK delegates had left.

Stirling Anglian stated that the hotel bill was not for pre-dinner drinks but for drinks and snacks in relation to a separate and distinct meeting of representatives of the manufacturer who arrived early to discuss the details of the organisation of the evening and the arrangements for the following day and to make sure that all were present by the time the delegates arrived. This was held in a meeting room at the hotel and included representatives from Stirling Anglian and the third party who joined that group for a meeting to co-ordinate the activities for the following day and also to decide the seating plan for dinner.

Stirling Anglian stated that there were 24 attendees at the dinner and that it had provided as complete a list of attendees as it had. The restaurant bill of €3,164.30 was for the meal and accompanying drinks, including pre-dinner drinks/aperitifs and water. However, Stirling Anglian noted that several UK attendees left the dinner early and a number of the drinks were consumed by representatives from the manufacturer who stayed at the restaurant later. In reality, the UK delegates in the main (as well as Stirling Anglian representative [sic]) drank water or soft drinks given the extreme heat and humidity which people from the UK were not used to. Most of the wine was ordered 'for the table' by the manufacturer (as host) but left untouched. Therefore, the restaurant bill simply did not reflect the arrangements for the UK attendees. Rather, it included drinks consumed mostly by the 8 representatives from the manufacturer at the end of the meal which was entirely separate from the hospitality provided to the UK attendees. Also, the bill did not seem to include all the bottles of water consumed. In addition, Stirling Anglian recalled several of the UK delegates asking for soft drinks yet only one was billed.

For these reasons, Stirling Anglian submitted it was impossible to tell which items on the bill were attributable to the UK attendees and those which were consumed by representatives from the manufacturer who stayed on at the restaurant after the meal and paid the bill at the end of the evening. Stirling Anglian stated its original letter merely included the crude cost per head breakdown based on the figures it had at the time. Since reviewing the items on the bill in detail it was clear that there were some irregularities and that a large proportion of it related to drinks consumed after dinner by employees of the manufacturer. Details of the £70 cost per head calculation was provided.

Stirling Anglian understood that a house special aperitif was provided which was available as an alcoholic or non-alcoholic beverage. Thirty-two aperitifs were listed on the bill and Stirling Anglian assumed that the restaurant calculated this on the basis of the number of jugs ordered by the manufacturer. Not everyone had a glass (most had coffee or more water). Stirling Anglian did not see anything excessive or lavish about the house aperitif.

Stirling Anglian stated that its German manufacturer considered that the level of hospitality provided to the UK delegates at the restaurant was reasonable and what one would typically expect to receive in Germany. The German Code applied to members of the "Freiwillige Selbstkontrolle für die Arzneimittelindustrie e.V." (FSA) ("Voluntary Self-regulation for the Pharmaceutical Industry"). The manufacturer was not a member of the FSA but the position under the Code was the same in that hospitality must be reasonable and within socially-acceptable bounds. When arranging the menu for the dinner, the manufacturer restricted the menu to reasonable choices. This was also consistent with the feedback from the meeting itself (report) and supported by the fact that no UK attendees complained about the hospitality (or any aspect of this advisory board for that matter). This was also consistent with Stirling Anglian's interpretation of events. With the benefit of hindsight, it would have been preferable to have a completely separate bill for the dinner and a separate tab for drinks ordered by the manufacturer so that the cost could be clearly broken down.

Stirling Anglian stated that the only slides used during the morning presentation were those by the manufacturer (previously provided). No slides were used and there were no speaker's notes for the Stirling Anglian speaker who articulated the company's corporate vision and values. This was a relatively informal, scene-setting introduction to the company followed by an interactive discussion.

Stirling Anglian appreciated that the Panel thought that pre-reading might be useful but it simply was not necessary for every advisory board particularly when the company was asking for advice on matters that were well within their expertise. Also the most valuable advice was an expert's instant reaction to a series of questions put to them individually and as a group. In a small session scenario, this advice worked very well for Stirling Anglian and allowed the company to fine tune its positioning so that it had the robust messages in place when meeting commissioners, who often had an instant reaction to what Stirling Anglian told them. This approach might be in contrast to a situation where a clinician was asked to digest detailed clinical trial information with a view to advising on clinical trial design etc. In such circumstances, Stirling Anglian could appreciate the potential need for pre-reading but much depended on the circumstances.

In addition, Stirling Anglian emphasised that there were just 12 consultants as opposed to a situation where hundreds of consultants were present in an advisory board. This approach would have a traditional "meeting" environment and Stirling Anglian would expect a Q&A session to be less useful since it would be general and non-specific. Stirling Anglian made these points because it noted the Panel's comments in Case AUTH/2747/1/15. Stirling Anglian emphasised that its arrangements for the meeting were very different to the situation in that case in various ways as described above. The company wanted to make it clear that it did not think there was a one-size-fits all approach to advisory boards in terms of precise time spent providing background information, the time spent in obtaining advice, how the advice was rendered and how the advice was digested by the company.

PANEL RULING

The Panel noted that Stirling Anglian had signed the form agreeing to join the list of non member companies that have agreed to comply with the Code and accept the jurisdiction of the PMCPA on 18 May 2015. The meeting at issue was held nearly 7 weeks after this agreement on 3 July. The Panel noted that the company's activities from 18 May 2015 including the meeting in question had to comply with the Code. The Panel also noted that in response to a question about what policies etc the company adhered to before 18 May 2015 to ensure such meetings met high ethical standards the company submitted that it had and would always endeavor to ensure that it interacted with colleagues in a manner compatible with the Code. There was no evidence that Stirling Anglian had reviewed activities and materials including the meeting arrangements on joining the non members list. In addition, the Panel noted that even before 18 May 2015 Stirling Anglian would have had to ensure that the arrangements complied with relevant UK legal requirements.

The Panel noted that Stirling Anglian had raised a number of procedural matters which the Panel considered in the usual way as part of its ruling.

The Panel noted Stirling Anglian's concern about another article on The Daily Telegraph website (31 July) which referred to this case and comments made by the Director of the PMCPA. The Daily Telegraph article referred to the Director calling upon 'industry figures to pass on complaints to help it [the PMCPA] "deal with these issues and problems"'. The article explained that the PMCPA had dealt with cases about advisory board meetings and if anyone had evidence of activities that they were concerned about in relation to the Code they should submit complaints to the PMCPA to be dealt with. The article then went on to refer to its recent coverage of advisory board meetings and that the PMCPA was 'currently carrying out an inquiry into a trip for NHS officials funded by … Stirling Anglian to the German spa town of Baden-Baden'.

The Panel noted that in accordance with established procedure the Director provided a factual response to press enquiries. The ABPI had organised a press briefing to discuss disclosure of transfers of value and the development of the ABPI central platform for such disclosure. The Director of the PMCPA had been invited to present about the Code in general and a Daily Telegraph journalist at the meeting had asked relevant questions. The Panel did not accept that

very general factual comments by the Director that there had been breaches of the Code ruled in relation to advisory boards and the discrete factual comment that the PMCPA was taking action in the present case would be prejudicial or compounded the damage to Stirling Anglian's reputation as submitted by the company. As in the present case, the PMCPA never publicly commented on the merits of an ongoing case. The present case would be considered in the normal way in accordance with the Constitution and Procedure.

The PMCPA Constitution and Procedure was clear that when it appeared from media reports that a company might have breached the Code the matter was treated as a complaint. Like all complaints the matter would be judged on the evidence provided by the parties.

The Panel noted that in accordance with Paragraph 6.1 of the Constitution and Procedure one of the authors of The Daily Telegraph articles (25 July) was asked whether he/she wanted to be involved in the case and whether they had any additional information to submit. In response the journalist stated that the reports spoke for themselves but was willing to be involved to the extent that the journalist would consider any questions. If any further information was received from the journalist it would be sent to Stirling Anglian for comment prior to any consideration by the Panel.

The Panel noted that it was a well established principle under the Code that a pharmaceutical company was responsible for the actions of third party agents acting on behalf of that company and in this regard, it considered that Stirling Anglian was responsible under the Code for the activities of its agents these being the third party named in the article and the manufacturer in relation to all the arrangements for the meeting in question. The Panel also noted that even if Stirling Anglian did not consider the manufacturer to be its agent for the purpose of the meeting, Stirling Anglian was still responsible under the Code for ensuring that all of the meeting arrangements including those elements organised by the manufacturer complied with the Code. In addition, the Panel noted that it was in Stirling Anglian's commercial interest for the NHS to be confident in the supply chain for Stirling Anglian's medicines irrespective of which company manufactured those medicines.

The Panel noted Stirling Anglian's submission that it could not be held liable or responsible under Clause 2 for the subsequent comments made by the named pharmacist and reported in The Daily Telegraph. The Panel noted its comments above about Stirling Anglian's responsibility for its agents and third parties and noted Stirling Anglian's responsibility under the Code for the third party including Clause 2 matters was limited to its role in relation to organising the meeting. Subsequent comments as published in The Daily Telegraph were only relevant in so far as they formed part of the complaint to which Stirling Anglian could respond under the Constitution and Procedure.

The Code applied to pharmaceutical companies. The PMCPA had no jurisdiction with regard to taking matters up with third parties directly as mentioned by Stirling Anglian.

The Panel noted the allegations as set out in the articles and editorial in The Daily Telegraph of 25 July and the company's responses. In the Panel's view it had to consider the acceptability of the advisory board and tour of the manufacturing facility, including their overseas location and the level of hospitality.

The Panel noted that it was acceptable for companies to pay health professionals and others for relevant advice. Nonetheless, the arrangements for such meetings had to comply with the Code, particularly Clause 23. To be considered a legitimate advisory board the choice and number of participants should stand up to independent scrutiny; each should be chosen according to their expertise such that they would be able to contribute meaningfully to the purpose and expected outcomes of the advisory board. The number of participants should be limited so as to allow active participation by all. The agenda should allow adequate time for discussion. The number of meetings and the number of participants should be driven by need and not the invitees' willingness to attend. Invitations to participate should state the purpose of the advisory board meeting, the expected advisory role and the amount of work to be undertaken. If an honorarium was offered it should be made clear that it was a payment for such work and advice. Honoraria must be reasonable and reflect the fair market value of the time and effort involved.

As stated in the supplementary information to Clause 22, Meetings and Hospitality, there had to be valid and cogent reasons for holding meetings at venues outside the UK.

The Panel noted Stirling Anglian's conflicting submissions regarding the selection criteria. Stirling Anglian submitted that selected delegates included those who, *inter alia*, had questions about its manufacturing facilities and supply chain and that the meeting gave attendees the opportunity to conduct due diligence on the supply chain and manufacturing partners. The Panel noted that those were not valid selection criteria for advisory boards which should be to address *bona fide* questions of the company, not of the attendees.

The Panel examined the agenda. Participants were not required to do any pre-reading or other preparation and the Panel noted Stirling Anglian's submission on this point. The meeting appeared to have two distinct parts; the morning lasted 2 hours plus an hour for lunch. It started at 09.30 with an hour on 'Operating and Company History'. This was followed by an hour on 'Presentation SAP' by Stirling Anglian. At 11:30 half the group then took a tour of the 'Production and Laboratory' with 'Highlight Macrogol filling lines' followed by lunch and the remainder of the group had lunch then the tour.

The afternoon meeting started at 13.30 with 'Questions and discussions on what you have seen today'. This was followed by two group discussions each of 45 minutes on CosmoCol and theiCal-D3. 'The Pipeline: Innovation, Tackling specials, new products and technology' was discussed for 15 minutes. The last session was 30 minutes on 'What have we learned today?', 'What action will you undertake on your return to the UK as a consequence of this event?' and 'If I were SAP I would …. Please complete the sentence'. All the discussions were group discussions other than the last session which was 'delegates in turn' and all discussion were 'facilitated by [the third party]'. The meeting closed at 16:00.

The Panel noted that the dedicated time on the agenda for the attendees to provide advice was not clear and allowing time for group discussions did not appear to be sufficient. Even if it were, this amounted to less than 2 hours (13:45 – 15:30).

The Panel noted that the description of the accommodation and evening meal in The Daily Telegraph article was different to that submitted by Stirling Anglian. The Panel noted that a letter drafted by Stirling Anglian's lawyers and signed by the named pharmacist retracted comments in relation to certain elements of hospitality referred to in the article. The letter stated that the comments made to the undercover reporter 'were false or grossly exaggerated' and he wished to correct the public record. The letter referred to the role of the third party in identifying various health professionals and experts in medicines management to provide advice to Stirling Anglian about how best to raise awareness of the company, its manufacturing/ supply chain credentials and its medicinal products. It referred to Stirling Anglian paying economy airfare and £500 per day for attending. Hotel accommodation, dinner entertainment and ground transportation was paid by the manufacturer. The statement explained that delegates stayed in a straightforward business hotel near to Stirling Anglian's manufacturer's factory and a room at the hotel cost approximately £130 a night. He stated that he had grossly exaggerated when stating that the hotel was "probably the best in Baden Baden", that in the rooms "the waste bins were gold plated" and that the rooms of any delegate had a jacuzzi. There was no factual basis to state that the hotel "was top 10 in the world". The statement that a £1,000 was paid for champagne during the dinner entertainment on 2 July 2015 was inaccurate. The cost of the dinner (including any drinks) was approximately £70 per person. The statement concluded that the author had no reason to believe Stirling Anglian had breached the ABPI Code.

The Panel noted with concern Stirling Anglian's submission that advisory boards were a 'necessary and indeed entirely appropriate mechanism to engage with our customers and build awareness of our products'. Further that questions about the supply chain was a '*bona fide* reason for holding an advisory board in Germany'. The Panel noted that advisory boards were not an appropriate way to engage with customers and build awareness of products. The purpose must be for the company to obtain advice on *bona fide* questions.

The Panel examined the report on the meeting and was concerned that it, in parts, treated the entire meeting as an advisory board.

The meeting report noted that delegates all agreed that the trip was well executed, enjoyable and sociable. They did not feel, however, that the level of hospitality was in any way excessive. They appreciated the hospitality offered by the manufacturer and enjoyed the presentations and factory tour. Some remarked that they were highly delighted to have been invited. There was unanimous agreement that every delegate would attend another advisory board of this type, if invited! The meeting report noted that the format of the advisory board was similar to the boards which were very successful. The manufacturer presented the history of the business, factory capacity and quality which produced a number of questions and comments. There was acknowledgement of good capacity for manufacturer and supply. There was a good degree of interest around twin dosing and resulting improved efficiency. One delegate mentioned use of calcium and vitamin D3 in caplet form, but stated the problem due to the total number of caplets per day. A third delegate stated at this point CosmoCol would be a particularly easy switch to make offering cost savings, improved flavour and improved range of flavours. Discussion around shelf life of CosmoCol was very positive.

The meeting report noted that a presentation was given by Stirling Anglian detailing pricing, product range and pipeline. Samples of theiCal-D3 were handed out. This prompted discussion round cost, savings and the advantage of once daily dosing. Discussion moved onto other pipeline products and returned to Macrogol pricing. It was acknowledged that Stirling Anglian had driven down Macrogol prices in the UK. Certain other specific questions were raised at this point including on price, supply guarantee and questions on communications around pipeline products.

The factory tour of the plant was thought to be interesting and useful by all delegates.

The advisory board commenced after a buffet lunch and delegates were invited to respond to various questions including:

> 'What do you think about the meeting so far?'
>
> 'How important do you feel it is to visit the factory in Germany? Could this be achieved by an advisory board in the UK?'
>
> 'Prior to this meeting had you heard of Cosmocol?' and 'What are your thoughts on action on return?'

The Panel was concerned that the questions and responses received indicated that this was not a *bona fide* advisory board. Responses referred to generous hospitality, that the visit to the factory in

Germany was essential and switching to CosmoCol. Two of the delegates were not aware of CosmoCol prior to the meeting.

The discussion then switched the theiCal-D3. Questions included: 'What are your thoughts on theiCal-D3?' and 'What are your barriers to change?'

The Panel noted that responses included comments about the benefit of the once daily dosage regime and palatability. In general, delegates preferred this option to multiple doses of caplets. Comments around the favourable price point were received and widely acknowledged. Some delegates requested personal information around savings for their CCG, which Stirling Anglian agreed to provide.

The report then referred to a specific question from a delegate around future pipeline products from Stirling Anglian and their proposed costings. Stirling Anglian replied by giving approximate dates for proposed products which were desired by the delegates and their proposed costs were warmly anticipated.

The Panel noted that the question 'What will your general actions be on return?' was put to each delegate individually and according to the meeting report most of the answers included favourable comments about CosmoCol and switching and/or amending guidelines. There were also references to the theiCal-D3 switch programme. There was only one negative comment in relation to the prohibitive cost of a switch to CosmoCol.

The Panel noted the details of the presentations and discussions in the meeting report. The report appeared in parts to treat the whole meeting as an advisory board.

The Panel noted the company's submission that the meeting arrangements combined a factory visit with an advisory board and that the payment was for the advice received. It appeared to the Panel that according to the report, more emphasis was placed on the visit to the manufacturers and building confidence in Stirling Anglian and its products and understanding what the attendees' actions were on returning from the meeting rather than a genuine advisory board. Further, it was difficult to understand what advice was sought and would be obtained from the attendees, two of whom had attended another advisory board in another German city.

The Panel noted Stirling Anglian's submission that this was the fifth such meeting held at the manufacturing site and five other advisory boards had been held, giving a total of 10 since 2013. The Panel did not have the agendas or other information about these other meetings but considered that if there was any similarity in the agendas it was difficult to see how this number of meetings could be justified. In addition, the Panel queried whether there was a *bona fide* need for advice such as to justify the advisory board meeting in question.

The Panel noted that the meeting for UK health professionals was held outside the UK and, as noted above, there had to be valid and cogent reasons for holding such meetings outside the UK. The Panel was concerned that the primary justification for holding the meeting outside the UK was the need for NHS staff to conduct due diligence on Stirling Anglian's manufacturing facilities and supply chain. The Panel noted the tour of the manufacturing facilities lasted an hour and queried whether in the particular circumstances of this case it was really necessary for the health professionals to travel to Germany to be reassured about the products and their supply. It would have been preferable for the manufacturers to come to the UK or to present using remote technology.

With regard to the acceptability of meetings held outside the UK, the Panel noted the supplementary information to Clause 22.1 gave two examples including that given the location of the relevant resource or expertise that was the object or subject matter of the meeting, it made greater logistical sense to hold the meeting outside the UK. The supplementary information also stated that as with meetings held in the UK, in determining whether such a meeting was acceptable or not, consideration must also be given to the educational programme, overall cost, facilities offered by the venue, nature of the audience, subsistence provided and the like. As with any meeting it should be the programme that attracted delegates and not the associated hospitality or venue. In any event, in the Panel's view, the acceptability of the visit to the manufacturing facilities could not be considered separately to the rest of the meeting. The two elements of the meeting were inextricably linked and the acceptability of the arrangements had to be considered in the round. This was especially so given that in parts of its response Stirling Anglian applied advisory board criteria to the entire day.

The Panel considered that overall the arrangements were not a valid advisory board: It was of concern that payment was received for 2 days at £500 per day rather than just for that part of the meeting (one afternoon) that Stirling Anglian described as the advisory board element. On the material before the Panel there did not appear to be a clear unequivocal issue upon which Stirling Anglian had sought advice which necessitated an advisory board; nor had the role of the participants in relation to the advisory board been made clear in the email invitation and elsewhere. The Panel noted its general comments above about the arrangements for the meeting including the selection criteria, content, feedback and fee for service payments. The Panel was especially concerned that at the end of the advisory board participants addressed what they would do differently as a result of the meeting which, in the Panel's view, demonstrated that the primary focus of the day was in providing information to and influencing participants rather than the provision of advice to the company. The Panel was concerned that the time spent obtaining advice appeared to be extremely limited and further no preparation was needed. Taking all the factors into account the Panel

did not consider that the arrangements either for the whole day or just the afternoon were such that the UK health professionals had attended a genuine advisory board meeting. It therefore ruled a breach of Clause 23.1.

The Panel considered that, as it had ruled the arrangements did not meet the criteria for advisory boards, UK health professionals had been paid to attend a meeting where medicines were promoted. The Panel queried whether it was ever acceptable to combine two company meetings such that products were promoted at part of the meeting and another part was a genuine advisory board. The Panel considered that UK health professionals had received payment to attend a meeting which the Panel considered promoted medicines including pipeline products. Any payment received for an advisory board that did not meet the requirements of Clause 23.1 was contrary to the requirements of Clause 18.1. In addition, the payment was for two days and not limited to what Stirling Anglian described as the advisory body element. Further, it appeared that as a result of attending the meeting health professionals' general actions indicated that switches to Stirling Anglian's products would be instigated. The Panel considered that the meeting was an inducement to recommend Stirling Anglian's medicines. A breach of Clause 18.1 was ruled.

The Panel noted that the third party was providing services on behalf of Stirling Anglian. One of the staff members was head of medicines management. The report referred to comments made by the named pharmacist 'on the zero switchback rate on [his area]'. The Panel noted that under Clause 21 contracts under which institutions, organisations, or associations provided any type of service were only allowed if such services or other funding were, *inter alia*, not an inducement to prescribe, supply, administer, recommend, buy or sell any medicine. The Panel noted its ruling above of a breach of Clause 18.1 and thus considered that the service amounted to an inducement. The Panel noted that Stirling Anglian had not exercised due diligence over the service. A breach of Clause 21 was ruled.

The Panel then considered the level of hospitality. It was concerned that irrespective of whether it was justifiable to visit the manufacturer, the arrangements were unacceptable. There was no need for the delegates to stay in Baden-Baden. Accommodation nearer to the manufacturer should have been used. The hotel used in Baden-Baden was not appropriate, it appeared to be a lavish and deluxe venue. In this regard, the Panel noted the retraction statement regarding the reported comments in the articles signed by the named pharmacist and the Panel's comments above in this regard. Regardless of the retraction statement, the location and facilities were still more akin to leisure travel than business purposes. The Panel was also concerned about the cost of dinner. Stirling Anglian's submission was inconsistent in this regard. One part stated that dinner and drinks cost €70 another part stated it did not exceed £70. The latest response confirmed that the cost per head (without tax (€400.52) and gratuities (€280)) was €100.99 around £71.43. The Panel noted the receipts for the pre-dinner drinks at the hotel which cost €447. Stirling Anglian submitted that this was not for the UK invitees but for staff from Stirling Anglian, the manufacturers and the third party. The Panel noted that the latter submission appeared to be inconsistent with an earlier submission which clearly stated on an agenda '18.30 meet at the Hotel… welcome drink 19.30 Dinner at the Restaurant…'. Overnight accommodation cost €199.

The Panel noted that the bill for the evening meal listed a number of main courses which cost more than £13-24, for example, €34-38. The bill included an additional bottle of wine to that listed by Stirling Anglian. Twenty four people attended the dinner at a cost per head (excluding tax and gratuities) of £71.43.

Some of the delegates commented positively on the hospitality in their expense claims. The report stated that 'the trip was well executed, enjoyable and sociable' and that the level of hospitality was not excessive.

The Panel did not consider that the hospitality was secondary to the main purpose of the event ie subsistence only. The level was not appropriate and was out of proportion to the occasion. Further, the costs exceeded the level that recipients would normally adopt when paying for themselves. A breach of Clause 22.1 was ruled.

The Panel noted the supplementary information to Clause 22.2 Maximum Cost of a Meal which included that the maximum of £75 plus VAT and gratuities (or local equivalent) and that this would only be appropriate in very exceptional circumstances such as a dinner at a residential meeting for senior consultants or a learned society conference with substantial educational content. It also made it clear that the limit did not apply when a meeting was held outside UK in a European country where the national association was a member of EFPIA and thus covered by EFPIA Codes. In such circumstances the limits in the host country code would apply.

The Panel noted the limits in the German Code were relevant. The English translation of the FSA (Freiwillige Selbstkontrolle für die Arzneimittelinclustrie e.V.) Code of Conduct on the Collaboration with Healthcare Professionals (December 2014) and Guidelines (effective 27 January 2015) were relevant. Sections 9.2 and 14.2 of the Guidelines were similar and Section 9.2 stated:

'The "hospitality arrangement" is "reasonable" and does not exceed "reasonable bounds" as long as it is socially acceptable. An amount of roughly EUR 60.00 is a benchmark for what is still considered a reasonable hospitality arrangement in Germany, under consideration of price increases and the value-added tax increase since the Code of Conduct took effect in 2004 (effectively: July 2008).'

Section 9.2 of the Guidelines related to Section 20 of the FSA Code, 'Invitation to job-related, science-oriented training events'. Section 14.2 of the Guidelines referred to Section 22 of the FSA Code, 'Hospitality'.

The Panel noted the German limit of €60 and that around €100 or £71.43 was spent per head for dinner (excluding tax and gratuities). This was in excess of the local limit for a meal and therefore a breach of Clause 22.2 was ruled.

The Panel considered that, overall, high standards had not been maintained and a breach of Clause 9.1 was ruled.

The Panel noted that Clause 2 was reserved for use as a sign of particular censure. The health professionals that attended the meeting had received a payment for two days at £500 per day in connection with the promotion of medicines including pipeline products. The Panel noted that unacceptable payments was listed in the supplementary information to Clause 2 as an example of an activity likely to be in breach of that Clause. The Panel was extremely concerned that the role of the participants had not been made clear in the invitation or elsewhere. The Panel was also extremely concerned about the poor impression given by all of the arrangements. It noted its rulings above regarding the hospitality. Given Stirling Anglian's ultimate responsibility for all of the arrangements including those parts organised by the third party and its manufacturing partner, the company did not appear to have exercised due diligence and ensured that third party activities met the requirements of the Code. The Panel considered that the arrangements brought discredit upon and reduced confidence in the pharmaceutical industry. A breach of Clause 2 was ruled.

The Panel noted its comments and rulings above and considered that its concerns about the arrangements and the company's procedures warranted consideration by the Appeal Board. The Panel thus reported Stirling Anglian to the Appeal Board in accordance with Paragraph 8.2 of the Constitution and Procedure.

During the consideration of this case the Panel was concerned that the arrangements had not been certified. In this regard, it requested that Stirling Anglian was reminded of the requirements of Clause 14.2. The Panel was also concerned at the informal and unprofessional nature of some of the emails from Stirling Anglian to the pharmacist attendees. Some of these were headed 'Baden Baden Ad Board', reference was also made to 'the trip' this week, 'enjoying yourselves' and were signed off 'Take care'. The Panel requested that its concerns in this regard were drawn to the company's attention. It also requested that Stirling Anglian be reminded of the requirements of the Code in relation to disclosure of transfers of value.

COMMENTS FROM STIRLING ANGLIAN ON THE REPORT FROM THE PANEL

Stirling Anglian formally apologised for the impact caused by recent events related to this case, particularly the unwelcome publicity for the industry. The company recognised both the serious nature of the matters at issue and the effect that the public reporting of these events had both within the pharmaceutical industry and for the wider public.

Stirling Anglian submitted that when it was first told about an interview between an undercover reporter from The Daily Telegraph and a director of a company with whom it was engaged, it was surprised and dismayed by the way in which the company director presented both himself and the activities of his company in support of Stirling Anglian. Stirling Anglian continued to believe that the account given was exaggerated and did not represent the instructions and understanding it had given. However, Stirling Anglian accepted that the report in The Daily Telegraph reflected the statements made by the named pharmacist and that this, in turn, raised legitimate concerns which required investigation by the PMCPA.

Stirling Anglian submitted that as a relatively new company, it had endeavoured to abide by the principles of the Code. The company had trained its staff in this area and Code compliance had featured strongly in discussions at board meetings. Stirling Anglian honestly believed that it had acted within industry norms and in line with the Code. However, the company had read the Panel's ruling and now accepted that things could have, and should have, been done differently. It analysed the position as follows:

1 Stirling Anglian should have ensured continuous monitoring of its advisory board activities to determine that they met the requirements of the Code and that there was a legitimate need for the services and also for an onsite factory tour (as opposed to video-conferencing).
2 The level of oversight of the activities of the third party was deficient. This was finally manifested in the meeting report which clearly showed a level of performance far removed from Stirling Anglian's original intent and instruction. While Stirling Anglian contended that the third party moved away from its original brief, it accepted the principle of responsibility for the actions of this third party provider.
3 By allowing the combination of the various components of the meeting – the factory tour, raising awareness of the company and discussing the needs of the NHS over a full-day, the company did not maintain the level of separation of activity that was expected under the Code for advisory boards. Stirling Anglian accepted that the impression given was that the event was not a genuine advisory board.
4 The selection criteria for attendees was not clear, transparent and robust.
5 While attempting to facilitate arrangements for the meeting by liaison with regard to travel and other arrangements, there was not the correct degree of separation between Stirling Anglian and the attendees. Stirling Anglian also accepted that some communications with attendees, while intended to be polite and convivial, could be seen as unprofessional when seen in the context of other concerns.
6 Stirling Anglian had never intended to provide lavish or excessive accommodation or hospitality. This aspect was arranged by its manufacturer which used local services and providers with whom it had previous business relationships. Stirling Anglian should have been more directive

as to the standard of accommodation arranged – a hotel that a manufacturer used to accommodate normal business visitors might be less suited to an advisory board. A clear separation between various activities at that time should have been maintained and that a far clearer trail of expenditure should have been recorded. The company was deficient in not providing clearer guidance to its German partners in this regard. This was amplified by the third party's poor interpretation of the Code. Stirling Anglian was let down by the third party on this point, but it accepted responsibility for that.

Stirling Anglian stated that it had carefully reflected on the Panel's rulings and accepted them in full; it had provided the required undertaking and ceased this form of activity entirely. Such activity would not be used by Stirling Anglian in the future.

Stirling Anglian had also commissioned an external audit of its processes which would take place in November 2015, which would take the form of a gap analysis of current processes and include an action plan to correct any remaining deficiencies. A formal report would be submitted to the Stirling Anglian board.

Stirling Anglian recognised that most of this could have been prevented had it sought advice from the PMCPA before embarking on this course of action. Stirling Anglian was resolved to seeking such advice more proactively in future.

Stirling Anglian concluded that these events had a profound effect on the company both collectively and at a personal level. Stirling Anglian was a new company, founded by people who believed strongly in the values of the NHS. Stirling Anglian was trying to make a difference in a highly adversarial environment. To find that it had fallen short of the standards expected of it was intensely distressing. The company was deeply sorry that this had happened, and was resolved to put things right.

APPEAL BOARD CONSIDERATION OF THE REPORT FROM THE PANEL

The Appeal Board was very concerned about the profound lack of Code expertise and oversight within Stirling Anglian that had allowed the meeting to go ahead. In the Appeal Board's view the arrangements for the meeting had been shambolic. The Appeal Board noted, from Stirling Anglian at the consideration of the report,that the company had relied on the third party provider to ensure that the meeting complied with the Code. The Appeal Board was further concerned that in its comments on the report from the Panel Stirling Anglian stated that it had '…accepted that the impression given was that the event was not a genuine advisory board'. The Appeal Board noted that it was much more than the impression of the meeting which was wrong; the arrangements were such that the meeting was in fact a promotional event, clearly in breach of the Code. That it was more than the impression was accepted by the company representatives at the consideration of the report.

The Appeal Board noted that the company had accepted all the Panel's rulings of breaches of the Code including a breach of Clause 2 and that it had stopped organising advisory boards until it was confident that it had appropriate oversight. The Appeal Board further noted the company's genuine contrition and that it had commissioned an external agency to audit its processes. Further, the Stirling Anglian representatives at the consideration of the report stated that the company had appointed a new general manager, was updating its procedures, training staff and considering employing compliance expertise.

Nonetheless, the Appeal Board was extremely concerned that UK health professionals had attended the meeting on the false understanding that it was an advisory board and had been paid to do so. This was unacceptable. Consequently, the Appeal Board decided, in accordance with Paragraph 11.3 of the Constitution and Procedure, to require Stirling Anglian to issue a corrective statement to all the UK attendees at the meeting. The corrective statement should refer to the case report. Under Paragraph 11.3 details of the proposed content and mode and timing of dissemination of the corrective statement must be provided to the Appeal Board for approval prior to use. [The corrective statement, which was agreed by the Appeal Board prior to use, appears at the end of this report].

The Appeal Board also decided, given its serious concerns about the conduct of Stirling Anglian as set out above, to require, in accordance with Paragraph 11.3 of the Constitution and Procedure, an audit of the company's procedures in relation to the Code, to take place in January 2016. On receipt of the audit report, the Appeal Board would consider whether further sanctions were necessary.

APPEAL BOARD FURTHER CONSIDERATION

Stirling Anglian was audited in January 2016 and on receipt of the report of the audit and the company's comments in February, the Appeal Board was encouraged by Stirling Anglian's willingness to improve its procedures and processes to comply with the Code, but noted from the report that significant progress was needed.

The Appeal Board was extremely concerned that despite a report that highlighted deficiencies in the company's knowledge and understanding of the Code and its failures with respect to compliance, Stirling Anglian had not provided any detail on when and how it would address those matters.

Stirling Anglian subsequently provided a further detailed response as requested. The Appeal Board was concerned that in an action plan some actions were marked as active with no indication of the expected date of completion. The Appeal Board decided that the company should be re-audited in June 2016 at which point it would be expected to demonstrate significant improvement.

Stirling Anglian was audited in June 2016 although the Appeal Board was encouraged that the audit

highlighted that Stirling Anglian had made meaningful improvements in compliance and that much work had been done, it also noted that there was still more to do including continuing issues regarding third party interactions. Stirling Anglian needed to ensure that its progress to date was maintained and built upon.

The Appeal Board decided that Stirling Anglian should be re-audited in April/May 2017 at which point the Appeal Board expected it to be able to demonstrate further and sustained improvement.

Stirling Anglian was re-audited in May 2017 and the report was considered by the Appeal Board in June.

The Appeal Board noted that there had been numerous staff changes at Stirling Anglian and it used a contract sales force and a third party marketing agency. The Appeal Board considered that the company needed to be vigilant about the effective governance of using third parties and maintaining compliance. The Appeal Board was encouraged by the progress made which needed to be built on and then maintained. Given the company's history it should ensure that compliance was at the forefront of everything it did. Training on the Code and attention to detail still needed to be improved.

The Appeal Board noted that the companies standard operating procedures (SOPs) were due to be reviewed and updated by August 2017 and it decided that Stirling Anglian should provide the PMCPA with the outcome of its review, evidence of training and any new SOPs by early September.

On receipt of Stirling Anglian's response the Appeal Board considered that the PMCPA should ask Stirling Anglian to amend further its SOPs in light of certain concerns. On the basis that this work was completed promptly, the progress shown to date was continued and a company-wide commitment to compliance was maintained, the Appeal Board decided that, on balance, no further action was required.

Complaint received	**27 July 2015**
Undertaking received	**21 October 2015**
Appeal Board consideration	**12 November 2015, 25 February 2016, 17 March, 21 July, 22 June, 12 October 2017**
Corrective statement issued	**16 December 2015**
Interim case report published	**16 December 2015**
Case completed	**12 October 2017**

On 16 December 2015 Stirling Anglian sent the following corrective statement to all UK delegates at the meeting.

'Corrective statement

On 2/3 July, you attended a meeting organised by Stirling Anglian Pharmaceuticals Ltd, held in Baden-Baden. The meeting was described as an "Advisory Board".

An article in The Daily Telegraph on 25 July raised concerns about the excessive hospitality provided at the meeting and the matter was taken up by The Prescription Medicines Code of Practice Authority as a complaint under the ABPI Code of Practice for the Pharmaceutical Industry (Case AUTH/2783/7/15). The Code of Practice Panel ruled that the arrangements did not meet the criteria for an advisory board and that UK health professionals had thus been paid to attend a promotional meeting. The Panel also considered that the meeting was an inducement to recommend Stirling Anglian's medicines and that the hospitality provided was not appropriate, was out of proportion to the occasion and that the costs exceeded the level that recipients would normally adopt if paying for themselves. The Panel considered that Stirling Anglian had failed to uphold high standards and had brought discredit upon, and reduced confidence in, the pharmaceutical industry. The Panel considered that its concerns warranted further consideration and thus reported Stirling Anglian to the Code of Practice Appeal Board. The Appeal Board was extremely concerned that health professionals had attended the meeting on the false understanding that it was a genuine advisory board. The Appeal Board required Stirling Anglian to send you this corrective statement and a copy of the published report for the case which contains full details. This is enclosed.

Details of this case (Case AUTH/2783/7/15) are also available on the PMCPA website (www.pmcpa.org.uk).'

CASES AUTH/2825/3/16 and AUTH/2826/3/16

JANSSEN v BOEHRINGER INGELHEIM and LILLY

Promotion of Jardiance

Janssen-Cilag complained about a Jardiance (empagliflozin) letter distributed by Boehringer Ingelheim and Eli Lilly and Company (the Alliance) representatives which was stapled to a copy of Zinman *et al* (2015), (the EMPA-REG study) and a one sided A4 sheet of prescribing information. The letter referred to cardiovascular outcome data.

Janssen explained that Jardiance was a sodium glucose transporter 2 (SGLT2) inhibitor indicated to improve glycaemic control in type 2 diabetic adults either as monotherapy or combination therapy. The only reference to any cardiovascular outcomes in the Jardiance summary of product characteristics (SPC) was in Section 5.1 as follows:

> **'Cardiovascular safety**
> **In a prospective, pre-specified meta-analysis of independently adjudicated cardiovascular events from 12 phase 2 and 3 clinical studies involving 10,036 patients with type 2 diabetes, empagliflozin did not increase cardiovascular risk.'**

Janssen stated that the US Food and Drug Administration (FDA) mandated that all new glucose-lowering agents should include a meta-analysis of the cardiovascular safety outcome studies to be carried out by the market authorization holder on new molecules licensed after July 2008, to demonstrate that the therapy would not result in an unacceptable increase in cardiovascular risk in patients with type 2 diabetes. Hence the above SPC wording. In addition, the Alliance initiated The EMPA-REG study which was listed in the risk management plan for Jardiance.

Zinman *et al* (2014) and Zinman *et al* (2015) described in detail the rationale, design and baseline characteristics of the EMPA-REG study together with the following caveat regarding the results:

> **'The results may not be generalizable (e.g., to patients with type 2 diabetes without cardiovascular disease), the risk–benefit profile for this drug class will need further elucidation (particularly for adverse events), and the ultimate position of empagliflozin among multiple drugs in the clinical management of type 2 diabetes will still need to be defined. Thus, it will be important to confirm these results with findings from other ongoing trials of SGLT2 inhibitors' (Ingelfinger and Rosen 2016).'**

In view of the EMPA-REG study results the Alliance applied for a new indication for the prevention of cardiovascular events to be included in Section 4.1 of the Jardiance SPC. No decision had been made by the Committee for Medicinal Products for Human Use (CHMP) as yet.

Janssen noted that the letter at issue, dated January 2016, was designed to inform health professionals about the results of the EMPA-REG study. A large part of the letter described the cardiovascular risk reduction seen with Jardiance. By proactively disseminating this letter, via its sales force, the Alliance had promoted the use of Jardiance to reduce cardiovascular risk ahead of an approval of the licensed indication. Although a statement 'Jardiance is not indicated for the treatment of weight loss, blood pressure control or cardiovascular risk reduction' was in the section describing the posology of Jardiance, this restriction was not clear from the outset as it appeared on page 2 of the letter and was not prominently displayed.

Janssen also alleged that the promotional letter closely, and inappropriately, resembled a 'Dear Doctor' letter, which was reserved for special communication to health professionals of important events such as safety alerts, and so was misleading in this regard. Moreover, the letter was signed by senior medical employees of the Alliance who held overall responsibility for compliance with the Code.

A number of breaches of the Code were alleged.

The detailed response from the Alliance is given below.

The Panel noted that page 1 of the letter bore no company name, logo or address and no prominent name or logo of a medicine. The envelope was plain. It was not immediately obvious who the letter was from or what it was about. In that regard the Panel noted that the material had been handed out to a health professional after a 1:1 Jardiance call with an Alliance representative and whilst the recipient would have had the benefit of that interaction, anyone else picking up the material might not realise where it had come from. The briefing material regarding the use of the material (dated 12 January 2016) stated that the EMPA-REG study represented a significant milestone in the treatment of diabetes but that the company was unable to discuss it in detail until the relevant authorization and training was provided. With regard to 'the relevant authorization', the Panel noted that the CHMP agenda for its February 2016 meeting showed that an application for a licence extension for Jardiance to include prevention of cardiovascular events based on the EMPA-REG study results had been submitted. The briefing material stated that the EMPA-REG study should only be given out until 30 June 2016 but without any discussion other than the following mandatory verbatim:

> **'You may be aware of the regulatory requirement to conduct cardiovascular outcome studies for all new antidiabetic agents. The cardiovascular**

outcome study for Jardiance was published in the New England Journal of Medicine in September 2015.

In this folder you will find a reprint of the paper. The study forms part of a potential SPC update and I am unable to discuss it further with you. However, the folder includes an accompanying letter from our Medical Directors which indicates how further information may be obtained together with Jardiance prescribing information.'

The letter was addressed 'Dear UK Healthcare Professional'. The second of the first two very short introductory paragraphs stated that Jardiance was a glucose-lowering agent for the treatment of adults with type 2 diabetes; it was not stated, as in the SPC, that it was indicated solely to improve glycaemic control. The most prominent section on page 1 was headed 'Recent Cardiovascular Outcomes Data' and took up the rest (approximately 75%) of the page. In that regard the Panel noted that, due to concerns that glucose-lowering medicines might be associated with adverse cardiovascular outcomes (type 2 diabetes was itself a major risk factor for cardiovascular disease), the EMPA-REG study was a cardiovascular safety study mandated by the regulators; it was designed to address long-term (median 3.1 years) safety concerns, not to generate efficacy data for a possible new indication. Four bullet points detailed the main results from Zinman *et al* (2015) including that Jardiance significantly reduced the relative risk of the combined primary endpoint, of cardiovascular death, non-fatal heart attack or non-fatal stroke by 14% vs placebo. This was in contrast to the Jardiance SPC which stated that Jardiance did not increase cardiovascular risk. Page 2 of the letter stated the licensed indication for Jardiance (to improve glycaemic control in type 2 diabetes) and that the medicine was not indicated for, *inter alia*, cardiovascular risk reduction. It was further stated that if the reader had any questions or would like to discuss the EMPA-REG study with an Alliance medical advisor, this could be arranged by contacting the medical information department. The letter appeared to have been jointly sent from a medical director from each company.

In the Panel's view it was clear from the briefing given to the representatives that Zinman *et al* (2015) would form the basis of a proposed change to the SPC and in that regard representatives were instructed not to proactively or reactively discuss the study. By proactively distributing the material at issue, however, the Alliance was knowingly using its representatives to solicit queries about the study, the results of which it knew were inconsistent with the Jardiance SPC. The Panel noted that although the Code did not prevent the legitimate exchange of medical and scientific information during the development of a medicine, provided that such information or activity did not constitute promotion, representatives distributing the material at issue after a 1:1 Jardiance call, clearly constituted the promotion of Jardiance.

The Panel considered that the prominence given within the letter to the cardiovascular outcome data from the EMPA-REG study promoted Jardiance for cardiovascular risk reduction for which it was not licensed. The results of the study went beyond the SPC statement that Jardiance did not increase cardiovascular risk. The results were not presented in the context of the safety profile for Jardiance. The statement on page 2 that Jardiance was not indicated for cardiovascular risk reduction was insufficient to mitigate the otherwise misleading and primary impression given by page 1 and the reference to outcomes data. In the Panel's view, the material was preparing the market for an anticipated licence extension. A breach of the Code was ruled which was upheld on appeal.

The Panel noted the allegation that the letter resembled a 'Dear Doctor' letter and was therefore disguised promotion. The Panel assumed that the 'Dear Doctor' letters referred to were those sent by companies to convey important product safety information at the request of the MHRA. The Panel considered that given the very bland and not obviously promotional appearance of the letter, some recipients might assume that it was important safety information, or other non-promotional information, even if it had been handed to them by a representative. In the Panel's view, not all recipients would be so familiar with 'Dear Doctor' letters such that they would immediately recognise any difference. In the Panel's view the representatives' mandatory verbatim was not sufficiently clear about the status of the material; in any event the letter should be able to stand alone with regard to compliance with the Code. In the Panel's view, despite the material being distributed by representatives, its promotional intent was not immediately obvious and in that regard it was disguised. A breach of the Code was ruled which was upheld on appeal.

The Panel noted that the Code required companies to appoint a senior employee to be responsible for ensuring that the company met the requirements of the Code. The Alliance met these requirements and so no breach of the Code was ruled.

The Panel considered that high standards had not been maintained. A breach of the Code was ruled which was upheld on appeal. The Panel was further concerned that the Alliance appeared to have knowingly distributed material which was inconsistent with the Jardiance SPC and which it would use to support a licence extension for a currently unlicensed indication. A breach of Clause 2, a sign of particular censure, was ruled and upheld on appeal.

The Panel noted its reasons for ruling breaches of the Code as set out above. In addition, the Panel was extremely concerned that the Alliance had given its representatives material to distribute to health professionals which it knew they could not discuss with those health professionals. In the Panel's view this gave a wholly inappropriate signal to the representatives regarding compliance and was completely unacceptable; it compromised the representatives' position and demonstrated a very poor understanding of the Code on behalf of the signatories. In that regard, and in accordance with

Paragraph 8.2 of the Constitution and Procedure, the Panel decided to report the Alliance to the Appeal Board for it to consider whether further sanctions were appropriate.

The Appeal Board noted its comments and rulings of breaches of the Code including a breach of Clause 2. The Appeal Board considered that the Alliance's actions either showed a disregard for, or a fundamental lack of understanding of, the requirements of the Code. The amount of time the companies had spent discussing the position before issuing the letter implied they were aware of the risks involved. The Appeal Board did not accept, as submitted by the Alliance, that the issues in this case were due to a grey area of the Code. It appeared that the Alliance had decided to put commercial gain before compliance. This was totally unacceptable.

The Appeal Board was very concerned that health professionals had been provided with material which promoted Jardiance for an unlicensed indication. This was unacceptable. Consequently, the Appeal Board decided, in accordance with Paragraph 11.3 of the Constitution and Procedure, to require the Alliance to issue a corrective statement to all recipients and to take steps to recover the material. (The corrective statement, which was agreed by the Appeal Board prior to use, appears at the end of this report).

The Appeal Board also decided that, given its concerns set out above, to require, in accordance with Paragraph 11.3, an audit of both Lilly and Boehringer Ingelheim's procedures in relation to the Code with an emphasis on the activities of the Alliance. The audits would take place as soon as possible. On receipt of the audit reports, the Appeal Board would consider whether further sanctions were necessary.

Boehringer Ingelheim and Lilly were audited in July 2016 and the audit reports were considered by the Appeal Board in September.

The Appeal Board noted from both audit reports concerns about the governance of the Alliance although it was pleased to note a greater involvement of the compliance function on the senior governance committee.

The Appeal Board noted from the Boehringer Ingelheim audit report that, *inter alia*, there were concerns about the company's standard operating procedures (SOPs), staff training and control of advisory boards. The Appeal Board considered that staff throughout the company needed to urgently improve and demonstrate their knowledge and understanding of the Code and commitment to compliance.

The Appeal Board noted that Boehringer Ingelheim had completed some of the work on its compliance action plan but it still had much to do. The Appeal Board noted its comments above and considered that Boehringer Ingelheim should be re-audited in March 2017 when it would expect the company's action plan to be complete and the company able to demonstrate considerable improvement in compliance culture and process.

The Appeal Board noted from the Lilly audit report that compliance and ethics were highly valued at the company and its staff had understood and genuinely regretted the failings in this case. However, the audit report highlighted concerns about the company's SOPs, its approval process and governance of advisory boards.

The Appeal Board noted that some work on Lilly's compliance plan was already complete and that all actions were due to be completed by the end of October 2016. The Appeal Board considered that Lilly should be re-audited around the same time as Boehringer Ingelheim. On receipt of the report for the March 2017 re-audit in relation to Boehringer Ingelheim and the company's response to subsequent questions raised by the Appeal Board, the Appeal Board decided that no further action was required.

On receipt of the report for the March 2017 re-audit in relation to Lilly and the company's responses to subsequent questions raised by the Authority and points raised by a whistleblower the Appeal Board decided that, on balance, no further action was required.

Janssen-Cilag complained about a Jardiance (empagliflozin) 'Dear UK Healthcare Professional' covering letter (ref UK/EMP/00241) distributed by Boehringer Ingelheim Ltd and Eli Lilly and Company Ltd (the Alliance) representatives. The two sided, A4 letter was stapled to a copy of Zinman *et al* (2015), 'Empagliflozin, Cardiovascular Outcomes, and Mortality in Type 2 Diabetes' (the EMPA-REG study) and a one sided A4 sheet which gave the prescribing information for Jardiance. The three items were stapled together and put in an envelope to be given to health professionals after a 1:1 call by representatives.

Jardiance was indicated in the treatment of type 2 diabetes to improve glycaemic control in adults: as monotherapy when diet and exercise alone did not provide adequate glycaemic control in patients for whom use of metformin was considered inappropriate due to intolerance and in combination with other glucose-lowering medicinal products including insulin, when these, together with diet and exercise, did not provide adequate glycaemic control.

COMPLAINT

Janssen noted the licensed indication for Jardiance (a sodium glucose transporter 2 (SGLT2) inhibitor) and provided a copy of the summary of product characteristics (SPC). The only reference to any cardiovascular outcomes in the SPC was in Section 5.1 as follows:

> 'Cardiovascular safety
> In a prospective, pre-specified meta-analysis of independently adjudicated cardiovascular events from 12 phase 2 and 3 clinical studies involving 10,036 patients with type 2 diabetes,

empagliflozin did not increase cardiovascular risk.'

Janssen stated that in 2008 the US Food and Drug Administration (FDA) mandated that all new glucose-lowering agents should include a meta-analysis of the cardiovascular safety outcome studies to be carried out by the market authorization holder on new molecules licensed after July 2008, to demonstrate that the therapy would not result in an unacceptable increase in cardiovascular risk in patients with type 2 diabetes. Hence the above wording in Section 5.1 of the Jardiance SPC. In addition, the Alliance initiated The EMPA-REG study which was listed in the risk management plan for Jardiance.

The primary composite outcome of the study was '… death from cardiovascular causes, non-fatal myocardial infarction, or non-fatal stroke, as analysed in the pooled empagliflozin group versus the placebo group'. The study recruited a specifically selected group of diabetics as the entry criteria mandated that all patients had to have established cardiovascular disease. During the course of the study, investigators were encouraged to adjust glucose-lowering therapy at their discretion to achieve glycaemic control according to local guidelines after the first 12 weeks. HbA1c reduction was not a primary endpoint of the study, the gold standard marker for blood glucose-lowering in type 2 diabetes clinical trials.

Full details regarding the study were in the paper 'Rationale, design, and baseline characteristics of a randomized, placebo-controlled cardiovascular outcome trial of empagliflozin (EMPA-REG OUTCOME)' (Zinman *et al* 2014) and in Zinman *et al* (2015) together with the following caveat regarding the results:

> 'The results may not be generalizable (e.g., to patients with type 2 diabetes without cardiovascular disease), the risk–benefit profile for this drug class will need further elucidation (particularly for adverse events), and the ultimate position of empagliflozin among multiple drugs in the clinical management of type 2 diabetes will still need to be defined. Thus, it will be important to confirm these results with findings from other ongoing trials of SGLT2 inhibitors' (Ingelfinger and Rosen 2016).

In view of the EMPA-REG study results the Alliance applied for a new indication of the prevention of cardiovascular events to be included in Section 4.1 of the Jardiance SPC. This was reviewed by the Committee for Medicinal Products for Human Use (CHMP) and shown on its agenda of 22 February, 2016. No decision had been made by the CHMP as yet.

Janssen noted that the covering letter at issue, dated January 2016, was designed to inform health professionals about the results of the EMPA-REG study. A large part of the letter described the cardiovascular risk reduction that had been seen with Jardiance. Janssen submitted that by proactively disseminating this letter, via its sales force, the Alliance had promoted the use of Jardiance to reduce cardiovascular risk ahead of an approval of the licensed indication. Although a statement 'Jardiance is not indicated for the treatment of weight loss, blood pressure control or cardiovascular risk reduction' was in the section which described the posology of Jardiance, this restriction was not clear from the outset as it appeared on page 2 of the letter and was not prominently displayed.

Janssen also alleged that the letter closely resembled a 'Dear Doctor' letter, which was reserved for special communication to health professionals of important events such as safety alerts, and so was misleading in this regard. This promotional letter had inappropriately used a 'Dear Doctor' letter style and format. Moreover it was approved and signed by the medical directors of both companies who held overall responsibility for compliance with the Code.

Janssen therefore alleged that the covering letter was in breach of the Code as it: promoted Jardiance for an unlicensed indication prior to the grant of a marketing authorization (breach of Clauses 3.2 and 2); misused a 'Dear Doctor' letter as promotional material and was therefore disguised promotion signed by senior members of both companies (breach of Clauses 1.12, 9.1 and 12.1) and represented failure of the senior employees within Boehringer Ingelheim and Eli Lilly to ensure the companies met the requirement of the Code (breach of Clauses 1.12 and 2).

Janssen further noted its allegations of breaches of the Code and its concern that the covering letter might be being used in other European countries given the European accountabilities of the Lilly personnel involved in the inter-company dialogue.

RESPONSE

The Alliance submitted that Jardiance was granted its marketing authorization in 2014 and was indicated for glucose control in adults with type 2 diabetes. The current wording in Section 4.1 of the SPC read:

> 'Jardiance is indicated in the treatment of type 2 diabetes mellitus to improve glycaemic control in adults as:
>
> - **Monotherapy**
> When diet and exercise alone do not provide adequate glycaemic control in patients for whom use of metformin is considered inappropriate due to intolerance.
> - **Add-on combination therapy**
> In combination with other glucose-lowering medicinal products including insulin, when these, together with diet and exercise, do not provide adequate glycaemic control (see Sections 4.4, 4.5 and 5.1 for available data on different combinations).'

The marketing authorization was granted on the basis of a comprehensive clinical development programme that included HbA1c as the primary endpoint in the clinical trials and weight and blood pressure as secondary/exploratory endpoints. All promotional material carried that explanatory

information and that Jardiance was not indicated for weight loss or blood pressure control.

For new glucose-lowering agents, pharmaceutical companies were mandated by the regulators (European Medicines Agency (EMA) and FDA) to conduct dedicated cardiovascular outcome safety studies. There had been several of these studies reported to date for two other classes of oral anti hyperglycaemic medicines and EMPA-REG study was the first cardiovascular outcome study to report for the SGLT2 inhibitor class.

The Alliance stated that Zinman *et al* (2015), the EMPA-REG study, was disclosed at the European Association for the Study of Diabetes (EASD) in September 2015 and published in the New England Journal of Medicine (NEJM) in November 2015. The study population was limited to adults with type 2 diabetes who had a history of stroke, coronary artery disease, myocardial infarction or peripheral vascular disease as per the EMA guidance. Patients were not at glycaemic goal on existing therapy.

The primary endpoint was a composite cardiovascular endpoint, of cardiovascular death, non-fatal myocardial infarction and non-fatal stroke. HbA1c was measured as part of the efficacy parameters of the study. The results of the study confirmed non-inferiority, but, in addition, a 14% reduction in the composite endpoint was observed driven by a 38% reduction in cardiovascular death. This was over a median follow-up period of just over 3 years. In addition, there was a 32% reduction in all-cause mortality and a 35% reduction in hospitalisation for heart failure.

The covering letter at issue led with an introduction to Zinman *et al* (2015) and the indication for Jardiance followed by a synopsis of the study including safety data relating to cardiovascular and non-cardiovascular events. New and relevant data about the use of Jardiance as a glucose-lowering agent and the impact it had on cardiovascular outcomes was included in the letter and was balanced with the appropriate caveats about the composition of the study population that were relevant to the restrictions of the Jardiance SPC.

The Alliance submitted that the EMPA-REG study was conducted in adults with type 2 diabetes as per the SPC. The endpoints and data collected were consistent with the SPC which specifically mentioned cardiovascular outcomes within Section 5.1 and HbA1c as a recognised biomarker for diabetes control. Data from EMPA-REG study had been submitted to the EMA for inclusion within Sections 4.1 and 5.1 of the Jardiance SPC. However, the proposed amendments would not change the target disease, method of treatment or enlarge the eligible patient population for treatment with Jardiance. The overall design of the study was consistent with the Jardiance SPC and the data presented in the study did not enlarge the target disease, target population or method of treatment of type 2 diabetes with Jardiance. The Alliance noted that the covering letter referred to the current indication regarding glycaemic control and clearly stated that Jardiance was currently not indicated for cardiovascular risk reduction.

The Alliance stated that the covering letter together with a copy of Zinman *et al* (2015) and the Jardiance prescribing information (ref EMP/UK/00241) were distributed by the field force in accordance with the Code with an associated briefing document (ref EMP/UK/00240) (copy provided). The MHRA had provided clear guidance on the drafting of 'Dear Doctor' letters including a template. From this template it was clear that the letter at issue did not resemble a 'Dear Doctor' letter. Furthermore, the letter included prescribing information and was disseminated by the field force at the end of a call and within a clear folder. The letter did not therefore resemble a 'Dear Doctor' letter in appearance and the way in which it was distributed by the sales force also made it clear that it was not a 'Dear Doctor' letter. The letter and activity by the Alliance was certified in January 2016.

The Alliance denied that its activities were in breach of the Code.

The Alliance denied a breach of Clause 1.12. The dissemination of the letter was a promotional activity and certified accordingly. Responsible senior employees were appointed to ensure the Alliance met the requirements of the Code.

The Alliance did not consider the activity breached Clause 3.2 which stated that promotion '…must be in accordance with the terms of its marketing authorization and must not be inconsistent with the particulars listed in its summary of product characteristics'. Further, the supplementary information to Clause 3.2 stated that 'the promotion of indications not covered by the marketing authorization is prohibited by this clause'. The Alliance considered that this allowed for new and important data to be disseminated in a promotional capacity if the data was not inconsistent with the SPC, and no indication was promoted which was not covered by the marketing authorization.

Janssen appeared to criticise the fact that HbA1c reduction was not a primary outcome of the EMPA-REG study, but the Alliance noted that HbA1c was a surrogate marker of diabetes control, whereas the EMPA-REG study had measured and reported hard clinical endpoints associated with diabetes namely all-cause mortality, cardiovascular heart and hospitalisations due to heart failure.

Type 2 diabetics had an increased risk for cardiovascular events and Section 5.1 of the Jardiance SPC referred to a meta-analysis of independently adjudicated cardiovascular events from phase 2 and 3 clinical trials. In this meta-analysis, Jardiance did not increase cardiovascular risk. This was an analysis performed as part of the European Public Assessment Report (EPAR). Importantly, the results from the EMPA-REG study, in referring to cardiovascular outcomes in the context of treating adult type 2 diabetics, were thus consistent with the current SPC that Jardiance did not increase cardiovascular risk.

The covering letter was also clear that Jardiance was not indicated for cardiovascular benefit; Jardiance was presented as a glucose-lowering agent for the treatment of type 2 diabetes and the letter simply shared new and relevant clinical trial data that was consistent with the SPC.

The marketing authorization for Jardiance stated that it was authorised for use as a glucose-lowering agent. The letter at issue clearly stipulated the indication of Jardiance in its context as a glucose-lowering agent and stated 'Jardiance is not indicated for the treatment of weight loss, blood pressure control or cardiovascular risk reduction'. It did not state that Jardiance should be used for any patients other than adult, type 2 diabetics.

With regard to Janssen's statement that the Alliance had submitted for a new indication on the prevention of cardiovascular events, the Alliance noted that in November 2015 the data from the EMPA-REG study was submitted to the EMA for inclusion within Section 5.1 of the Jardiance SPC and also amendment of the text within Section 4.1 of the SPC.

While 'new indication' was not defined in EU law, the Alliance referred to an EU regulatory guidance document (Guidance on a new therapeutic indication for a well-established substance, November 2007) which listed the types of changes which might be regarded as a new indication. The additional cardiovascular outcome data did not change the target disease, target population, mode of therapy or method of treatment for type 2 diabetes. This guidance supported the Alliance's position that the change to the SPC would not constitute a new indication and that it had not promoted a new indication for Jardiance.

The letter at issue led with an introduction to Zinman *et al* (2015) and the indication for Jardiance and approximate reductions in HbA1c demonstrated in phase 3 studies. An overview was then given of the cardiovascular outcomes and safety data from the EMPA-REG study (about half a page) and the remainder (one page) re-iterated the licensed indication as per Section 4.1 of the Jardiance SPC. It was also specifically stated that Jardiance was not indicated for cardiovascular risk reduction. In that regard, the letter therefore clearly presented the results for the EMPA-REG study in the context of Jardiance as a blood glucose-lowering agent and was consistent with the safety related data in the SPC.

The cardiovascular mortality and hospitalisation for heart failure data collected in the EMPA-REG study and submitted to the regulatory authorities did not change the population eligible for treatment with Jardiance. According to the current SPC, patients with type 2 diabetes and high cardiovascular risk could be treated in accordance with the particulars listed in the SPC. Overall the trial design and results were not inconsistent with the Jardiance SPC and therefore the Alliance did not consider that the covering letter was in breach of Clause 3.2.

In summary:

- Any addition of cardiovascular outcome data within Sections 4.1 and 5.1 of the Jardiance SPC would not represent a new indication according to the respective EU Regulatory Guidance Document
- The second paragraph of the letter stated: 'Empagliflozin is a glucose-lowering agent indicated for the treatment of adults with type 2 diabetes mellitus'
- Later the letter stated: 'Please note that Jardiance (empagliflozin) is indicated for the treatment of type 2 diabetes mellitus to improve glycaemic control in adults as…', and the exact current indication was provided
- To avoid any doubt to the recipient, this was followed by the clear statement: 'Empagliflozin is not indicated for the treatment of weight loss, blood pressure control or cardiovascular risk reduction'
- Overall the trial design and results provided valuable data to the health profession which was not inconsistent with the Jardiance SPC.

The Alliance thus denied a breach of Clause 3.2.

Regarding Clause 9.1, the Alliance submitted that it had always maintained high standards. The covering letter did not use inappropriate language, did not tease about anything without providing any actual evidence and was tasteful. It was thus difficult to see how it could cause offence.

The letter was certified in accordance with the requirements of the Code and the data was appropriately promoted as additional information (not as an indication) within the context of the licensed indications. The letter was certified by two UK registered medical practitioners within the Alliance and a non-medical signatory.

The Alliance submitted that the letter was not disguised promotion and so did not breach Clause 12.1. The letter was approved as a promotional item. The letter, a copy of Zinman *et al* (2015) and the Jardiance prescribing information, attached together in a clear plastic folder, constituted a single item and had been certified and distributed accordingly. The letter was clearly promotional and had not been disguised as non-promotional. The first sentence of the letter made it clear that a copy of a clinical paper was being provided and not a safety update; the letter did not resemble the MHRA recomended template for 'Dear Doctor' letters. The identity of the responsible pharmaceutical companies was also obvious.

A certified briefing document was provided to the sales force regarding the distribution of the letter in a promotional manner. The letter had been distributed to diabetologists, general practitioners, diabetes specialist nurses and GP practice leads ie only relevant health professionals with an interest in diabetes and only at the end of a 1:1 promotional call. A 'Dear Doctor' letter would not be provided within a clear folder alongside a publication nor would it be provided by the sales force at the end of a promotional call. The sales force mandatory

verbatim (copy provided) also made the contents of the folder clear to the health professional.

In summary:

- The letter looked very different to a 'Dear Doctor' letter and did not follow the MHRA guidance on the drafting of such a letter
- The letter was stapled with a copy of Zinman *et al* (2015) and the prescribing information and provided in a clear folder, therefore entirely different in appearance to a 'Dear Doctor' letter
- The letter had been distributed at the end of a promotional call by representatives, a practice completely different from how a 'Dear Doctor' letter would be handled
- The promotional material and activity was certified in January 2016.

Therefore, the distribution of the folder and contents had not been done in a manner similar to the distribution of a 'Dear Doctor' letter and the Alliance disputed that the activity was in breach of the Code.

With regard to the alleged breach of Clause 2, the Alliance disagreed that the promotional activity at issue brought discredit upon, or reduced confidence in, the industry or would otherwise constitute a breach of Clause 2. It did not fall within the categories of activities mentioned in the supplementary information to Clause 2.

The Alliance believed that it took appropriate steps to ensure compliance with the Code, including contacting the PMCPA for informal advice. Rather than putting patients at risk or damaging the industry reputation, the Alliance considered that the activity would ultimately help patient safety and benefit the reputation of the industry. The Alliance believed the appropriate dissemination of this valuable data in a careful and responsible way in compliance with the Code benefited health professionals and ultimately patients.

In summary, the Alliance did not consider that its distribution of Zinman *et al* (2015) with a covering letter and attached prescribing information was in breach of Clauses 1.12, 2, 3.2, 9.1 or 12.1. In addition, its promotion of Jardiance had been consistent with the particulars listed in the SPC, no new indication had been promoted and the covering letter and contents of the folder did not resemble a 'Dear Doctor' letter.

PANEL RULING

The Panel noted that page 1 of the covering letter bore no company name, logo or address and no prominent name or logo of a medicine. The only design element was a header of pale coloured diagonal lines running from the middle of each page to the outside right. The envelope was plain. It was not immediately obvious who the letter was from or what it was about. In that regard the Panel noted that the package of material had been handed out to a health professional after a 1:1 Jardiance call with an Alliance representative and whilst the recipient would have had the benefit of that interaction, anyone else picking up the material might not realise where it had come from. The briefing material regarding the use of the material was dated 12 January 2016 and stated that the EMPA-REG study represented a significant milestone in the treatment of diabetes but that the company was unable to discuss the details of the study until the relevant authorization and training was provided. With regard to 'the relevant authorization' referred to, the Panel noted that the CHMP agenda for its February 2016 meeting showed that an application for a licence extension for Jardiance to include prevention of cardiovascular events based on the EMPA-REG study results had been submitted. The briefing material clearly stated that EMPA-REG study should only be given out until 30 June 2016 and that when it was given out there should not be any proactive or reactive discussion about the study with health professionals other than the following mandatory verbatim:

> 'You may be aware of the regulatory requirement to conduct cardiovascular outcome studies for all new antidiabetic agents. The cardiovascular outcome study for Jardiance was published in the New England Journal of Medicine in September 2015.
>
> In this folder you will find a reprint of the paper. The study forms part of a potential SPC update and I am unable to discuss it further with you. However, the folder includes an accompanying letter from our Medical Directors which indicates how further information may be obtained together with Jardiance prescribing information.'

The covering letter at issue was addressed 'Dear UK Healthcare Professional'. The second of the first two very short introductory paragraphs stated that Jardiance was a glucose-lowering agent for the treatment of adults with type 2 diabetes; it was not stated, as in the SPC, that it was indicated solely to improve glycaemic control. The most prominent section on page 1 was headed 'Recent Cardiovascular Outcomes Data' and took up the rest (approximately 75%) of the page. In that regard the Panel noted that, due to concerns that glucose-lowering medicines might be associated with adverse cardiovascular outcomes (type 2 diabetes was itself a major risk factor for cardiovascular disease), the EMPA-REG study was a cardiovascular safety study mandated by the regulators; it was designed to address long-term (median 3.1 years) safety concerns, not to generate efficacy data for a possible new indication. Four bullet points detailed the main results from Zinman *et al* (2015) including that Jardiance significantly reduced the relative risk of the combined primary endpoint, of cardiovascular death, non-fatal heart attack or non-fatal stroke by 14% vs placebo. This was in contrast to the Jardiance SPC which stated that Jardiance did not increase cardiovascular risk. Page 2 of the letter stated the licensed indication for Jardiance (to improve glycaemic control in type 2 diabetes) and that the medicine was not indicated for the treatment of weight loss, blood pressure control or cardiovascular risk reduction. It was further stated that if the reader had any questions or would like to discuss the

EMPA-REG study with an Alliance medical advisor, this could be arranged by contacting the medical information department. The letter appeared to have been jointly sent from a medical director from each company.

The Panel noted that Clause 3.2 of the Code stated that the promotion of a medicine must be in accordance with the terms of its marketing authorization and must not be inconsistent with the particulars listed in its SPC. In the Panel's view it was clear from the briefing given to the representatives that the results from Zinman *et al* (2015) would form the basis of a proposed change to the SPC and in that regard representatives were instructed not to proactively or reactively discuss the study. By proactively distributing the material at issue, however, the Alliance was knowingly using its representatives to solicit queries about the study, the results of which it knew were inconsistent with the Jardiance SPC. The Panel noted that although Clause 3 did not prevent the legitimate exchange of medical and scientific information during the development of a medicine, provided that such information or activity did not constitute promotion which was prohibited under that or any other clause, the distribution of the material at issue by representatives following a 1:1 Jardiance call, clearly constituted the promotion of Jardiance.

The Panel considered that the prominence given within the letter to the cardiovascular outcome data from the EMPA-REG study promoted Jardiance for cardiovascular risk reduction for which it was not licensed. The results of the study went beyond the SPC statement that Jardiance did not increase cardiovascular risk. The results were not presented in the context of the safety profile for Jardiance. The statement on page 2 of the letter that Jardiance was not indicated for cardiovascular risk reduction was insufficient to mitigate the otherwise misleading and primary impression given by page 1 of the letter and the reference to outcomes data. In the Panel's view, the material was preparing the market for an anticipated licence extension. A breach of Clause 3.2 was ruled.

The Panel noted the allegation that the covering letter resembled a 'Dear Doctor' letter and was therefore disguised promotion. The Panel assumed that the 'Dear Doctor' letters referred to were those sent by companies to convey important product safety information at the request of the MHRA. The Panel considered that given the very bland and not obviously promotional appearance of the letter, it was not unreasonable to think that some recipients would assume that it was important safety information, or other non-promotional information, even if it had been handed to them by a representative. In the Panel's view, not all recipients would be so familiar with the template for 'Dear Doctor' letters such that they would immediately recognise any difference. In the Panel's view the representatives' mandatory verbatim was not sufficiently clear about the status of the material; in any event the letter should be capable of standing alone with regard to compliance with the Code. In the Panel's view, despite the material being distributed by representatives, its promotional intent was not immediately obvious and in that regard it was disguised. A breach of Clause 12.1 was ruled.

The Panel noted that Clause 1.12 required companies to appoint a senior employee to be responsible for ensuring that the company met the requirements of the Code. The Panel noted that the Alliance had appointed senior employees to ensure it met the requirements of the Code and so no breach of Clause 1.12 was ruled.

The Panel noted its comments and rulings above and considered that high standards had not been maintained. A breach of Clause 9.1 was ruled. The Panel was further concerned that the Alliance appeared to have knowingly distributed material which was inconsistent with the Jardiance SPC and which it would use to support a licence extension for a currently unlicensed indication. The Panel considered that a ruling of a breach of Clause 2, a sign of particular censure, was warranted and a breach of that clause was ruled.

The Panel noted its reasons for ruling a breach of the Code as set out above. In addition the Panel was extremely concerned that the Alliance had given its representatives material to distribute to health professionals which it knew they could not discuss with those health professionals. In the Panel's view this gave a wholly inappropriate signal to the representatives regarding compliance and was completely unacceptable; it compromised the representatives' position and demonstrated a very poor understanding of the Code on behalf of the signatories. In that regard, and in accordance with Paragraph 8.2 of the Constitution and Procedure, the Panel decided to report the Alliance to the Code of Practice Appeal Board for it to consider whether further sanctions were appropriate.

During the consideration of this case, the Panel noted that the package of material provided to the health professionals consisted of three separate pieces stapled together; the covering letter, a copy of Zinman *et al* (2015) and the prescribing information in that order. The supplementary information to Clause 4.1 stated that each promotional item for a medicine must be able to stand alone and that a letter could not rely on an accompanying piece of material for the provision of the prescribing information. The Panel noted the order in which the materials were presented and that the one page sheet with the Jardiance prescribing information did not bear the header of pale coloured diagonal lines as seen on both pages of the letter. In that regard the prescribing information and the letter appeared to be two wholly separate pieces. The Panel was concerned that the letter thus did not meet the requirements of the Code and it requested that the Alliance be advised of its concerns.

APPEAL BY BOEHRINGER INGELHEIM and LILLY

The Alliance appealed the Panel's rulings of breaches of Clauses 2, 3.2, 9.1 and 12.1.

The Alliance stated that the material at issue (the covering letter, a copy of Zinman *et al* (2015) and the Jardiance prescribing information) was withdrawn

from use on 20 April pending the Appeal Board's decision. No other promotional material referred to the EMPA-REG study.

The Alliance submitted its reasons for its appeal were:

- Cardiovascular safety studies were mandated by the regulatory authorities and empagliflozin was studied in the EMPA-REG study as a diabetes agent. The Alliance had a responsibility to disseminate this important safety data to health professionals because it was relevant to patient outcomes.
- The Alliance took compliance extremely seriously and it submitted that it had acted within the letter and spirit of the Code. The Alliance carried out extensive local and global medico-legal and compliance consultation including consultations with the PMCPA before distributing the material at issue.
- The endpoints and data collected were not inconsistent with the Jardiance SPC which included cardiovascular safety outcomes within Section 5.1, no new indication was promoted, and therefore dissemination of the material at issue was not in breach of Clause 3.2.
- The dissemination of the material was carried out in a controlled manner following detailed briefing. The Alliance submitted that it had demonstrated due diligence and had operated in a conscientious manner.

Background

The Alliance submitted that cardiovascular safety studies were mandated by the EMA and FDA to determine the long-term cardiovascular safety of new glucose-lowering agents. In 2010, rosiglitazone (a leading diabetes treatment at that time) was withdrawn from the European market following cardiovascular safety concerns and set a precedent for the requirement for diabetes medicines to undergo safety trials for cardiovascular outcomes. Thus, UK prescribers had a heightened sensitivity to such safety data in relation to diabetes medicine. The results of cardiovascular outcome trials for other diabetes medicines had been disseminated to health professionals and included in promotional materials before the data was included in the relevant SPC.

The Alliance took a responsible and considered approach to the activity

The Alliance noted the events which it submitted led it to take the considered decision to ask its representatives to provide key health professionals with the material at issue at the end of a 1:1 Jardiance sales call.

At the beginning of 2015, the Alliance began to explore the implications of the possible outcomes of the EMPA-REG study. This included internal cross-functional and corporate/global level discussions and also a one hour teleconference with the PMCPA in April 2015 on the clear and accepted understanding that its advice was non-binding.

The Alliance noted that the results of the EMPA-REG study were first disclosed in Stockholm in September 2015 at the EASD conference and were recognised by the health professionals attending as being relevant and important.

Following publication of the results in the NEJM, the Alliance submitted that it had consulted extensively between medical, legal, regulatory and compliance at a country and corporate level. In addition, the Alliance met with the PMCPA in October 2015 to understand its view of promotional activity involving the EMPA-REG study. Whilst the Alliance understood that this guidance was non-binding, and it took full responsibility for its decision to disseminate the material at issue, this demonstrated that it took compliance very seriously and went to great lengths to consider and determine how this important safety data could be distributed.

The EMPA-REG study results were not inconsistent with the Jardiance SPC

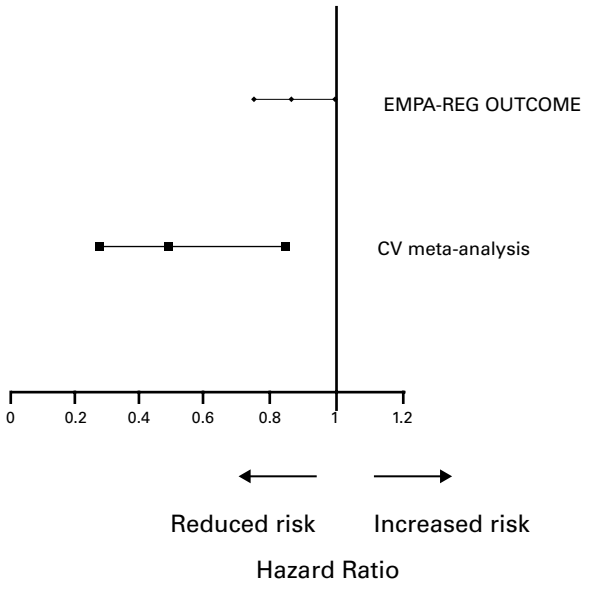
The Alliance submitted that as submitted above, the data from the EMPA-REG study was submitted to the EMA for inclusion within Sections 4.1 and 5.1 of the Jardiance SPC. The Alliance set out its proposed new wording of Section 4.1. (That wording was provided to, and commented on by, Janssen but is not provided here because of commercial sensitivity).

The Alliance submitted that the requested amendments to the Jardiance SPC were within its existing indication for treatment of type 2 diabetes, based on the EMPA-REG data. The Alliance noted that although this change had been requested, it could not be sure in what form, if at all, it would be granted, by the EMA. The material at issue was therefore considered on the basis that the SPC was, and would remain, unchanged.

The Alliance submitted that the wording relating to cardiovascular outcomes within the current Jardiance SPC was in Section 5.1. This text referred to data submitted to the EMA and was data included within the empagliflozin EPAR. Within the phase 2/3 empagliflozin clinical studies the meta-analysis of adjudicated cardiovascular events demonstrated a hazard ratio of 0.48 (95% C.I. 0.27-0.85).

The Alliance submitted that the results of this meta-analysis demonstrated superiority and the wording of the SPC read 'In a prospective, pre-specified meta-analysis of independently adjudicated cardiovascular events from 12 phase 2 and 3 clinical studies involving 10,036 patients with type 2 diabetes, empagliflozin did not increase cardiovascular risk'. Since the existing meta-analysis data demonstrated superiority (but was categorised in the SPC as '… did not increase cardiovascular risk'), the results of EMPA-REG study were therefore not inconsistent with the reference to cardiovascular outcomes within the current Jardiance SPC. The following graphical representation depicted the point estimate of the hazard ratio, the upper bound 95% and the lower bound 95% confidence intervals for the EMPA-REG study and the meta-analysis of adjudicated cardiovascular events:

Forest plot displaying, lower 95% CI, point estimate and upper 95% CI for EMPA-REG OUTCOME and CV meta-analysis



The proposed amendments to the empagliflozin SPC were not a new indication

The Alliance re-iterated that the proposed amendments were not a new therapeutic indication. Although 'therapeutic indication' was not defined in EU law, EU regulatory guidance stated that a new indication would normally include the following:

- a new target disease,
- different stages or severity of a disease
- an extended target population for the same disease, e.g. based on a different age range or other intrinsic (e.g. renal impairment) or extrinsic (e.g. concomitant product) factors
- change from the first line treatment to second line treatment (or second line to first line treatment), or from combination therapy to monotherapy, or from one combination therapy (e.g. in the area of cancer) to another combination
- change from treatment to prevention or diagnosis of a disease
- change from treatment to prevention of progression of a disease or to prevention of relapses of a disease
- change from short-term treatment to long-term maintenance therapy in chronic disease.'

The Alliance submitted that the EU regulatory guidance supported its position that it had not promoted a new indication for Jardiance. The additional cardiovascular outcome safety data did not change the target disease, target population, mode of therapy or method of treatment for type 2 diabetes. The current licence for Jardiance which included all adults with type 2 diabetes clearly included the patient population studied with the EMPA-REG study.

The Alliance accepted that it had to comply with the Code in addition to the relevant law, and the Code might be more restrictive than the law in certain areas. Nevertheless, the underpinning law on which the Code was based might be useful as an aid to interpreting the rationale for certain sections of the Code. Clause 3.2 of the Code was based on Article 87(2) of Directive 2001/83 (enacted into UK law by the Human Medicines Regulations 2001, s280) which provided:

'All parts of the advertising of a medicinal product **must comply with** the particulars listed in the summary of product characteristics' (emphasis added).

The Alliance noted that a case before the Court of Justice of the European Union (CJEU) provided some useful guidance on the interpretation of the meaning of Article 87(2) of the Directive, even though the language used in Clause 3.2 of the Code ('… not inconsistent with …') differed from that of Article 87(2). The CJEU's decision in the case made clear that information which conflicted with or distorted the SPC would always fall foul of the 'must comply with' requirement, paragraphs 41-42. However, information which confirmed or clarified (and was in any event compatible with) the SPC might be acceptable, even if that information was not identical to the information contained in the SPC, paragraph 5.1. In this particular situation, the current SPC stated that empagliflozin was not associated with an increase in cardiovascular risk so the material in question, reasonably read and in its context, was not inconsistent with this current SPC.

For the above reasons, the Alliance strongly refuted the Panel's ruling of a breach of Clause 3.2 and disagreed with the ruling of a breach of Clause 2.

Controlled distribution by representatives

The Alliance submitted that in order to disseminate the EMPA-REG safety data in a balanced and fair way, it would provide the material at issue only after a 1:1 Jardiance sales call. It also decided to take a conservative approach and avoid any possibility for speculation (whether by representatives or health professionals) about a future change to the SPC or about potential off-label use for cardiovascular indications outside diabetes, by instructing the sales force not to discuss the data further. The provision of the material was conducted in a controlled and monitored manner.

During a three month period material at issue was provided to 2,687 out of approximately 20,000 UK health professionals interested in diabetes. The material was disseminated in less than one in five Alliance calls in the first quarter of the year. All activities were recorded by the representatives in their respective customer relationship database. There had been no known concerns or complaints by health professionals regarding the dissemination of the material.

In relation to the Panel's ruling of a breach of Clause 12.1 (disguised promotion), the Alliance clarified the context in which the material was provided. As outlined in the briefing document 'The paper can be provided to diabetologists; diabetes nurse specialists; GP and nurse practice leads in diabetes only and must follow a 1:1 Jardiance call'. Representatives used the Jardiance sales aid for 1:1

calls. Only after the 1:1 Jardiance call using the sales aid, could the material be provided to the health professional. The Alliance submitted that, at the conclusion of the call, health professionals could be in no doubt as to the approved label for Jardiance and of the unambiguous promotional nature of the interaction.

The Alliance submitted that there was no attempt to disguise the material as anything other than promotional. The Alliance letterhead with the diagonal lines was its standard imagery and was used widely in its promotional materials.

The Alliance did not agree with the Panel's conclusion that health professionals would not be sufficiently familiar with a 'Dear Doctor' letter. These types of alerts were regularly issued by the MHRA to health professionals and the Alliance provided copies of those sent on 9 July 2015 and on 14 March 2016 explaining the potential risk of diabetic ketoacidosis associated with SGLT2 inhibitors. The fact that the letter was addressed to 'Dear Healthcare Professional' and signed by the Alliance's medical directors would not have been sufficient to, and was not intended to, confuse any health professional, given that the context of the meeting and the very first sentence of the letter made it clear that a reprint was being provided.

The Alliance strongly refuted the Panel's statement that the promotional activity sent a 'wholly inappropriate signal to the representatives regarding compliance and was completely unacceptable'. The Alliance submitted that the provision of this important new safety data was carried out in a way which was not inconsistent with the current Jardiance SPC, was not for a new therapeutic indication and did not constitute the promotion of an unlicensed indication under Clause 3.2. The Alliance took compliance issues extremely seriously and it decided to provide diabetes health professionals with the EMPA-REG safety data in a considered, consultative and conscientious manner.

COMMENTS FROM JANSSEN

Janssen maintained that the Alliance's promotion of the cardiovascular event prevention data with the EMPA-REG study, prior to the granting of a licence on the new indication, using a 'Dear Doctor' style letter, clearly constituted disguised promotion of Jardiance in discord with the current Jardiance indication and marketing authorization and represented a significant failure to maintain high standards. In addition, the content of the briefing document to field teams suggested either the Alliance knowingly distributed this material despite its inappropriate nature, or a lack of understanding of the Code, thus bringing discredit to, and reducing confidence in, the industry. Janssen thus alleged that the Alliance had breached Clauses 2, 3.2, 9.1 and 12.1.

Promotion of the EMPA-REG study was not within current Jardiance approved indication and was inconsistent with the SPC

Janssen reiterated that Section 4.1, Therapeutic indications, of the Jardiance SPC clearly stated the current licensed indication of Jardiance was to improve glycaemic control.

> 'Jardiance is indicated in the treatment of type 2 diabetes mellitus to improve glycaemic control in adults as:
>
> Monotherapy
>
> When diet and exercise alone do not provide adequate glycaemic control in patients for whom use of metformin is considered inappropriate due to intolerance.
>
> Add-on combination therapy
>
> In combination with other glucose-lowering medicinal products including insulin, when these, together with diet and exercise, do not provide adequate glycaemic control (see Sections 4.4, 4.5 and 5.1 for available data on different combinations)'.

Janssen alleged that contrary to the current Jardiance licence and as stated in Zinman *et al* (2014), the primary composite outcome of the EMPA-REG study was cardiovascular event prevention (and not improved glycaemic control). Janssen emphasized that HbA1c reduction, the gold standard marker for diabetes control, blood glucose-lowering in type 2 diabetes clinical trials, was not a primary endpoint nor considered as a key secondary endpoint of the study. Janssen thus alleged that the EMPA-REG study was not designed with the intent for glycaemic control and thus promotion of this study, with a focus of cardiovascular event prevention, was not in line with the current Jardiance marketing authorization.

Proposed amendments to the Jardiance SPC were a new indication

Janssen noted that the Alliance refuted that the proposed amendments to the Jardiance SPC were a new therapeutic indication despite its action which clearly indicated the opposite. The Alliance had filed a new indication submission to the regulatory authority and the wording amendment on Section 4.1 proposed by the Alliance clearly put prevention of cardiovascular events as a separate indication.

Janssen refuted the Alliance's claim that cardiovascular prevention did not constitute a new indication under EU regulatory guidelines which stated:

> '... a "new therapeutic indication" may refer to diagnosis, prevention or treatment of a disease. In this context a new indication would normally include the following:
> - a new target disease.'

Janssen alleged that the use of Jardiance in the prevention of cardiovascular events in patients with type 2 diabetes, in addition to improved glycaemic

control for which Jardiance was currently licensed, undoubtedly constituted the prevention/treatment of a target disease (cardiovascular events) in this case. This was further evidenced by the wording used in the CHMP meeting:

> 'Extension of indication to include a **new indication on prevention of cardiovascular events** based on the final data of the cardiovascular safety phase 3 clinical trial EMPA-REG OUTCOME' (emphasis added).

Janssen rebutted the Alliance's argument that the EU regulatory guidance supported its position that it had not promoted a new indication for Jardiance and that the additional cardiovascular outcome safety data did not change the target disease because the current licence for Jardiance included all adult patients with type 2 diabetes and clearly showed that the patient population studied with the EMPA-REG study was already included within the current licensed population.

Janssen noted that Jardiance was only currently indicated for one element of type 2 diabetes management – to improve glycaemic control. It was inappropriate and misleading to infer that the licensed indication of Jardiance included cardiovascular event prevention just because the study population in the EMPA-REG study and current licence of Jardiance were both adults with type 2 diabetes.

Janssen acknowledged that the meta-analysis of adjudicated cardiovascular events based on phase 2/3 Jardiance studies demonstrated a hazard ratio of 0.48 (95% CI 0.27-0.85) and was captured in the EPAR. These results were not captured in the Jardiance SPC and were largely based on adverse events reported during the phase 2/3 studies. Moreover, Section 5.1, Pharmacodynamic properties, of the SPC stated that Jardiance did not increase cardiovascular risk vs cardiovascular event prevention which the Alliance had promoted. Therefore, it could not be interpreted as providing evidence of cardiovascular event reduction with Jardiance.

> 'Cardiovascular safety
> In a prospective, pre-specified meta-analysis of independently adjudicated cardiovascular events from 12 phase 2 and 3 clinical studies involving 10,036 patients with type 2 diabetes, empagliflozin did not increase cardiovascular risk.'

Thus, the proposed amendments to the Jardiance SPC was a new indication and the promotion of cardiovascular event prevention before licence extension approval constituted an off-licence promotion of Jardiance.

Disguised promotion using a 'Dear Doctor' style letter

Janssen alleged that the material at issue lacked any of the usual Jardiance promotional branding, colours and brand imagery, and was signed by the medical directors in the Alliance, rather than by their commercial counterparts. The letter had no company logos nor any clear warning on the first page to indicate it was promotional in nature. The design closely resembled a 'Dear Doctor' letter normally reserved for communication of important product safety information requested by the MHRA. Janssen therefore refuted the Alliance's claim that 'The Alliance letterhead with the diagonal lines was the standard imagery used by the Alliance and was used widely in Alliance promotional material'.

Janssen expressed concern of the possible negative impact on patient safety by the Alliance using promotional material designed in a similar style to a 'Dear Doctor' letter. Jardiance and other medicines in the same class were subjected to additional safety monitoring by the regulatory authority, in fact, two 'Dear Doctor' letters on this particular class of medicine were issued as requested by the MHRA in the last 12 months. Using a letter that closely resembled a 'Dear Doctor' letter for promotion might weaken the effectiveness of the MHRA mandated communication of important safety signals in the future.

The Alliance's failure to maintain high ethical and compliance standards

Janssen noted that the EMPA-REG study results were first released in September 2015 at the EASD annual meeting and subsequently published in the NEJM following the meeting presentation. Since then, the Alliance submitted a label update to include a new indication of cardiovascular event prevention, as noted in the CHMP meeting agenda of February 2016.

Janssen noted the sales force briefing document for the material at issue (issued 12 January 2016) stated:

> '… we are unable to discuss the details of this clinical paper until the relevant authorisation and training is provided.'
>
> '… time limited exception in the UK that the sales force can disseminate … without discussion … now until the end of June 2016.'
>
> '… there should not be any discussion with regards to the EMPA-REG OUTCOME (ERO) data between sales field force and HCPs.'

Janssen alleged that this clearly indicated that the Alliance knew that a new indication had been applied for and was pending regulatory authorization and therefore should not have been discussed with health professionals, particularly by the sales force. The following mandatory verbatim issued to the sales force, to be used during dissemination of the material, further supported Janssen's allegation:

> 'The study forms part of potential SPC update and I am unable to discuss it further with you.'

Janssen alleged that the briefing document suggested that either the Alliance knowingly distributed the material despite its inappropriate and non-compliant nature, or it represented a severe lack of understanding of the Code thus, bringing discredit to, and reducing confidence in, the industry.

Janssen acknowledged that the Alliance had consulted the PMCPA and local and global medico-legal and compliance prior to initiating EMPA-REG study promotional activity. Despite these consultations, Janssen alleged that the Alliance had prepared promotional material disguised as a 'Dear Doctor' letter which promoted an unlicensed indication for Jardiance.

Janssen alleged that the manner and intent in which the material was disseminated and the way in which the sales force was briefed, were taken under the approval of the respective medical directors from the Alliance. On this occasion, they and the final signatories, who were responsible for ensuring that their companies met the requirements of the Code, failed to take a responsible and considered approach to these activities.

In conclusion, Janssen alleged that the Alliance had brought the industry into disrepute by promoting the EMPA-REG study results prior to the granting of a new indication of the prevention of cardiovascular events in adults with type 2 diabetes in breach of Clauses 2, 3.2, 9.1 and 12.1 of the Code.

APPEAL BOARD RULING

The Appeal Board noted the Alliance's submission that the outcome of the EMPA-REG study was important safety data that it wanted to share with health professionals. The Appeal Board noted that the primary composite outcome of the study was death from cardiovascular causes, non-fatal myocardial infarction or non-fatal stroke. Patients were type 2 diabetics at high cardiovascular risk. According to Zinman *et al* (2015) all patients had established cardiovascular disease and had received no glucose-lowering agents for at least 12 weeks before randomization, with HbA1c of at least 7% and no more than 9%, or had received stable glucose-lowering therapy for at least 12 weeks before randomization with HbA1c of at least 7% and no more than 10%. Many patients did not reach their glycaemic targets with an adjusted mean HbA1c level at week 206 of 7.81% in the pooled empagliflozin group and 8.16% in the placebo group. The study concluded that patients who received Jardiance had significantly lower rates of the primary composite CV outcome and of death from any cause compared to placebo.

The Appeal Board acknowledged that the data would be of interest and importance to health professionals. It noted the Alliance representatives' statement at the appeal that the EMPA-REG study was a highly cited study and that the study was required by regulators. Dissemination of the data had to comply with the Code. The Appeal Board noted that the material at issue was handed out to a health professional after a 1:1 promotional Jardiance call with an Alliance representative and the representative was instructed not to discuss it. The Appeal Board noted from the Alliance's representatives at the appeal that health professionals in primary care were targeted as they were responsible for the majority of prescriptions of diabetes medicines and unlike secondary care health professionals, were mostly unaware of the EMPA-REG study. The Appeal Board noted from the representatives from the Alliance that distribution of the material at issue by the sales representatives would be likely to increase the market share of Jardiance.

The Appeal Board disagreed with the Alliance's submission that the proposed wording for the Jardiance SPC was not a new indication. In this regard it noted that the agenda for the CHMP meeting dated 22 February 2016 stated that in relation to Jardiance it was considering an:

> 'Extension of indication to include a new indication on prevention of cardiovascular events, based on the final data of the cardiovascular safety phase III clinical trial EMPA-REG OUTCOME.'

The Appeal Board noted that the proposed new wording did not refer to a prerequisite lack of glycaemic control as in the current indications. The Appeal Board noted the Alliance's submission regarding the data from the CV meta-analysis which was the basis for the statement in the current SPC that 'Jardiance did not increase cardiovascular risk'. The Forest plot displaying the hazard ratio and confidence intervals indicated that the CV meta-analysis data showed reduced risk with the confidence interval between just over 0.2 and just over 0.8. The same plot showed the EMPA-REG study hazard ratio as 0.86 and confidence intervals nearer to 1 (0.74 to 0.99). The CV meta-analysis data were further to the left of reduced risk side than the EMPA-REG data.

The Appeal Board noted that approximately three quarters of the letter discussed cardiovascular outcome data and in this regard did not accept the companies' submission that the emphasis of the letter was on cardiovascular safety. The Appeal Board considered that the prominence given within the 'Dear UK Healthcare Professional' letter to the cardiovascular outcome data (efficacy data) from the EMPA-REG study was such that it promoted Jardiance for cardiovascular risk reduction, which was inconsistent with the current Jardiance SPC which stated in Section 5.1 that Jardiance did not increase cardiovascular risk. This was based on the CV meta-analysis data. In the Appeal Board's view there was a difference between risk reduction and not increasing risk. The statement on page 2 of the letter that Jardiance was not indicated for cardiovascular risk reduction was insufficient to negate the misleading impression. In the Appeal Board's view, the material was preparing the market for an anticipated licence extension. Consequently, the Appeal Board upheld the Panel's ruling of a breach of Clause 3.2. The appeal on this point was unsuccessful.

The Appeal Board considered that as the 'Dear UK Healthcare Professional' letter included no obvious branding to identify that it was from the Alliance, some recipients might assume that it was important safety information such as a 'Dear Doctor' letter sent at the request of the MHRA. The Appeal Board noted from the Alliance's representatives at the appeal that with the benefit of hindsight it would have included a company logo and changed how the letter was addressed to make it more obviously promotional.

The Appeal Board noted that the letter should be capable of standing alone with regard to compliance with the Code. In the Appeal Board's view, despite the letter being distributed by representatives, the fact that it was promotional was not immediately obvious. This was especially so for subsequent readers of the material who did not receive it from the representative. The Appeal Board considered that the material was disguised and upheld the Panel's ruling of a breach of Clause 12.1. The appeal on this point was unsuccessful.
The Appeal Board noted its comments and rulings above and considered that high standards had not been maintained. The Appeal Board upheld the Panel's ruling of a breach of Clause 9.1. The appeal on this point was unsuccessful.

The Appeal Board noted that the Alliance had used the data from the EMPA-REG study to support an application for a licence extension. In the Appeal Board's view, the letter was so positive about cardiovascular risk reduction that this would encourage health professionals to switch previously controlled diabetes patients at risk of cardiovascular events to Jardiance to reduce that cardiovascular risk. This was inconsistent with its SPC and was an unlicensed indication. The Appeal Board noted that in response to a question, the representatives from the Alliance confirmed that they were familiar with the numerous case precedents where companies claimed additional benefits for medicines outside of licence and had been ruled in breach of the Code. The Appeal Board was surprised that the collective knowledge and experience of both Lilly and Boehringer Ingelheim could consider that the provision of the material at issue was anything other than promotion of an unlicensed indication. The Appeal Board upheld the Panel's ruling of a breach of Clause 2. The appeal on this point was unsuccessful.

COMMENTS FROM BOEHRINGER INGELHEIM and LILLY ON THE REPORT FROM THE PANEL

At the consideration of the report the representatives from the Alliance submitted that it was fully committed to operating in an ethical and compliant manner and it took compliance with the Code very seriously. The Alliance had a robust governance framework within which compliance formed the backbone. Compliance featured on the monthly Alliance Country Governance meeting chaired by the managing directors. The respective medical directors were standing members and assumed responsibility for compliance at these meetings. The Alliance held a monthly compliance meeting which was attended by each medical director, compliance director/senior leader and senior medical and marketing leaders. The Alliance had a global and a local 'Policy Alignment Document' setting clear expectations on how it would operate according to company procedures and the Code. All employees were required to undergo regular training on the Code including attendance at PMCPA seminars. The Alliance had regularly consulted with the PMCPA around proposed/potential activities and it would continue to do so. Both Lilly and Boehringer Ingelheim actively participated in the PMCPA Compliance Network meetings. The Alliance regularly trained employees on all standard operating procedures (SOPs). The Alliance had a joint SOP for the approval of promotional materials in the UK. The Alliance required three signatories for its promotional materials which went beyond the Code requirement of one signatory. The Alliance had regular forums for signatories in order to share best practice.

The Alliance submitted that the central issue in these cases was the interpretation of Clause 3.2 in relation to the EMPA-REG study data, which was a technical point in a grey area of the Code. A difference in interpretation in an unclear area of the Code did not mean that the Alliance had inadequate compliance processes in place.

APPEAL BOARD CONSIDERATION OF THE REPORT FROM THE PANEL

The Appeal Board noted its comments and rulings of breaches of the Code in the above including a breach of Clause 2. The Appeal Board considered that the Alliance's actions either showed a disregard for, or a fundamental lack of understanding of, the requirements of the Code. The amount of time the companies had spent discussing the position implied they were aware of the risks involved. The Appeal Board did not accept that the issues in this case were due to a grey area of the Code. It appeared that the Alliance had decided to put commercial gain before compliance with the Code. This was totally unacceptable.

The Appeal Board was very concerned that 2,687 health professionals had been provided with the material at issue which had promoted Jardiance for an unlicensed indication. This was unacceptable. Consequently, the Appeal Board decided, in accordance with Paragraph 11.3 of the Constitution and Procedure, to require the Alliance to issue a corrective statement to all recipients of the material at issue. [The corrective statement, which was agreed by the Appeal Board prior to use, appears at the end of this report].

In addition, the Appeal Board decided, in accordance with Paragraph 11.3, to require the Alliance to take steps to recover the material.

The Appeal Board also decided that, given its concerns set out above, to require, in accordance with Paragraph 11.3 of the Constitution and Procedure, an audit of both Lilly and Boehringer Ingelheim's procedures in relation to the Code with an emphasis on the activities of the Alliance. The audits would take place as soon as possible. On receipt of the audit reports, the Appeal Board would consider whether further sanctions were necessary.

APPEAL BOARD FURTHER CONSIDERATION

Boehringer Ingelheim and Lilly were audited in July 2016 and the audit reports were considered by the Appeal Board in September.

The Appeal Board noted from both audit reports concerns about the governance of the Alliance

although it was pleased to note a greater involvement of the compliance function on the senior governance committee.

The Appeal Board noted from the Boehringer Ingelheim audit report that, *inter alia*, there were concerns about the company's standard operating procedures (SOPs), staff training and control of advisory boards. The Appeal Board considered that staff throughout the company needed to urgently improve and demonstrate their knowledge and understanding of the Code and commitment to compliance.

The Appeal Board noted that Boehringer Ingelheim had completed some of the work on its compliance action plan but it still had much to do. The Appeal Board noted its comments above and considered that Boehringer Ingelheim should be re-audited in March 2017 when it would expect the company's action plan to be complete and the company able to demonstrate considerable improvement in compliance culture and process.

The Appeal Board noted from the Lilly audit report that compliance and ethics were highly valued at the company and its staff had understood and genuinely regretted the failings in this case. However, the audit report highlighted concerns about the company's SOPs, it's approval process and governance of advisory boards.

The Appeal Board noted that some work on Lilly's compliance plan was already complete and that all actions were due to be completed by the end of October 2016. The Appeal Board considered that Lilly should be re-audited around the same time as Boehringer Ingelheim

On receipt of the reports for the March 2017 audits, the Appeal Board would consider whether further sanctions were necessary.

Boehringer Ingelheim and Lilly were audited in March 2017 and the audit reports were considered by the Appeal Board in April.

The Appeal Board was encouraged by the progress made by Boehringer Ingelheim which needed to be maintained. The Appeal Board noted, however, that the re-audit report highlighted that there were still concerns to be addressed in certain areas. In that regard it decided that Boehringer Ingelheim should provide to the PMCPA the outcome of its reviews and updates of materials and activities by early July.

On receipt of further responses in July the Appeal Board considered that Boehringer Ingelheim had addressed the majority of the recommendations in the re-audit report and the company was making good progress. The Appeal Board noted a number of activities/actions were due to be undertaken. On the basis that this work was completed reasonably promptly, the progress shown to date was continued and a company-wide commitment to compliance was maintained, the Appeal Board decided that no further action was required.

The Appeal Board was encouraged by the progress made by Lilly which needed to be maintained. The Appeal Board noted, however, that the re-audit report highlighted that there were still concerns to be addressed in certain areas. In that regard it decided that Lilly should provide to the PMCPA the outcome of its reviews and updates of materials and activities including copies of any updated standard operating procedures (SOPs) and the outcome of its reviews/ audits by early July.

The Appeal Board was advised in July that the PMCPA had been contacted by a whistle blower regarding the papers provided by Lilly at the audits. On receipt of further responses in September the Appeal Board noted that Lilly's investigation did not support the whistle blower's concerns.

In relation to the follow-up to the March 2017 re-audit, the Appeal Board noted the PMCPA's review of the company's procedures and noted that these were, in general, much improved. However, the Appeal Board thought that it would be helpful to receive clarification of several points including to the company's responses to points raised by the whistle blower. On receipt of further information in October the Appeal Board considered that despite certain concerns about, *inter alia*, Lilly's process for examination and approval of advisory boards and their materials Lilly had satisfactorily answered its request for clarification. Bearing in mind the progress made and on the basis that the company's commitment to compliance was maintained the Appeal Board considered that, on balance, its concerns did not warrant further action.

Complaint received	**2 March 2016**
Undertakings received:	
Boehringer Ingelheim	**7 June 2016**
Lilly	**9 June 2016**
Appeal Board consideration	**19 May 2016, 8 September, 26 April 2017, 20 July, 7 September**
Corrective statement issued	**29 July 2016**
Interim Case Report first Published	**28 July 2016**
Case completed	**12 October 2017**

On 29 July 2016, the Alliance sent the following corrective statement to recipients of the 'Dear UK Healthcare Professional' at issue.

'Corrective statement

Between 12 January and 20 April 2016, a letter addressed to 'Dear UK Healthcare Professional' (ref UK/EMP/00241) was provided to you by a sales representative on behalf of Boehringer Ingelheim Ltd and Eli Lilly and Company Ltd (the Alliance). The letter was stapled to a copy of Zinman *et al* (2015), 'Empagliflozin, Cardiovascular Outcomes, and Mortality in Type 2 Diabetes' (the EMPA-REG study) and a 1 sided A4 sheet which gave the prescribing information for Jardiance (empagliflozin).

Following a complaint under the ABPI Code of Practice for the Pharmaceutical Industry, the Code of Practice Appeal Board ruled that the letter was inconsistent with the Jardiance summary of product characteristics and constituted disguised promotion. The Appeal Board also ruled that the Alliance had failed to maintain high standards and had brought discredit upon and reduced confidence in the pharmaceutical industry. As a result of the above the Alliance has been required to issue this corrective statement and to circulate a copy of the published report for the case which contains full details. This is enclosed. In addition the Alliance has been required to recover the material at issue. If you still have the material at issue please return it in the attached prepaid envelope as soon as possible. If you no longer have the material at issue, please confirm this by completing the attached reply slip and return in the attached envelope.

Details of these cases (Cases AUTH/2825/3/16 and AUTH/2826/3/16) are also available on the PMCPA website (www.pmcpa.org.uk).'

CASE AUTH/2923/12/16

HOSPITAL PHARMACIST v MERCK SHARP & DOHME

Remicade advertisement

A hospital pharmacist, complained about a two page advertisement for Remicade (infliximab) issued by Merck Sharp & Dohme. The first page showed an illustration of an intact dandelion seed head beneath which was 'August 2016'. The claim '17 years of Clinical Experience with over 2.4 Million Patients treated worldwide', referenced to data on file, also appeared together with the product logo which incorporated the strapline 'more than a name' which was also referenced to the data on file. Prescribing information was on page two.

The complainant stated that on first seeing the advertisement he/she was immediately drawn to the very large illustration of the blue sky and pollen flower and instantly inclined to believe that the medicine in question was licensed in allergy/ hay fever. This was not helped by the fact that 'Remicade' was in a particularly small font compared to that used elsewhere in the advertisement and as it was right at the bottom of the advertisement it could be missed by health professionals whereas the pollen illustration took up more than half of the page.

The complainant stated that this was particularly worrying as when he/she turned over the page for the prescribing information he/she saw that Remicade was not licensed for hay fever or allergy but for rheumatological conditions such as rheumatoid arthritis. The complainant noted that a spiral was depicted in the product logo and also in the centre of the pollen therefore further highlighting his/her point that Merck Sharp & Dohme had clearly linked the medicine to the pollen and thus implied that Remicade was licensed for conditions linked to pollen such as hay fever. The complainant alleged that this was misleading and might be taken as disguised promotion for an unlicensed indication.

The complainant stated that 'August 2016' was absolutely meaningless to any health professional; he/she did not understand what the date implied or what it had to do with Remicade by simply looking at the advertisement. Also as noted above, 'Remicade' was in small font at the end of the advertisement and so could be missed and thus the advertisement came across as pointless.

The complainant further alleged that the claim '17 years of Clinical Experience with over 2.4 Million Patients treated worldwide' was meaningless to health professionals as again it appeared like the 'August 2016' statement much larger (the Code stated that extremes of format and size should be avoided). Both of these statements appeared before the name of the medicine and so came across as meaningless and could lead to confusion especially if the medicine name was missed.

The complainant noted the strapline 'more than a name' was incorporated into the product logo and alleged that this was quite clearly a hanging comparison/exaggeration and there was no explanation/substantiation on why Remicade provided 'more' (more could be interpreted as a superlative under the Code).

Overall the complainant alleged that the advertisement was misleading, disguised promotion for an unlicensed indication and implied that Remicade was superior in some way without substantiation. The complainant alleged that high standards had not been maintained at all times and as such this had reduced his/her confidence in the pharmaceutical industry.

The detailed response from Merck Sharp & Dohme is given below.

The Panel noted that children often blew away the seeds of a dandelion clock in a game to find out what time it was. In that sense, a dandelion clock was used to measure the passage of time as in hours on a clock and not the passage of time as in years. The Panel thus did not consider that there was a clear connection between the picture of a dandelion clock and the claim regarding 17 years of clinical experience as submitted by Merck Sharp & Dohme. Nor did the Panel consider that it would be obvious to readers that the spiral in the middle of the dandelion clock, replicated in the product logo, represented the passage of time.

Despite the prominent depiction of the dandelion clock, the Panel did not consider that the advertisement promoted Remicade for allergy/ hay fever. The product logo, although in slightly smaller font than the claim about 17 years' clinical experience, was printed in bold type and in that regard the Panel did not consider that it would be easily missed as alleged. The advertisement had appeared in a health professional journal; readers would be aware that Remicade (infliximab) was a monoclonal antibody and so would be unlikely to think that it could be used for allergy/hay fever. There was no text in the advertisement to suggest such a use. The depiction of the dandelion clock did not, in and of itself, suggest that Remicade could be used for allergy/hay fever. No breach of the Code was ruled. This ruling was upheld on appeal by the complainant. In the Panel's view, the creative part of the advertisement did not promote Remicade for any indication at all. The prescribing information was printed overleaf and so in that regard the Panel considered that the advertisement promoted the rational use of Remicade. No breach of the Code was ruled. This ruling was appealed by the complainant.

The Panel noted the complainant's allegation with regard to the font size used in the advertisement.

In the Panel's view, the extremes of format or size referred to in the cited clause referred to the physical size of materials, not of the font size used within them. In that regard the Panel ruled no breach of the Code.

The Panel noted the allegation that the strapline, 'more than a name', in the product logo was misleading and implied some special merit. In the Panel's view it was not obvious what 'more than a name' was meant to convey; it did not agree with Merck Sharp & Dohme's submission that it was a simple statement of fact that Remicade was a branded prescription only medicine. Nor did it agree with the complainant's view that 'more than a name' was a hanging comparison. Overall the Panel considered that the strapline conveyed very little about Remicade and in that regard it was not misleading. No breach of the Code was ruled. This ruling was appealed by the complainant. The Panel also did not consider that the strapline was a superlative or that it implied some special merit. No breach of the Code was ruled. This ruling was appealed by the complainant.

The Panel noted its comments and rulings above and considered that high standards had been maintained. No breach of the Code was ruled which was upheld on appeal from the complainant. It thus followed that there had been no breach of Clause 2 and so the Panel ruled accordingly.

The Appeal Board noted that the advertisement at issue contained the statement '17 years of Clinical Experience with over 2.4 Million Patients treated worldwide' and the strapline 'more than a name' which were referenced to Merck Sharp & Dohme's data on file (PSUR). The data on file consisted of just over two lines of text (derived from the full PSUR) which noted that the latest global commercial exposure figure for Remicade, from its launch in 1998 to August 2015 was 2,437,109. The Appeal Board noted that the content of data on file was decided by the company.

The Appeal Board did not consider that, as submitted by Merck Sharp & Dohme the strapline simply drew attention to the brand and its anniversary. In the Appeal Board's view it implied that Remicade was more than its constituent, infliximab, because, *inter alia*, it had 17 years of clinical data and thereby implied a special merit versus other infliximabs. The Appeal Board considered that this implied a special merit for Remicade which was not substantiated by the data on file. No efficacy or safety data had been provided. The Appeal Board ruled a breach of the Code. The appeal on this point was successful.

Further the Appeal Board considered that the claim 'more than a name' was ambiguous and the claim and the referenced data on file were not sufficiently complete to allow the reader to form their own opinion on the therapeutic value of the medicine. A breach of the Code was ruled. The appeal on this point was successful.

The Appeal Board noted its rulings of breaches of the Code. Notwithstanding the fact that the advertisement included the prescribing information for Remicade overleaf, the Appeal Board considered that in addition the advertisement failed to promote the rational use of Remicade. It exaggerated the properties of Remicade and failed to present it objectively. The Appeal Board ruled a breach of the Code. The appeal on this point was successful.

A hospital pharmacist, complained about a two page advertisement for Remicade (infliximab) (ref RHEU-1191218-0001) issued by Merck Sharp & Dohme Limited and published in The Pharmaceutical Journal between October and December 2016.

The first page of the advertisement showed an illustration of an intact dandelion seed head beneath which was 'August 2016'. The claim '17 years of Clinical Experience with over 2.4 Million Patients treated worldwide', referenced to data on file, also appeared together with the product logo which incorporated the strapline 'more than a name' which was also referenced to the data on file. Prescribing information was on page two.

Remicade was indicated for various conditions including rheumatoid arthritis, Crohn's disease, ulcerative colitis, ankylosing spondylitis, psoriatic arthritis and psoriasis.

COMPLAINT

The complainant stated that Merck Sharp & Dohme had not operated in a responsible, ethical and professional manner with regard to the advertisement.

The complainant stated that on first seeing the advertisement he/she was immediately drawn to the very large illustration of the blue sky and pollen flower and instantly inclined to believe that the medicine in question was licensed in allergy/hay fever. This was not helped by the fact that 'Remicade' was in a particularly small font compared to that used elsewhere in the advertisement and as it was right at the bottom of the advertisement it could be missed by health professionals whereas the pollen illustration took up more than half of the page.

The complainant stated that this was particularly worrying as when he/she turned over the page for the prescribing information he/she saw that Remicade was not licensed for hay fever or allergy but for rheumatological conditions such as rheumatoid arthritis. The complainant noted that a spiral was depicted in the product logo and also in the centre of the pollen therefore further highlighting his/her point that Merck Sharp & Dohme had clearly linked the medicine to the pollen and thus implied that Remicade was licensed for conditions linked to pollen such as hay fever. The complainant alleged that this was particularly misleading and might be taken as disguised promotion for an unlicensed indication. Therefore, breaches of Clause 3 (in particular 3.2) and Clause 7.8 were alleged.

The complainant stated that 'August 2016' was absolutely meaningless to any health professional; he/she did not understand what the date implied or what it had to do with Remicade by simply looking at the advertisement. Also as noted above, 'Remicade' was in small font at the end of the advertisement and so could be missed and thus the advertisement came across as pointless.

The complainant further alleged that the claim '17 years of Clinical Experience with over 2.4 Million Patients treated worldwide' was meaningless to health professionals as again it appeared like the 'August 2016' statement much larger (the Code stated in Clause 9.7 to avoid extremes of format and size). Both of these statements appeared before the name of the medicine and so came across as meaningless and could lead to confusion especially if the medicine name was missed.

The complainant noted the strapline 'more than a name' incorporated into the product logo and alleged that this was quite clearly a hanging comparison/ exaggeration and there was no explanation/ substantiation on why Remicade provided 'more' (more could be interpreted as a superlative under Clause 7.10). The complainant thus alleged a breach of Clause 7 as Clause 7.10 stated that claims should not imply that a medicine or an active ingredient had some special merit, quality or property unless this could be substantiated and Clause 7.2 required that information, claims and comparisons must be accurate, balanced, fair, objective and unambiguous and must be based on an up-to-date evaluation of all the evidence and reflect that evidence clearly; claims must not mislead either directly or by implication, by distortion, exaggeration or undue emphasis.

Overall the complainant submitted that the advertisement was misleading, disguised promotion for an unlicensed indication and implied that Remicade was superior in some way without substantiation. The complainant alleged breaches of Clauses 9 and 2 as high standards had not been maintained at all times and as such this had reduced his/her confidence in the pharmaceutical industry.

In writing to Merck Sharp and Dohme the Authority asked it to bear in mind the requirements of Clauses 2, 3.2, 7.2, 7.8, 7.10, 9.1 and 9.7 of the Code.

RESPONSE

Merck Sharp & Dohme stated that it took compliance with the Code extremely seriously and acknowledged the high standards required for the promotion of medicines.

Merck Sharp & Dohme submitted that when the advertisement was published, Remicade had been on the market for 17 years as a 100mg powder for concentrate for solution for infusion. Treatment had to be initiated and supervised by qualified physicians experienced in the diagnosis and treatment of rheumatoid arthritis, inflammatory bowel diseases, ankylosing spondylitis, psoriatic arthritis or psoriasis. Remicade should be administered intravenously.

The artwork in the advertisement was of a 'dandelion clock', well recognised in Britain as a symbolic measure of the passage of time. The Oxford Living Dictionary defined a dandelion clock as 'the downy, spherical seed head of a dandelion. Origin: From the child's game of blowing away the seeds to find out what time it is'. The date 'August 2016', cited in the advertisement represented the 17 year anniversary of the granting of the first marketing authorization for Remicade in August 1999.

The claim '17 years of Clinical Experience with over 2.4 Million Patients treated worldwide' was a factual statement about the number of years that Remicade had been available, and the number of patients treated.

This advertisement was intended to remind health professionals that after 17 years, Remicade was still available and still had therapeutic value for appropriate patients.

Prescribing information was provided as required by the Code and provided important information (including indications, dosage, precautions and warnings, and contraindications) for health professionals before they prescribed the medicine. In addition, the prescribing information clearly advised prescribers to 'Refer to Summary of Product Characteristics (SmPC) before prescribing'. The Remicade logo incorporated the strapline 'more than a name'. In summary the overall artwork and wording was to highlight to health professionals that Remicade was still a therapeutic option for appropriate patients, when prescribed in accordance to the prescribing information.

The artwork of a 'dandelion clock' did not refer, either directly or indirectly, to pollen, allergy or hay fever. It was there to provide a commonly recognised symbol of time. Whilst a dandelion seed head contained single seeded fruits and no pollen, Merck Sharp & Dohme noted that the artwork did not illustrate seed dispersal which further re-enforced Merck Sharp & Dohme's assertion that the artwork was far removed from the concept of allergy or hay fever associated with the spread of pollen. It was there to represent a symbol of time and the 'dandelion clock' was a commonly accepted and understood representation of time in British culture. Biologically the dandelion clock was not pollen itself nor did it contain pollen and it did not resemble pollen as the seeds were too large to be routinely inhaled by hay fever sufferers and cause symptoms. Additionally, there was no spreading of pollen to indicate that the artwork was related to allergy or hay fever. There was also no attempt to represent the symptoms, pathology or anatomy associated with hay fever and allergy.

The swirl ('spiral') alongside Remicade was also used within the dandelion, as part of the dandelion clock to represent the passage of time; Merck Sharp & Dohme did not believe that the swirl could be linked to pollen, hay fever or allergy.

Merck Sharp & Dohme confirmed that it was not involved in any research regarding the use of Remicade in allergy or hay fever. Nor was it aware

of any independently sponsored research regarding the use of Remicade in hay fever or allergy. Merck Sharp & Dohme was not seeking any form of licence for either of these disease areas and was also not aware of any published case reports of the use of infliximab in the treatment of allergy or hay fever. In summary, Merck Sharp & Dohme disputed that the advertisement promoted Remicade for indications (ie allergy, hay fever or otherwise) not covered by the marketing authorization (Clause 3.2) or that the artwork misled as to the nature of the medicine (Clause 7.8, supplementary information). The artwork/imagery was not a claim *per se*.

As discussed, above the date 'August 2016' together with the 'dandelion clock' represented the passage of time and 17 years of clinical experience with Remicade. Clause 9.7 stated that extremes of format and size must be avoided. The advertisement was A4 in size and would be viewed by the recipient as a whole page. Merck Sharp & Dohme disagreed that within the context of an A4 advertisement the size of the artwork or the font size of either the claim or the date were of extreme format or size, and thus it denied a breach of Clause 9.7. Merck Sharp & Dohme also maintained that due to the orderly format of the advertisement with simple artwork and very little text, the brand name Remicade with the generic name, infliximab, directly below, was of sufficient size to identify the medicine in question.

Merck Sharp & Dohme submitted that after reading the August 2016 date, the eye was immediately drawn to the adjacent text situated below which read '17 years of Clinical Experience with over 2.4 Million Patients treated worldwide'; clearly linking August 2016 with the passage of 17 years, during which time over 2.4 million patients had been treated with Remicade. Merck Sharp & Dohme disagreed with the complainant's view that the text was meaningless, or that the date and statement could not be understood to be linked. Again, Merck Sharp & Dohme reiterated that the advertisement was A4 in size and would be viewed by the recipient as a whole page.

Merck Sharp & Dohme submitted that 'more than a name' was not a comparative or exaggerated claim. "More than a name" was a simple statement of fact that Remicade was a branded prescription only medicine. It was a statement that linked in with the overall impression of the advertisement and reminded health professionals that Remicade had 17 years of clinical experience and had therapeutic value for appropriate patients. Clause 7.10 stated that promotion should encourage the rational use of a medicine by presenting it objectively and without exaggerating its properties. The supplementary information stated that superlatives were those grammatical expressions which denoted the highest quality or degree, such as best, strongest, widest etc. Merck Sharp & Dohme did not believe that the inclusion of this statement either exaggerated the properties of Remicade, nor was a superlative as defined by the supplementary information to Clause 7.10. Merck Sharp & Dohme also submitted that 'more than a name' was not a 'hanging comparison' (Clause 7.2) as the statement did not present any property of the medicine favourably in relation to an unqualified comparator.

In summary, Merck Sharp & Dohme submitted that the advertisement was in accordance with the Code and did not breach Clauses 3.2, 7.2, 7.8, 7.10, or 9.7. Hence Merck Sharp & Dohme contended that high standards had been maintained (Clause 9.1) respecting the special status of medicines, and it had operated in a transparent, responsible, ethical and professional manner. Merck Sharp & Dohme submitted that it had not brought discredit to, or reduced confidence in, the industry (Clause 2).

PANEL RULING

The Panel noted that children often blew away the seeds of a dandelion clock in a game to find out what time it was. In that sense, a dandelion clock was used to measure the passage of time as in hours on a clock and not the passage of time as in years. The Panel thus did not consider that there was a clear connection between the picture of a dandelion clock and the claim regarding 17 years of clinical experience as submitted by Merck Sharp & Dohme. Nor did the Panel consider that it would be obvious to readers that the spiral in the middle of the dandelion clock, replicated in the product logo, represented the passage of time.

Despite the prominent depiction of the dandelion clock, the Panel did not consider that the advertisement clearly promoted Remicade for allergy/hay fever. The product logo, although in slightly smaller font than the claim about 17 years' clinical experience, was printed in bold type and in that regard the Panel did not consider that it would be easily missed as alleged. The advertisement had appeared in a health professional journal; readers would be aware that Remicade (infliximab) was a monoclonal antibody and so would be unlikely to think that it could be used for allergy/hay fever. There was no text in the advertisement to suggest such a use. No breach of Clause 3.2 was ruled. This ruling was not appealed. In the Panel's view, the depiction of a dandelion clock did not, in and of itself, suggest that Remicade could be used for allergy/hay fever. No breach of Clause 7.8 was ruled. This ruling was appealed by the complainant. In the Panel's view, the creative part of the advertisement did not promote Remicade for any indication at all. The prescribing information was printed overleaf and so in that regard the Panel considered that the advertisement promoted the rational use of Remicade. No breach of Clause 7.10 was ruled. This ruling was appealed by the complainant.

The Panel noted the complainant's allegation of a breach of Clause 9.7 with regard to the font size used in the advertisement. In the Panel's view, the extremes of format or size referred to in Clause 9.7 referred to the physical size of materials, not of the font size used within them. In that regard the Panel ruled no breach of Clause 9.7. This ruling was not appealed.

The Panel noted the allegation that the strapline, 'more than a name', in the product logo was

misleading and implied some special merit. In the Panel's view it was not obvious what 'more than a name' was meant to convey; it did not agree with Merck Sharp & Dohme's submission that it was a simple statement of fact that Remicade was a branded prescription only medicine. Nor did it agree with the complainant's view that 'more than a name' was a hanging comparison. Overall the Panel considered that the strapline conveyed very little about Remicade and in that regard it was not misleading. No breach of Clause 7.2 was ruled. This ruling was appealed by the complainant. The Panel also did not consider that the strapline was a superlative or that it implied some special merit. No breach of Clause 7.10 was ruled. This ruling was appealed by the complainant.

The Panel noted its comments and rulings above and considered that high standards had been maintained. No breach of Clause 9.1 was ruled. This ruling was appealed by the complainant. It thus followed that there had been no breach of Clause 2 and so the Panel ruled accordingly.

APPEAL BY THE COMPLAINANT

The complainant stated that after reading the response from Merck Sharp & Dohme and the Panel ruling he/she still considered the advertisement to be misleading and not within the spirit of the Code.

The complainant noted Merck Sharp & Dohme's in-depth knowledge on the 'dandelion clock' but stated that Merck Sharp & Dohme was confused by its analogy stating in its response that the 'dandelion clock' was '… blowing away the seeds to find out what time it is', this was obviously referring to the time in hours, not the number of years a medicine had been licensed for. Therefore, this illustration was inappropriate for this Remicade advertisement.

The complainant alleged that Merck Sharp & Dohme had assumed that readers of The Pharmaceutical Journal would simply look at the dandelion clock and instantly link the 17 year anniversary to it, however as stated above the illustration had no correlation to this anniversary. Merck Sharp & Dohme clearly seemed to be confused by the meaning behind the dandelion clock however, it expected health professionals reading The Pharmaceutical Journal to simply know what they were referring to. The readers of The Pharmaceutical Journal were medical professionals not plant/seed/flower/history experts and had varying roles within the pharmacy (retired, recently graduated, pharmacists, technicians, pre-registration, students) and also from different sectors ie hospital, community, academia, industry. The complainant as a pharmacist had never heard of the dandelion clock until reading Merck Sharp & Dohme's response.

The complainant alleged that Merck Sharp & Dohme seemed to contradict itself, on one hand it stated that the illustration of this dandelion clock did not include any spreading of the pollen/seeds. However, by using this dandelion clock and linking it to Remicade then there would certainly be seed dispersal as stated in its response the dandelion clock referred to '… blowing away the seeds to find out what time it is'.

The complainant alleged that the strapline 'more than a name' was cited by a reference which according to the advertisement was Merck Sharp & Dohme's data on file periodic safety update report (PSUR). The complainant was interested to see how this data actually substantiated the vague strapline/claim 'more than a name'. Merck Sharp & Dohme stated that the strapline showed Remicade was a branded prescription only medicine. The complainant was not sure why Remicade was any different from any other prescription-only medicine in that sense then, and why the strap line alluded to the fact that it provided more than just a name, surely this would be the case for any medicine! Therefore it could be argued that this strap line was indirectly exaggerating/promoting the benefits of Remicade without providing any further information.

The complainant stated that it was important to remember that not every reader of The Pharmaceutical Journal would have had experience dispensing, prescribing Remicade (infliximab) and as mentioned above the audience reading The Pharmaceutical Journal was wide. The complainant alleged that Merck Sharp & Dohme had produced an advertisement in which it had used an illustration which had nothing to do with its product and a strap line which again had no real meaning. As a reader of The Pharmaceutical Journal the complainant expected to see relevant, easy to understand and good quality advertisements, as health professionals did not have hours in their day to look at the hidden messages behind such advertisements from pharmaceutical companies or to google things like the dandelion clock. The complainant expected to understand exactly what was going on by looking at an advertisement straight away, this was not the case for this advertisement.

The complainant stated that the Code was in place to provide health professionals with confidence in the pharmaceutical industry. The materials Merck Sharp & Dohme produced needed to be relevant and clear to understand which had not been the case on this occasion. The complainant urged the Appeal Board to rule a breach of the Code as otherwise the case would set a precedent for other companies to use illustrations and straplines that had no correlation to the medicine they were advertising in professional health journals. This would lead to poor quality advertising which was simply not acceptable.

RESPONSE FROM MERCK SHARP & DOHME

Merck Sharp & Dohme submitted that it took compliance with the Code extremely seriously and acknowledged the high standards required for the promotion of medicines. Merck Sharp & Dohme submitted that the advertisement was in accordance with requirements of the Code and still disputed the complainant's view that it was in breach of Clauses 7.2, 7.8, 7.10, and 9.1.

Before responding to the continued concerns raised by the complainant in his/her appeal Merck Sharp &

Dohme provided background to the rationale of the artwork and the statements within the advertisement.

Merck Sharp & Dohme submitted that at the time of the advertisement, Remicade (infliximab) had been available on the market for 17 years as a 100 mg powder for concentrate for solution for infusion. The artwork in the advertisement was of a downy spherical seed head of the common dandelion plant, commonly known as a 'dandelion clock'. This was well recognised in Britain as a symbolic measure of the passage of time, as referred to in the Oxford Living Dictionaries' definition of a Dandelion Clock: 'Noun, British: The downy spherical seed head of a dandelion. Origin: From the Childs game of blowing away the seeds to find out what time it is'. Thus the creative element of the artwork in the advertisement represented the passage of time. Within the artwork was the date 'August 2016' followed underneath by the statement '17 years of Clinical Experience with over 2.4 Million Patients treated worldwide'. Merck Sharp & Dohme submitted that this date ('August 2016') represented the 17 year anniversary of the granting of the first marketing authorisation for Remicade (August 1999). The statement underneath was a factual statement about the number of years that Remicade had been available, and the number of patients treated.

Merck Sharp & Dohme submitted that the advertisement was intended as a reminder to health professionals that after 17 years, Remicade was still available and still had therapeutic value for appropriate patients. Although Merck Sharp & Dohme acknowledged that the advertisement might not be to the complainant's preference, it maintained that the advertisement was in accordance with requirements of the Code, and respected the special status of medicines.

The complainant's appeal stated that based on Merck Sharp & Dohme's response the 'dandelion clock' referred to time in hours and not years and the illustration was inappropriate for this Remicade advertisement.

In response to the original complaint concerning the Remicade advertisement, Merck Sharp & Dohme submitted that the artwork was of a downy spherical seed head of the common dandelion plant, commonly known as a 'dandelion clock'. This was well recognised in Britain as a symbolic measure of the passage of time. Thus the creative element of the artwork in the advertisement represented the passage of time. The statement following underneath '17 years of Clinical Experience with over 2.4 Million Patients treated worldwide' put this passage of time into context; the number of years that Remicade had been available and the number of patients treated.

Merck Sharp & Dohme submitted that the artwork did not mislead as to the nature of the medicine (Clause 7.8 [Supplementary Information]). This advertisement was intended as a reminder to health professionals that after 17 years, Remicade was still available and still had therapeutic value for appropriate patients.

Merck Sharp & Dohme suggested that if a health professional did not recognise or understand the 'dandelion clock' artwork and/or the date 'August 2016', they would still be able to read the statement underneath '17 years of Clinical Experience with over 2.4 Million Patients treated worldwide' and link this to the medicine, Remicade.

Merck Sharp & Dohme submitted that medical professionals would not need to be 'plant/seed/flower/history experts' to understand the advertisement. Prescribing information had been provided with this advertisement, as required by the Code, to provide important information (including indications, dosage, precautions and warnings, and contraindications) for health professionals before they prescribed this medication. It was also important to note that treatment was to be initiated and supervised by qualified physicians experienced in the diagnosis and treatment of rheumatoid arthritis, inflammatory bowel diseases, ankylosing spondylitis, psoriatic arthritis or psoriasis. Remicade infusions should also be administered by qualified health professionals trained to detect any infusion related issues.

As previously stated, Merck Sharp & Dohme did not consider that 'more than a name' was an exaggerated claim. 'More than a name' was a simple statement of fact that Remicade was a branded prescription only medicine. It was a statement that linked in with the overall impression of the advertisement, reminding health professionals that Remicade had 17 years of clinical experience and had therapeutic value for appropriate patients. The reference substantiated the number of patients treated with Remicade worldwide and the number of years that it had been commercially available, thus, indicating the wealth of clinical experience that had been accrued over this time. Clause 7.10 stated that promotion should encourage the rational use of a medicine by presenting it objectively and without exaggerating its properties. The supplementary information stated that superlatives were those grammatical expressions which denoted the highest quality or degree, such as best, strongest, widest etc. Merck Sharp & Dohme submitted that the inclusion of this statement neither exaggerated the properties of Remicade, nor was a superlative as defined by the supplementary information to Clause 7.10. Merck Sharp & Dohme also submitted that 'more than a name' could not be interpreted as a 'hanging comparison' (Clause 7.2) as the statement did not present any property of the medicine favourably in relation to an un-qualified comparator.

In summary Merck Sharp & Dohme submitted that this advertisement was not in breach of Clauses 7.2, 7.8, and 7.10. Hence Merck Sharp & Dohme submitted that high standards had been maintained (Clause 9.1) respecting the special status of medicines, and it had operated in a transparent, responsible, ethical and professional manner.

FINAL COMMENTS FROM THE COMPLAINANT

There were no final comments from the complainant.

APPEAL BOARD RULING

The Appeal Board noted that the advertisement at issue contained the statement '17 years of Clinical Experience with over 2.4 Million Patients treated worldwide' and the strapline 'more than a name' which were referenced to Merck Sharp & Dohme's data on file (PSUR). The data on file consisted of just over two lines of text (derived from the full PSUR) which noted that the latest global commercial exposure figure for Remicade, from its launch in 1998 to August 2015 was 2,437,109. The Appeal Board noted that the content of data on file was decided by the company.

The Appeal Board did not consider that, as submitted by Merck Sharp & Dohme in the context of the advertisement the strapline simply drew attention to the brand and its anniversary. In the Appeal Board's view it implied that Remicade was more than its constituent, infliximab, because, *inter alia*, it had 17 years of clinical data and thereby implied a special merit versus other infliximabs. The Appeal Board considered that this implied a special merit for Remicade which was not substantiated by the data on file. No efficacy or safety data had been provided. The Appeal Board ruled a breach of Clause 7.10. The appeal on this point was successful.

Further the Appeal Board considered that the claim 'more than a name' was ambiguous and the claim and the referenced data on file were not sufficiently complete to allow the reader to form their own opinion on the therapeutic value of the medicine. A breach of Clause 7.2 was ruled. The appeal on this point was successful.

The Appeal Board considered that the depiction of a dandelion clock, in and of itself, did not suggest that Remicade could be used for allergy/hay fever. The Appeal Board upheld the Panel's ruling of no breach of Clause 7.8. The appeal on this point was unsuccessful.

The Appeal Board did not consider in the circumstances that high standards had not been maintained and it upheld the Panel's ruling of no breach of Clause 9.1. The appeal on this point was unsuccessful.

During the preparation of the case report in the above case it was noted that the Appeal Board had not ruled on the complainant's appeal of the Panel's ruling of no breach of Clause 7.10 in relation to whether the advertisement promoted the rational use of Remicade. The Chairman apologised for this regrettable oversight and decided that the appeal of no breach of Clause 7.10 should be considered.

The Appeal Board noted that Clause 7.10 stated that promotion must encourage the rational use of a medicine by presenting it objectively and not exaggerating its properties. Exaggerated or all-embracing claims must not be made and superlatives must not be used except for those limited circumstances where they related to a clear fact about a medicine. Claims should not imply that a medicine or an active ingredient had some special merit, quality or property unless this could be substantiated.

The Appeal Board noted its comments and rulings of breaches of the Code above including that the strapline 'more than a name' implied a special merit for Remicade which was not substantiated by the data on file (Clause 7.10) and that the claim was ambiguous (Clause 7.2). Notwithstanding the fact that the advertisement included the prescribing information for Remicade overleaf, the Appeal Board considered that given these comments and rulings and the wording of Clause 7.10, it followed that the advertisement in addition, failed to promote the rational use of Remicade. It exaggerated the properties of Remicade and failed to present it objectively. The Appeal Board ruled a breach of Clause 7.10. The appeal on this point was successful. The Appeal Board considered that this ruling of a breach of Clause 7.10 did not impact on its ruling of no breach of Clause 9.1 of the Code.

Complaint received **20 December 2016**

Case completed **7 August 2017**

CASE AUTH/2943/3/17

EX-EMPLOYEE OF A SERVICE PROVIDER v BAYER

Conduct of employee and training material

An ex-employee of a service provider to Bayer plc complained about the conduct of a named Bayer employee, at an initial training course for Xarelto held in 2017.

Xarelto 10mg was indicated for the prevention of venous thromboembolism (VTE) in adults undergoing elective hip or knee replacement surgery. The 15mg and 20mg presentations were, *inter alia*, indicated for the treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) and for the prevention of recurrent DVT and PE.

The complainant's first concern was that the employee encouraged sales trainees to promote Xarelto for an off-licence indication.

The complainant explained that one of the questions in a revision quiz concerned the licensed indication as per the summary of product characteristics (SPC). The attendees were asked to select from a choice of four, an indication not on the SPC as a licensed indication. The Bayer employee told the class that of the four choices, only 'active cancer' was not licensed. Unfortunately, one of the choices was 'prevention of DVT following hip fracture surgery'. It was brought to the Bayer employee's attention that Xarelto was also not licensed for this indication. This was refuted by the employee who stated that Xarelto was licensed for this indication. The complainant referred to the SPC (Section 4.4, special warnings and precautions for use)' which read: 'Hip fracture surgery Rivaroxaban had not been studied in interventional clinical trials in patients undergoing hip fracture surgery to evaluate efficacy and safety'. The following day, the question was still included in the final examination in the same format. The complainant alleged that it was firmly emphasized to the trainees that Xarelto should be promoted for the use in fracture surgery.

The complainant was further concerned that the employee had encouraged a disrespectful and unprofessional attitude towards clinicians and this would encourage impressionable trainees to also treat clinicians with similar disrespect.

The detailed response from Bayer is given below.

The Panel noted that the parties' accounts differed; it was difficult in such circumstances to determine precisely what had happened. A judgement had to be made on the available evidence whilst noting that the complainant bore the burden of proof and had to establish his/her case on the balance of probabilities.

The Panel considered that the revision quiz was part of the representatives' briefing material. The revision quiz question asked participants to select an indication not on the Xarelto SPC from a selection of four. The complainant gave 'active cancer' as the answer given by the employee who denied stating that only active cancer was not licensed. The complainant noted one of the choices was 'Prevention of DVT following hip fracture surgery' for which Xarelto was not licensed. Bayer stated that this was a verbal quiz and there were no documents to confirm. Nonetheless there was general agreement in the interview transcripts that at the very least this matter had been raised and discussed.

The Panel noted that the complainant was incorrect in stating that the same question in relation to hip fracture surgery was included in the written formal assessment. However a similar answer 'Prevention of VTE following hip fracture surgery' was one of the four possible answers. In that regard the Panel noted the error pointed out by Bayer in that the answer sheet gave 'Treatment of acute DVT in a patient with severe renal impairment' as the answer to the question 'Which of these is not an indication for Xarelto?'. The correct answer should have been 'Prevention of VTE following hip fracture surgery'. In addition, the Panel noted that 'active cancer' was not one of the possible answers to the question about Xarelto's licensed indications.

The Panel did not agree that 'Prevention of VTE following hip fracture surgery was contraindicated as submitted by Bayer. The indications in the SPC for Xarelto 10mg were clear as prevention of VTE in elective hip or knee surgery. Section 4.4 special warnings and precautions for use stated that rivaroxaban had not been studied in interventional trials in patients undergoing hip fracture surgery to evaluate efficacy and safety.

It appeared from the interview transcripts that the attendees understood that products should not be promoted for unlicensed indications. It was questionable whether the licensed indications for Xarelto were made clear. It appeared that the discussion about off-label use added to the confusion. The interview transcripts showed that not all were absolutely clear about whether Xarelto could be promoted for prevention of VTE following hip fracture surgery. In addition the interview transcript of the Bayer employee in question showed a degree of confusion about the treatment of acute DVT in patients with severe renal impairment which was mistakenly recorded as the correct answer in the quiz answer sheet. This was compounded by the marking scheme for the formal assessment which referred to the use of Xarelto in hip fracture surgery as contraindicated rather than unlicensed. The Panel was particularly concerned that of the completed quiz papers provided, not one representative gave prevention of VTE following hip fracture surgery as the correct answer. In the Panel's view, this indicated that the training on the point was unclear.

The Panel considered that despite its serious concerns outlined above the complainant had not provided any evidence to show that an unlicensed indication had been promoted to health professionals so the Panel ruled no breach of the Code. The Panel considered that the assessment was not clear with regard to the licensed indications. Bayer acknowledged that there was some confusion regarding the licensed indications. The briefing materials supplied by Bayer used at the training were not clear about the licensed indications, for example data relating to VTE prevention in orthopaedic surgery was described as a licensed indication, and this was compounded by the assessment. The Panel therefore ruled breaches of the Code including that high standards had not been maintained. On balance, the Panel considered that the circumstances brought discredit upon, and reduced confidence in, the pharmaceutical industry. The Panel therefore ruled a breach of Clause 2 which was a sign of particular censure and reserved for such use.

The Panel noted that there was a difference of opinion with regard to whether the employee referred to the clinicians as stupid or the question as stupid. There was no evidence that such language had been used with health professionals or in response to their questions. The Panel considered that the matter of how representatives were to answer questions from health professionals should have been dealt with more professionally at the training as it might impact subsequent behaviours with health professionals etc. The discussions on these points at the company training event did not amount to a disparagement of clinicians, or their views. No breaches of the Code were ruled.

An ex-employee of a third party which provided services to Bayer plc, complained about the conduct of a named employee, at an initial training course for Xarelto held in 2017.

Xarelto 10mg was indicated for the prevention of venous thromboembolism (VTE) in adults undergoing elective hip or knee replacement surgery. The 15mg and 20mg presentations were, *inter alia*, indicated for the treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) and for the prevention of recurrent DVT and PE.

COMPLAINT

The complainant's first concern was that the employee encouraged sales trainees to promote Xarelto for an off-licence indication.

The complainant explained that at the end of the course a quiz as revision for the final examination had been held. One of the questions concerned the licensed indication as per the summary of product characteristics (SPC). Attendees were asked to select from a choice of four, an indication not on the SPC as a licensed indication. The employee told the class that of the four choices, only 'active cancer' was not licensed. Unfortunately, one of the choices was 'prevention of DVT following hip fracture surgery'. It was brought to the employee's attention that Xarelto was also not licensed for this indication. This was refuted and attendees were informed that Xarelto was licensed for this indication. Although when shown the relevant part of the SPC (Section 4.4, special warnings and precautions for use)' which read: 'Hip fracture surgery Rivaroxaban had not been studied in interventional clinical trials in patients undergoing hip fracture surgery to evaluate efficacy and safety', the employee insisted that Xarelto had been actively promoted for that indication for the last 10 years. The following day, the question was still included in the final examination in the same format. The employee insisted that marks be awarded according to his/her opinion, which firmly emphasized to the trainees that Xarelto should be promoted for the use in fracture surgery.

The complainant alleged a breach of Clauses 3 and 2 of the Code and noted that the examination papers were collected and held by Bayer.

The complainant was further concerned that the employee had encouraged a disrespectful and unprofessional attitude towards clinicians. The complainant explained that during the course, several trainees raised concerns regarding customer enquiries which they found difficult to manage. As they tried to raise the subject (genuine and frequent customer concerns regarding the safety of the product due to its half-life vs other agents in the same class) the employee shouted 'irrelevant' over their voices and even picked up one student's notes and threw them across the class. The class was told that when a clinician asked that question, the employee told them that they were 'stupid'. The complainant was concerned that this behaviour would encourage impressionable trainees to also treat clinicians with similar disrespect.

When writing to Bayer, the Authority asked it to consider the requirements of Clauses 8.2, 9.1, 15.2 and 15.9 in addition to Clauses 3.2 and 2 as cited by the complainant.

Further information was received from the complainant who stated that he/she was not able to supply documentary evidence of some of the behaviours as these were made verbally and relied on witness statements which he/she was not in a position to gather. However, the complainant stated that one of his/her complaints was the repeated assertion that Xarelto (rivaroxaban) was licensed and should be promoted for prevention of VTE post hip fracture surgery. Despite a challenge to this view, including showing the relevant part of the SPC, (section 4.4), the employee insisted that this was correct and included this indication in the final written examination.

The complainant provided a copy of his/her written examination as proof (question 15), which was marked as correct, but which he/she alleged was in fact incorrect. The complainant also provided a copy of the Xarelto SPC.

The complainant further stated that the employee asserted both verbally and in the written examination, that trainees should promote Xarelto

for prevention of VTE after hip fracture surgery. The complainant believed that this constituted an endorsement to promote off licence.

RESPONSE

Bayer explained that the residential course was organised to train contract sales representatives on Xarelto.

Bayer stated that the complainant in this case also complained via its Compliance Hotline. Bayer stated that this contained exactly the same matters as those cited in the complaint and three additional matters, (details were provided).

Bayer stated that it took the complainant's allegations very seriously and had carried out a detailed investigation including conducting interviews through external lawyers, with the employee and participants.

The training materials used during the course

Certification status of training materials

Bayer stated that it had reviewed the training materials used during the course and it became clear that a PowerPoint presentation entitled 'VTE Training' used for internal training courses, and a quiz used to measure performance at the end of the course, together with the relevant answers attached (copies of all materials provided) were not appropriately certified as required by Bayer's standard operating procedure (SOP) 105 'Certification of Promotional Items, Non-Promotional Items and Activities'.

Bayer explained that the employee was appointed to his/her current role in training in 2016 following the retirement of an independent contractor who was previously an employee of Bayer.

The relevant SOP required that the project owner (the person responsible for the relevant material or activity) should create a job bag for each relevant item in order to ensure that this was assessed for Code compliance. All promotional material must be certified prior to first use and then recertified at least every two years or withdrawn. Material which had been certified was marked with a footer which confirmed its status. The position with respect to the PowerPoint slides and the VTE quiz and answers was as follows:

- The 'VTE Training' slides were certified in March 2013 for external training of health professionals. This slide deck was amended intermittently for internal training of the field force; these changes and the new purpose for which the slides were to be used were, seemingly, not certified. There was, however, substantial overlap between the slides certified in 2013 and the slides used on the course. The slides were certified by Bayer in April 2017, without amendment, following this complaint, confirming that there was no error or deficiency in the information presented by the employee.
- A quiz and answers ('the certified quiz') used for the purposes of course validation following training on VTE and Xarelto was certified in February 2016. The VTE quiz and answers used for the purposes of the course was a variation of the certified quiz (approximately 50% of the questions were the same) however it was not certified as required by the SOP and Clauses 14.1 and 15.9 of the Code. The VTE quiz and answers had now been certified (subject to revision to the answer to Q15, see below).

Bayer stated that it had investigated how non-certified materials came to be used on the course, contrary to the SOP and the Code and despite the extensive training provided to all relevant staff, including the employee (who had undergone some 26 training courses on Bayer SOPs and Code compliance matters over the past three years) and had confirmed that he/she was fully aware of the content of the SOP and the requirements of the Code.

The employee had been briefed by the independent contractor in relation to the role and, during a handover meeting in June 2016, passed on the materials used for various training exercises, including slide decks and quizzes that could be used for validation. The only product related materials passed on which had been subsequently used by the employee, related to internal training on Xarelto and VTE or stroke prevention and atrial fibrillation (SPAF). It was understood at the time of the handover that the material was certified, although it would require recertification in due course in accordance with Bayer's procedures and the Code. While the employee accepted that he/she should have been alerted to the fact that this was not necessarily the case as a result of the absence of 'certification footers' on the materials, this was overlooked as a result of naivety.

The independent contractor had provided Bayer with a set of the training material provided to the employee in relation to VTE and SPAF. In addition to the PowerPoint slides and the VTE quiz and answers and the certified quiz referenced above, Bayer had identified the following:

i) Internal training course slides entitled 'SPAF Training' (copy provided) prepared by the independent contractor and originally certified in February 2014 for both training of health professionals and of the field force. Bayer now understood that the independent contractor amended the SPAF slide deck intermittently and these changes were, seemingly, not certified. There was, however, substantial overlap between the slides certified in 2014 and the 'SPAF Training' slide deck as provided by the independent contractor which was currently undergoing certification by Bayer.
ii) Six SPAF internal training course final quizzes and answers; two of these had been certified in 2013, one had been certified in 2016 and four had not been certified. The format of these documents was the same. All of the SPAF quizzes and answers which had not previously been certified, had been certified in April 2017: For all of the quizzes and answers, which had undergone certification, minor updates were required, to reflect changes in the price of Xarelto

over time and in relation to the quizzes and answers, some of the questions listed in the quiz document were different from the equivalent questions and answers in the answer sheet or the questions were presented in a different order or other minor changes were needed. Most of the changes reflected the fact that some amendment of the document had been made that had not been fully incorporated. These matters had now been addressed. The quizzes and answers which were previously certified in 2013 were currently undergoing recertification; the quiz and answers certified in February 2016 did not require recertification until February 2018.

iii) Five further VTE internal training course final quizzes and answers which all represented variations on the certified quiz but contained additional questions. Two of these had been certified in 2013 and three had not been certified. The format of these documents was the same as that for the SPAF quizzes and answers. All of the quizzes and answers which had not previously been certified, had been certified in April 2017. For all of these quizzes and answers, minor updates were needed on certification to reflect changes in price of Xarelto over time; As with the SPAF quizzes and answers, for certain of the quizzes and answers, some of the questions listed in the quiz document were different from the equivalent questions and answers in the answer sheet or the questions were presented in a different order or other minor changes were needed. Most of the changes reflected the fact that some amendment of the document had been made that had not been fully incorporated. These matters had now been addressed. The quizzes and answers which were previously certified in 2013 were currently undergoing recertification.

Actions taken by Bayer to reinforce certification requirements for internal training materials and to address the situation following its investigation of the materials used

Bayer stated that it had taken the following actions in relation to the complaint and, in particular, the failures noted above to certify certain materials used for internal training courses:

- As well as interviews with participants on the course, Bayer's investigation confirmed that no member of its training team, other than the employee, had used non-certified materials for training.
- No amendment to the PowerPoint slides used had been required as a result of the certification in April 2017; this confirmed that the internal training provided in accordance with this material was correct.
- Out of an abundance of caution, Bayer would introduce online validation tests for the full field force, to confirm that they all had correct and up-to-date knowledge about Xarelto; those who did not obtain a satisfactory validation score would have further training.
- Details of actions taken regarding the employee were provided which included reinforcing knowledge and understanding of the requirements of the Code and Bayer's SOPs.
- A training log had been created to capture every training intervention (dates, materials used, trainer) and all training materials (owner, date of certification, date due for recertification) as a way to ensure that all training materials were appropriately certified in the future. A copy of the log was provided.

Members of the training team were reminded by email on 12 and 19 April 2017 of the need to ensure that they were up-to-date with all Bayer SOPs and they were asked to reread the SOP which dealt with the Code and training; each had to confirm that they had read the email. The head of sales and marketing training had also met with the Bayer training team to reinforce, in person, the email of 12 April 2017 and the requirement to comply with Bayer SOPs and the Code. Attendance at this meeting was recorded and all non-attendees had been followed up on an individual basis.

Conclusion

The failure to use only currently certified material during the course was not consistent with the SOP and the associated training provided by Bayer to the relevant staff. In addition, Bayer accepted that use of the PowerPoint slides and the VTE quiz and answers at the course did not comply with Clauses 15.9 or 14.1 of the Code.

Bayer submitted that its thorough investigation had confirmed the source and extent of these omissions and that it had acted quickly to address the errors by the three individuals concerned and to reinforce its SOPs and the requirements of the Code with all of the training team.

Response to the specific issues raised by the complainant

Bayer stated that its response to the matters raised by the complainant were based on its review of the limited documentation available (the training materials used for the course), the interviews including with some of course participants, selected because they were involved in the incidents mentioned in the complaint. Bayer had additionally tried, without success, to speak to staff at the venue. Bayer further stated that its ability to investigate these matters had been prejudiced by the delay of over about a month, between the conclusion of the course and the complaint to PMCPA.

1 Alleged promotion of an off-licence indication for Xarelto

Bayer stated that its investigation did not indicate that the employee advised trainees that Xarelto should be promoted for an off-label indication.

Revision session

The practice questions used during the revision session and referenced by the complainant were verbal and there were no documents to confirm the questions or the answers proposed to the course participants. However investigations indicated that the content of the session included the following:

- The quiz included a question on the licensed indications for Xarelto with four possible answers. One of the possible answers was 'active cancer'.
- The employee explained that some clinicians would use the product off-label and representatives needed to be aware of this. In addition there seemed to have been discussion regarding different licensed indications in other countries.
- There were several discussions between the employee and the complainant about the licensed indications for Xarelto. These appear to have taken place while course participants were considering the questions in teams; the employee and some trainees stated that the discussions did not involve the class whereas others stated that the wider group did participate. The precise nature of these discussions was unclear, however it seemed that they involved the complainant and the employee reviewing the Xarelto SPC.
- There was no support from course participants for the allegation that the employee advised the class during the revision session that Xarelto had been actively promoted for 'prevention of DVT following hip fracture surgery' for 10 years and this was denied by the employee.
- All course participants confirmed that the employee stated unequivocally that off-label promotion was not permitted.
- The employee was quite clear as to the correct licensed indications for Xarelto.

Final quiz

Question 15 of the quiz used during the validation session at the end of the course addressed the licensed indications for Xarelto:

> 'Which of these is NOT an indication for Xarelto? (1)
> (a) prevention of VTE following total hip replacement:
> (b) secondary prevention of VTE after a PE
> (c) Prevention of VTE following hip fracture surgery
> (d) Treatment of acute DVT in a patient with severe renal impairment.'

The employee did not remain in the classroom throughout the quiz, but came in intermittently to confirm that there were no issues. The quiz was then marked by course participants (each one marking the quiz completed by another trainee) using the answers displayed on the screen.

The answer for question 15, noted that (c) Prevention of VTE following hip fracture surgery was 'contraindicated', but highlighted answer (d) as being correct.

- There was no evidence from the interviews conducted by Bayer that there was any discussion before the quiz regarding use of Xarelto for 'prevention of DVT following hip fracture surgery'.
- The questions administered during the quiz were not the same as those used during the revision session. In particular question 15 did not refer to 'active cancer' (an option given during the practice questions).
- The answer given to question 15 was incorrect. The correct answer should have been (c) consistent with the wording 'contraindicated' marked on the answer sheet. Xarelto was not indicated for the prevention of VTE following hip fracture surgery, but was indicated (with caution) for the treatment of acute DVT in patients with severe renal impairment, as long as creatinine clearance was ≥ 15 ml/min. During the course of the investigation the employee agreed that the original answer was incorrect.
- Bayer had identified completed quiz papers from the majority of attendees but had been unable to locate the remaining 7 quiz papers; it was unclear why these were not retained with the others. 14 of the quiz papers available to Bayer answered (d) to question 15 (ie an incorrect answer, but marked correct in accordance with the answers displayed on the screen). The final quiz paper did not include an answer to question 15. These answers showed confusion among course participants as to the licensed indication for Xarelto. This might have been a consequence of the previous day's discussion regarding the fact that some clinicians used Xarelto off-label for prevention of VTE in patients undergoing hip fracture surgery.

Overall conclusion

While there was clearly some confusion among course participants regarding the licensed indications for Xarelto, as demonstrated by the incorrect answers given to question 15 on the VTE quiz (not assisted by the error in the answers provided for marking purposes), this was likely to have resulted from the discussion the previous day on circumstances in which off-label use might be initiated by clinicians; there was no evidence that the employee advised trainees to promote an off-label indication contrary to Clause 3 of the Code. All course participants who were interviewed were clear that, while off-label use might occur, promotion of an unlicensed indication was prohibited.

Following notification of the complaint, the VTE quiz and answers had been certified as described above. No revision to the VTE quiz and answers was required as a result of certification save for question 15.

Xarelto was not actively promoted in orthopaedic surgery, however following certification of the VTE quiz and answers and in light of the answers given to question 15 following the course, Bayer had contacted the entire field force to ensure that it knew that Xarelto was not authorised for the prevention of VTE following hip fracture surgery.

2 Encouragement of a disrespectful and unprofessional attitude towards clinicians.

Bayer stated that based on its investigation, it believed that the complainant had misrepresented the employee's remarks and that a disrespectful or unprofessional attitude towards clinicians was not encouraged.

- This large group of 22 trainees included a range of experience levels. Trainees asked many questions

during the course and some of those asked by more junior participants were not relevant to the issues. While Bayer would support an interactive approach, there was a substantial amount of material to be covered during the time available and, in order to complete this, some discipline was required.
- Therefore the employee did characterise some of the more unlikely questions as 'irrelevant' in order to bring the class back to the point of the session and the employee did flick the papers of one trainee who asked such a question on the floor. These comments and actions were all undertaken in good humour and in a joking manner and, so far as Bayer was aware, no course participant took offence.
- The source and context of the 'stupid' comment was unclear. The course participants were generally unable to remember such a statement or denied that any such statement has been made. One participant stated that the employee had advised trainees in the context of 'how much' food should be taken with Xarelto, that if a clinician kept on asking a question after they had answered it, they should not 'dwell on it'. The participant did not understand that the employee had stated that doctors were 'stupid' and did not consider that trainees were being advised to treat clinicians disrespectfully.

In summary, therefore, the interviews with course participants provided no evidence that the employee encouraged a disrespectful or unprofessional attitude towards clinicians. There was no disparagement of clinicians or of their views contrary to Clause 8.2 of the Code. There was, in any event, no evidence that the employee's attitude towards clinicians failed to maintain high standards as required by Clause 9.1.

Overall conclusion

Bayer stated that its investigation of this complaint had revealed that the PowerPoint slides and VTE quiz and answers used for the training and validation of representatives, had not been certified in accordance with the Code, even though a substantially similar version of the quiz had been certified. The fact that this occurred, contrary to the SOP and the training provided to the individual responsible, was deeply regrettable. Subsequent investigation by Bayer had revealed use of PowerPoint slides and quizzes and answers used for internal training on SPAF that had also not been certified/recertified. All such non-certified material originated from the same source. No substantive errors in any of this material had yet been identified save for question 15 in the VTE quiz and answers and Bayer would shortly complete its certification/recertification of the 'SPAF Training' slide deck and the previously certified quizzes and answers (and would inform the PMCPA of the results of this certification/recertification - see below).

A detailed review of all other training material used by the Bayer training team for all other products had revealed no other deficiencies.

Bayer stated that it had acted promptly to address this issue. Further training on Code and Bayer SOP compliance had been instituted for the employee whose activities would be subject to close supervision to ensure that the requirements of the Code and Bayer's procedures were being implemented. A training log had been introduced to support existing arrangements for Code and Bayer SOP compliance by the Bayer training team.

In other respects, Bayer did not consider that the complaint had any foundation.

- Bayer respectfully requested the Panel to take into account its detailed investigation of the certification issue, the extensive corrective measures which had been instituted, which demonstrated that the deficiencies identified as a result of this complaint were not typical and that the company's procedures routinely worked well.
- In relation to the incidents, allegations made by the complainant had not been established and Bayer acted entirely properly to manage a situation that was not caused by any inappropriate action by any Bayer employee.

Finally, Bayer had experienced some difficulty in conducting its investigation of this complaint in circumstances where there was a delay of some four weeks after the training course in question before the complaint was made and where there was no documentary record in relation to most of the allegations. The recollections of the trainees who attended the course had undoubtedly been affected by this delay and it seemed likely that this was also the position with the complainant.

FURTHER RESPONSE

Bayer stated that in its response it referred to the certification of certain material used for internal training on Xarelto VTE and SPAF. One of these items was a set of internal training course power point slides entitled 'SPAF Training'. Unfortunately, on review Bayer had discovered that 17 slides were omitted in error, during the photocopying process. These were now provided.

The 'SPAF Training' slide deck was now certified, the changes included:

- Citations had been added to some of the slides to support product claims and, where posters were previously used as references, but data had now been published in peer reviewed journals, the citation had been revised;
- Some minor inaccuracies on graphs and artwork had been corrected (eg a reference to use of CT scans when in fact an MRI had been conducted);
- The slides referred to Clinical Guidelines on management of Atrial Fibrillation issued by NICE, which have now been superseded; the references and content of the slides have therefore been updated to reflect the current Guidelines.

A copy of the certified SPAF Training slide deck was provided.

PANEL RULING

The Panel noted that the parties' accounts differed; it was difficult in such circumstances to determine precisely what had happened. A judgement had to be made on the available evidence whilst noting that the complainant bore the burden of proof and had to establish his/her case on the balance of probabilities.

The Panel noted the response from Bayer that a broader complaint had been made to Bayer's compliance hotline. The three additional matters referred to by Bayer were not the subject of the complaint to the PMCPA and were not considered. The Panel noted that the complainant's identity had not been disclosed or confirmed by the Authority to Bayer.

In relation to the complaint made to the PMCPA, the Panel was only able to consider matters within the scope of the Code. It considered the complaint as follows.

1 Alleged promotion for an unlicensed indication

The Panel considered that the revision quiz was part of the representatives' briefing material as referred to in Clause 15.9 of the Code. The revision quiz question asked participants to select an indication not on the Xarelto SPC from a selection of four. The complainant gave 'active cancer' as the answer given by the employee who denied stating that only active cancer was not licensed. The complainant noted one of the choices was 'Prevention of DVT following hip fracture surgery' for which Xarelto was not licensed. The complainant stated that he/she highlighted that Xarelto was not so licensed. Bayer stated that this was a verbal quiz and there were no documents to confirm. Nonetheless there was general agreement in the interview transcripts that at the very least this matter had been raised and discussed. The complainant stated that a similar question was included in the formal assessment which took place the following day.

The Panel noted that the complainant was incorrect in stating that the same question was included in the written formal assessment. However a similar answer 'Prevention of VTE following hip fracture surgery' was one of the four possible answers. In that regard the Panel noted the error pointed out by Bayer in that the answer sheet gave 'Treatment of acute DVT in a patient with severe renal impairment' as the answer to the question 'Which of these is not an indication for Xarelto?'. The correct answer should have been 'Prevention of VTE following hip fracture surgery'. In addition, the Panel noted that 'active cancer' was not one of the possible answers to the question about Xarelto's licensed indications.

The Panel did not agree that 'Prevention of VTE following hip fracture surgery was contraindicated as submitted by Bayer. The indications in the SPC for Xarelto 10mg were clear as prevention of VTE in elective hip or knee surgery. Section 4.4 special warnings and precautions for use stated that rivaroxaban had not been studied in interventional trials in patients undergoing hip fracture surgery to evaluate efficacy and safety.

It appeared from the interview transcripts that the representatives understood that products should not be promoted for unlicensed indications. It was essential that representatives were clear about the licensed indications of the products they promoted. Training in this regard should be unambiguous. It was questionable whether the licensed indications for Xarelto were made clear to the representatives. It appeared that the discussion about off-label use added to the confusion. The interview transcripts showed that not all were absolutely clear about whether Xarelto could be promoted for prevention of VTE following hip fracture surgery. In addition the interview transcript of the employee showed a degree of confusion about the treatment of acute DVT in patients with severe renal impairment which was mistakenly recorded as the correct answer in the quiz answer sheet. This was compounded by the marking scheme for the formal assessment which referred to the use of Xarelto in hip fracture surgery as contraindicated rather than unlicensed. The Panel was particularly concerned that of the completed quiz papers provided, not one representative gave prevention of VTE following hip fracture surgery as the correct answer. In the Panel's view, this indicated that the training on the point was unclear.

The Panel considered that despite its serious concerns outlined above the complainant had not provided any evidence to show that an unlicensed indication had been promoted to health professionals so the Panel ruled no breach of Clause 3.2 of the Code. The Panel considered that the representatives' assessment was not clear with regard to the licensed indications. Bayer acknowledged that there was some confusion regarding the licensed indications. The briefing materials supplied by Bayer used at the training were not clear about the licensed indications, for example data relating to VTE prevention in orthopaedic surgery was described as a licensed indication, and this was compounded by the representatives' assessment. The Panel therefore ruled a breach of Clause 15.9.

The Panel was concerned that training materials for VTE had not been certified prior to use. These had been certified in April 2017 without amendment. This was of concern to the Panel given its comments about the training material above. The quiz and answers were certified in 2016 but the variation of the certified quiz had not been certified. It appeared that the marking sheet which contained the error had been certified.

The Panel noted Bayer's submission that the failure to certify was contrary to the Code and its SOPs. The complainant had not alleged any breach of the Code in relation to certification, but the failure to certify was in the Panel's view relevant. The Panel was concerned about the quality of the certification.

The Panel noted its ruling of a breach of Clause 15.9 above. It decided that high standards had not been maintained and a breach of Clause 9.1 was ruled. The Panel noted that it was essential to be clear about a medicine's licensed indications. It was apparent that Bayer had failed in that regard as evidenced by the training and validation materials. The employee appeared to be unclear about certain aspects of the product's licence. It was of particular concern that given the marking sheet containing the error had been certified and the variation of the certified quiz had never been certified, representatives beyond those on the training course at issue had, on the balance of probabilities, been exposed to such material. The Panel noted that in consequence Bayer had contacted its entire field force to ensure that they were clear that Xarelto was not licensed for the prevention of VTE following hip fracture surgery. On balance, the Panel considered that the circumstances brought discredit upon, and reduced confidence in, the pharmaceutical industry. The Panel therefore ruled a breach of Clause 2 which was a sign of particular censure and reserved for such use.

2 Alleged encouragement of a disrespectful and unprofessional attitude towards clinicians.

The Panel noted that there was a difference of opinion with regard to whether the employee referred to the clinicians as stupid or the question as stupid. There was no evidence that the representatives had used such language with health professionals or in response to their questions. The Panel considered that the matter of how representatives were to answer questions from health professionals should have been dealt with more professionally at the training as it might impact representatives' subsequent behaviours with health professionals etc. The discussions on these points at the company training event did not amount to a disparagement of clinicians, or their views. No breach of Clause 8.2 was ruled. Given there were different opinions about what the employee said, the Panel considered that it was not possible to establish, on the balance of probabilities, whether a disrespectful attitude had been encouraged. No breach of Clause 9.1 was ruled. It did not consider that the employee was a representative as such and therefore Clause 15.2 did not apply and no breach was ruled.

Complaint received **10 March 2017**

Case completed **21 July 2017**

CASE AUTH/2947/3/17

ANONYMOUS v SANOFI

Representatives' call rates

An anonymous, contactable complainant complained about representatives' call rates set by Sanofi.

The complainant gave details of Sanofi's expected call rate, minimum frequency and number of working days and explained that representatives' target customer bases varied. However, the target call rate was still set the same. The call rate/frequency was unrealistic to achieve in some instances. With 30 targets as an example, delivery on the company requirement would mean calling over 20 times in the year.

The complainant stated that if an appointment with a health professional was obtained, as an example, for 4 months' time then the ask had been what was being done to obtain one sooner as that was much too far away. There was a push for activity. If the customer could not be seen in relation to the Code this target still applied due to management or overall call rates. It put pressure to achieve this with a weekly report of activity and putting pressure on existing or newly built customer relations. This would lead to customers refusing to see representatives. Failure to achieve the expected call rate per day might result in performance plans to hit the required standard that might lead to disciplinary action against individuals if activity and sales were not achieved.

The complainant added that although the current focus was to maximise on the lead product, whilst maintaining the heritage product, numerous representatives had not been given this training or given a refresher. The complainant found it difficult to understand how representatives could be bonused on a product with no training and nearing the end of Quarter 1.

The detailed response from Sanofi is given below.

The Panel noted that the anonymous complainant appeared to be an employee of Sanofi. There appeared to be a difference of opinion between the complainant and the company regarding the number of targets for representatives.

The Panel noted that according to a redacted email provided by the complainant, the number of actual contacts per day was described as being well below the national level but accepted due to the number of new people and representatives were to deliver the expected higher call rate. The Panel considered that it was beholden on companies to make sure that such contact rates were placed within the context of the requirements of the Code. In addition, it would be helpful if representatives were given guidance and training on how such increased contact rates could be achieved.

The Panel examined the materials provided by Sanofi. The representatives' 2016 training gave the sales force key performance indicators (KPIs) and stated 'Contacts per day: […] (contacts equalled 'calls and meetings in accordance with ABPI requirements'). It further stated that the average frequency assumed the average number of times a customer was seen in 2016. Each of the 2 pages which discussed KPIs bore the following statement in contrasting black font: 'Provision must be taken in accordance with Clause 15.4 … whereby no more than 3 unsolicited faces-to-faces calls can be made per annum. If the limit were reached with no offer of request to revisit or attendance at a group meeting this customer may no longer be visited in 2016'. This latter statement also appeared on two pages of the representatives' training for 2017.

The Panel noted the average frequency of contacts per annum for 2016 ranged between 10 and 5 by account type. The company did not define the difference between calls and contacts. Comparable information did not appear in the 2017 training material which referred to a coverage and frequency percentage.

The Panel considered that there was a range in the number of target customers and an expectation that the representatives would focus on these. Although Sanofi had not defined the difference between calls and contacts in the materials they were clear that there were limitations on unsolicited calls in the ABPI Code. In relation to call rates, the Panel did not consider that the complainant had shown, on the balance of probabilities, that representatives had over called on health professionals and ruled no breach of the Code. With regard to the briefing material, although the 2016 and 2017 training material might have been clearer, including a definition of certain terms, the Panel did not consider that either advocated a course of action that was likely to lead to a breach of the Code with regard to calls on health professionals. No breach was ruled.

The Panel noted the briefing email provided by the complainant. It referred to, *inter alia*, delivery of the KPI of expected target customers per day and a minimum frequency of contacts with hospital doctors and nurses. The Panel noted its comments above about the need to make the requirements of the Code clear. This was particularly important when discussing an increased daily contact rate. The email was silent about the relevant requirements of the Code and in the Panel's view could not rely on the representatives' training material in this regard. Breaches of the Code were ruled including that high standards had not been maintained.

With regard to the complainant's allegation that training had not been provided for the heritage product, the Panel noted that the relevant product had not been named by the complainant. Sanofi assumed the heritage product was Lantus and had provided details about the training provided on that product. The Panel considered that in the circumstances the complainant had not proved his/her complaint on the balance of probabilities. The Panel therefore ruled no breach of the Code.

An anonymous, contactable complainant complained about representatives' call rates set by Sanofi.

COMPLAINT

The complainant gave details of the Sanofi Diabetes expected call rate, the minimum frequency and number of working days.

The complainant explained that representatives' target customer bases varied; some had as few as 30 whilst others had 120. However, the target call rate was still set the same. The target ask did not warrant the number. The call rate/frequency was unrealistic to achieve in some instances. With 30 targets as an example, delivery on the company requirement would mean calling over 20 times in the year.

The complainant stated that if an appointment with a health professional was obtained, as an example, for 4 months' time then the ask had been what was being done to obtain one sooner as that was much too far away. When mentioned this was difficult to achieve the response had been 'It is what it is'. There was a push for activity. If the customer could not be seen in relation to Clause 15.4 this target still applied due to management or overall call rates. It put pressure to achieve this with a weekly report of activity sent out and putting pressure on existing or newly built customer relations. This would lead to customers refusing to see representatives. Failure to achieve the expected call rate might result in performance plans to hit the required standard that might lead to disciplinary action against individuals if activity and sales were not achieved.

The complainant added that although the current focus was to maximise on the lead product, whilst maintaining the heritage product, numerous representatives had not been given this training (nor others given a refresher that might have had something some years ago). Initially representatives were informed that there would be training and having chased it up and asked if there was training, the answer had been 'There is no training'. The complainant found it difficult to understand how representatives could be bonused on a product with no training and nearing the end of Quarter 1.

The complainant provided a redacted copy of an email, 'Business Reviews – Focus and Action 2017', which referred to the expected number of contacts per day and a minimum frequency with hospital doctors and hospital nurses in 2017.

When writing to Sanofi, the Authority asked it to consider the requirements of Clauses 9.1, 15.1, 15.4 and 15.9.

RESPONSE

Sanofi stated that it took its obligation under the Code very seriously and was concerned to have received such a complaint, which appeared to originate from a member of staff. An internal investigation had included interviews with some members of staff however, particular care in this case had been taken to protect the complainant and as such the individual who wrote the email provided by the complainant had not been interviewed. Sanofi did not consider that this had adversely effected its response and it believed it had the information required to respond in full.

Sanofi stated that, in its view, the case hinged on two aspects, the first how representatives' activity and performance were monitored and subsequently rewarded and secondly how that was communicated to the representatives.

Sanofi explained that the redacted email provided by the complainant had been sent by a diabetes sales manager to all the representatives in his/her area. It was also copied to one of the regional business managers, two NHS outcomes managers and a medical science liaison (MSL).

Sanofi explained that representative performance was monitored, measured and rewarded in a variety of ways. There was a sales force incentive scheme which provided bonuses to representatives based purely on sales data, such as sales vs target and/or market share. This incentive scheme did not include any call rate measures. Details of the diabetes incentive schemes for 2016 and 2017 were provided.

Representatives were also managed within a company-wide performance management cycle which fed into an end of year appraisal. The performance management used a series of measures of the 'what' and the 'how' to measure both achievements and behaviours. For the sales teams this performance management cycle produced a performance rating at the end of the year which was used to calibrate performance across all sales teams. There was no additional bonus attached to this rating for the sales teams but it did feed into annual salary reviews and was considered during other management processes such as development and talent planning and promotions etc. Performance was assessed using a balance between output measures (such as sales) and input measures (such as call rates, meetings held and customer-facing days).

For call rates specifically in 2016 and 2017 these measures accounted for 15% of the overall performance measures. In both years the expectation for call rates was the same for the expected number of contacts a day on target customers.

The sales teams were briefed at the beginning of each year with regard to both the sales incentive scheme and the performance management measures which would be used for that year. Sanofi provided copies of certified briefing materials which

were presented at the beginning of the year kick-off meetings for 2016 and 2017.

Sanofi stated that target customers were defined based on involvement with diabetes and whether the company's therapies were suitable for their patients, insulin initiator status, customer type (consultant, diabetes specialist nurse, GP, practice nurse). Details of the average number of targets in secondary care and primary care and the range were provided.

Sanofi stated that it did not set individualised contact rates based on the number of target customers in a sales area. However, it was clear that this contact rate must be viewed in conjunction with the criteria set out within Clause 15 of the Code and no individual would be penalised or performance managed on the basis of this one key performance indicator alone.

Sanofi explained that its diabetes sales teams had promoted Toujeo (insulin glargine in a pre-filled pen) and Lyxumia (lixisenatide) throughout 2016. For 2017 they would promote Toujeo and Lantus (insulin glargine in a vial). Sanofi assumed that the complainant's reference to 'heritage product' referred to Lantus. In that regard representatives who were with the organisation pre-2016 would have received detailed Lantus training as they were promoting the product at this time. New joiners in 2016 completed an eLearning module on Lantus (copy provided) as part of their initial diabetes training course; this was continued despite the product not being promoted. All new joiners from 2017 onwards would receive Lantus training when they joined the organisation; this would consist of the same eLearning module as above plus face-to-face training during their initial diabetes training course. A copy of the agenda for this training was provided. In addition, an optional Lantus refresher training session was provided for the sales force in February 2017 and an agenda for this was provided; a copy of the pre-reading for attendees at this training was provided. This training was provided by teleconference/webinar and attended by 40 members of the sales force. Sanofi concluded that, based on its investigation, it did not consider that its current process for incentivising and performance managing its sales team was inappropriate or likely to lead to action which would breach the Code. Whilst call rates were used as part of the performance management process they did not have any impact on the attainment or level of the representative's bonus payments. Sanofi denied any breach of Clauses 9.1, 15.1, 15.4 and 15.9.

PANEL RULING

The Panel noted that the complainant was anonymous. The Constitution and Procedure for the Prescription Medicines Code of Practice Authority stated that anonymous complaints would be accepted but that like all other complaints, the complainant had the burden of proving his/her complaint on the balance of probabilities. All complaints were judged on the evidence provided by the parties.

The Panel noted that the anonymous complainant appeared to be an employee of Sanofi. There appeared to be a difference of opinion between the complainant and the company regarding the number of targets for representatives. The complainant referred to the range as being between 30 to 120 whereas Sanofi stated that this was higher and wider in both secondary care and primary care.

The Panel noted that according to the redacted email provided by the complainant, the number of actual contacts per day was described as being well below the national level but accepted due to the number of new people and representatives were to deliver the higher expected call rate. The Panel considered that it was beholden on companies to make sure that such contact rates were placed within the context of the requirements of the Code. In addition, it would be helpful if representatives were given guidance and training on how such increased contact rates could be achieved.

The Panel examined the materials provided by Sanofi. The representatives' training (dated January 2016) gave the sales force key performance indicators (KPIs) and stated 'Contacts per day: […] (contacts equalled 'calls and meetings in accordance with ABPI requirements'). It further stated that the average frequency assumed the average number of times a customer was seen in 2016. Each of the 2 pages which discussed KPIs bore the following statement in contrasting black font: 'Provision must be taken in accordance with Clause 15.4 … whereby no more than 3 unsolicited faces-to-faces calls can be made per annum. If the limit were reached with no offer of request to revisit or attendance at a group meeting this customer may no longer be visited in 2016'. This latter statement also appeared on two pages of the representatives' training for 2017.

The Panel noted the average frequency of contacts per annum for 2016 ranged between 10 and 5 by account type. The company did not define the difference between calls and contacts. Comparable information did not appear in the 2017 training material which referred to a coverage and frequency percentage.

The Panel considered that there was a range in the number of target customers and an expectation that the representatives would focus on these. Although Sanofi had not defined the difference between calls and contacts in the materials they were clear that there were limitations on unsolicited calls in the ABPI Code. In relation to call rates, the Panel did not consider that the complainant had shown, on the balance of probabilities, that representatives had over called on health professionals. The Panel ruled no breach of Clause 15.4. With regard to the briefing material, although the 2016 and 2017 training material might have been clearer, including a definition of certain terms, the Panel did not consider that either advocated a course of action that was likely to lead to a breach of the Code with regard to calls on health professionals. No breach of Clause 15.9 was ruled.

The Panel noted the briefing email provided by the representative and dated 16 January 2017. It

referred to, *inter alia*, delivery of the KPI of the expected call rate on target customers per day and a minimum frequency of 8 contacts with hospital doctors and nurses. The Panel noted its comments above about the need to make the requirements of the Code clear. This was particularly important when discussing an increased daily contact rate. The email was silent about the relevant requirements of the Code and in the Panel's view could not rely on the representatives' training material in this regard. A breach of Clause 15.9 was ruled.

With regard to the complainant's allegation that training had not been provided for the heritage product, the Panel noted that the relevant product had not been named by the complainant. Sanofi assumed the heritage product was Lantus and had provided details about the training provided on that product. The Panel considered that in the circumstances the complainant had not proved his/her complaint on the balance of probabilities. The Panel therefore ruled no breach of Clause 15.1.

Noting its ruling of a breach of Clause 15.9 in relation to the email the Panel considered that Sanofi had failed to maintain high standards and therefore ruled a breach of Clause 9.1.

Complaint received **22 March 2017**

Case completed **14 July 2017**

CASE AUTH/2948/3/17

GENERAL PRACTITIONER v NOVO NORDISK

Promotion of Tresiba

A general practitioner complained about a Tresiba (insulin degludec) email sent by Novo Nordisk.

The start of the email included the claims 'Get HbA1c DOWN with CONTROL' and 'NEW LOWER PRICE'. It gave details of a price reduction followed by 'You might be surprised by Tresiba treatment cost (Type 2 Basal only)'. The email then referred to a recent 35% price reduction and that studies in basal insulin had demonstrated that patients required a 10% lower insulin dose on Tresiba vs insulin glargine U100 (p= 0.0004) referenced to Vora *et al* 2015. This was followed by an asterisk which was explained beneath a comparison table as 'Type 2 Diabetes (basal oral): Tresiba = 0.39u/kg vs insulin glargine U100 = 0.43u/kg'. The next claim was that patients required a 17% higher insulin dose on insulin glargine U300 vs insulin glargine U100 referenced to Bolli *et al* 2015. This was followed by another symbol which was also explained beneath the comparison table as 'Absolute daily basal dose at end of trial: insulin glargine U300 = 0.62u/kg vs insulin glargine U100 = 0.53u/kg'.

A table then compared an illustrative dose (U), monthly cost and annual cost of Tresiba U100, Tresiba U200, Toujeo, (insulin glargine pre-filled pen; Sanofi), Lantus (insulin glargine; Sanofi) and Abasaglar (insulin glargine; Eli Lilly). At the doses chosen, Toujeo was the most expensive at £34.96 per month, then Tresiba (both U100 and U200 cost £34.04 per month), Lantus (£33.68) and Abasaglar (£28.64).

Tresiba was indicated for the treatment of diabetes mellitus. It was a basal insulin for once-daily administration.

The complainant took exception to the email as he had never given Novo Nordisk permission to send promotional material.

The complainant was concerned that the cost comparison chart which compared Tresiba with Lantus, Abasaglar and Toujeo was not evidenced based as there were no published clinical trials that directly compared Tresiba with the other insulins shown in the chart particularly given the lack of clinical evidence to demonstrate dose for dose equivalence on HbA1c effect.

Also the title, 'You might be surprised by Tresiba treatment cost (Type 2 Basal only)' seemed to relate only to type 2 basal diabetics. However, the studies used to make comparisons included type 1 diabetics. In addition it was not clear what was meant by the claim 'Successful reductions' and what comparison it was trying to make.

The detailed response from Novo Nordisk is given below.

The Panel considered that on the information provided by Novo Nordisk, in the absence of an agreement from the complainant to be identified to Novo Nordisk, there was no evidence before the Panel to establish whether the complainant had given permission to receive promotional emails. The Panel thus ruled no breach of the Code.

The Panel noted that the cost comparison table in the email was followed by an explanation of the doses used. It appeared that the primary messages from the email, were that there was a 35% price reduction across all Tresiba presentations and that this reduced treatment cost compared favourably to other insulins in relation to treatment of type 2 diabetes. The prominent cost comparison table stated an illustrative dose and invited readers to directly compare the monthly and annual costs of Tresiba, Toujeo, Lantus and Abasaglar. In the Panel's view, the initial impression might be that there was direct comparative data, and that was not so. In the absence of such comparative data, the basis of the comparison should be made clear. In this regard, text three paragraphs beneath the table read 'Assumed illustrative dose for IGlar of 40U/ day. Comparable annual treatment costs calculated using dose ratios from the BEGIN meta-analysis, the EDITION 3 trial (for glargine U300), Toujeo SmPC and Abasaglar SmPC'. This was followed by further explanation of the costs etc and then the prominent claim 'Tresiba is now at a comparable treatment cost to glargine U100 (Lantus) and glargine U300 in type 2 diabetes patients treated with basal only therapy' referenced to Vora *et al*, Bolli *et al* and MIMS December 2016. Two highlighted boxes then followed, one referred to the 35% price reduction and the second to the Scottish Medicines Consortium (SMC) and the All Wales Medicines Strategy Group (AWMSG) approvals for use in type 1 and type 2 diabetics. Three bullet points concluded the email, the first read 'Successful reductions in HbA1c', referenced to Rodbard *et al* 2013 and Bode *et al* 2013.

Vora *et al* was a meta-analysis of Tresiba and glargine in type 1 and type 2 diabetes mellitus (basal-bolus treated type 1, insulin naïve type 2 and basal-bolus treated type 2). The conclusions included that insulin naïve type 2 patients treated with Tresiba needed lower total doses of insulin than those treated with glargine. The results showed that the total daily dose at the end of trial was 10% lower (p=0.0004) with Tresiba in type 2 diabetic insulin naïve patients (end of trial dose Tresiba 0.39U/kg and glargine 0.43U/kg). In basal-bolus type 2 diabetic patients the total daily insulin dose did not differ statistically between treatments (Tresiba 1.22U/kg and glargine 1.18U/kg).

Bolli *et al* compared the safety and efficacy of glargine 300U with glargine 100U in insulin naïve patients with type 2 diabetes.

The SPC for Toujeo stated that when switching from insulin glargine 100U to Toujeo this could be done on a unit-to-unit basis but a higher Toujeo dose (approximately 10-18%) might be needed to achieve target ranges for plasma glucose levels.

The Panel was concerned that the data in the cost comparison was from a number of trials. Tresiba was not compared with each medicine mentioned, for example the comparison with Toujeo was based on two comparisons between Toujeo and Lantus and the other between Tresiba and Lantus.

The Panel noted that the data used in the comparison table were from type 2 patients only on basal insulin and derived from two studies. In these circumstances, the Panel did not consider it was misleading to reference the comparisons in the table to Vora *et al* which also investigated type 1 patients. Thus the Panel ruled no breach of the Code on this narrow point.

The Panel noted its comments above about the comparison chart. The first two paragraphs beneath the comparison table related to, and qualified, the dose claims above the table rather than the data in the table. The third paragraph which was in less prominent font than the two paragraphs that immediately preceded it sought to explain the data in the comparison table. In the Panel's view, the assumptions used for the illustrative doses were not sufficiently complete or prominent. The Panel considered that the comparison table was misleading and ruled breaches of the Code.

The claim 'Successful reductions in HbA1C' appeared beneath two highlighted boxes, one of which referred to type 1 and type 2 diabetes. Above the highlighted boxes was the prominent comparative claim about treatment costs for Tresiba in type 2 diabetes compared to glargine. It was not clear whether the following three bullet points including 'Successful reductions in HbA1c' related to type 1 and type 2 diabetes. However, Tresiba was indicated for use in both conditions and both conditions were referred to in the box immediately above. The referenced studies Rodbard *et al* was in type 2 diabetes patients and Bode *et al* 2013 was in type 1 diabetes patients. The Panel did not accept Novo Nordisk's submission that the prominent comparative claim vs Lantus and glargine U300 summarized the information presented in the first section. Visually it sat immediately above the highlighted boxes and, in the Panel's view, its prominence, position, green font and design gave the context for the claims beneath. The claim 'Successful reductions in HbA1c' might be read as applying to all three products, others might read it as a benefit for Tresiba compared to Lantus and glargine U300. There was some relevant data in Rodbard *et al* and Bode *et al*. Nonetheless, and on balance, it was not sufficiently clear. Breaches of the Code were ruled.

In relation to the allegation that it was not clear what was meant by 'Successful reductions in HbA1c', the Panel noted Novo Nordisk's submission about treat-to-target trials and their primary endpoints. The Panel did not consider the claim misleading on this point as alleged. The Panel did not consider that it was misleading to reference the claim to studies on both type 1 and type 2 patients given the reference to such patients in the box immediately above. The Panel ruled no breaches of the Code including that the company had not failed to maintain high standards.

A general practitioner complained about a Tresiba (insulin degludec) email (ref UK/TB/1116/0498) sent by Novo Nordisk Ltd.

The start of the email included claims 'Get HbA1c DOWN with CONTROL' and 'NEW LOWER PRICE'. It referred to a price reduction from £72 to £46.60 (5 x 3mL 100U/mL Penfill/FlexTouch) and from £86.40 to £55.92 (3 x 3ml 200U/mL FlexTouch) on 1 July 2016. This was followed by 'You might be surprised by Tresiba treatment cost (Type 2 Basal only)'. The email then referred to the recent 35% price reduction and that studies in basal insulin had demonstrated that patients required a 10% lower insulin dose on Tresiba vs insulin glargine U100 (p= 0.0004) referenced to Vora *et al* 2015. This was followed by an asterisk which was explained beneath a comparison table as 'Type 2 Diabetes (basal oral): Tresiba = 0.39u/kg vs insulin glargine U100 = 0.43u/kg'. The next claim was that patients required a 17% higher insulin dose on insulin glargine U300 vs insulin glargine U100 referenced to Bolli *et al* 2015. This was followed by another symbol which was also explained beneath the comparison table as 'Absolute daily basal dose at end of trial: insulin glargine U300 = 0.62u/kg vs insulin glargine U100 = 0.53u/kg'.

A table then compared an illustrative dose (U), monthly cost and annual cost of Tresiba U100, Tresiba U200, Toujeo, Lantus and Abasaglar. At the doses chosen, Toujeo was the most expensive at £34.96 per month, then Tresiba (both U100 and U200 cost £34.04 per month), Lantus (£33.68) and Abasaglar (£28.64).

Tresiba was indicated for the treatment of diabetes mellitus and was available in 100 units/ml (U100) and 200 units/ml (U200). It was a basal insulin for once-daily administration preferably at the same time every day.

COMPLAINT

The complainant explained that the mailer had been sent to his practice's email account. He usually took little notice of pharmaceutical company promotional mailers sent in the post. However, in this case he had taken exception to the material at issue because it was sent by email although he had never given Novo Nordisk permission to send him such promotional material which was annoying. Also the complainant took issue with a number of misleading messages made in comparison to a number of established treatments that his practice commonly used to manage its insulin dependent diabetics.

The complainant stated that he had discussed the material with colleagues. There were shared significant concerns that the cost comparison chart which compared Tresiba with Lantus (insulin glargine; Sanofi), Abasaglar (insulin glargine; Eli Lilly) and Toujeo (insulin glargine pre-filled pen; Sanofi) was not evidenced based as there were no published clinical trials that directly compared Tresiba with the other insulins shown in the chart. The complainant did not understand how Novo Nordisk could make fair cost comparisons with these other insulins given the lack of clinical evidence to demonstrate dose for dose equivalence on HbA1c effect.

Also the title on the material, 'You might be surprised by Tresiba treatment cost (Type 2 Basal only)' seemed to relate only to type 2 basal diabetics. However, the studies used to make comparisons included studies that were in type 1 diabetics which was a very different patient population. The first reference, Vora *et al* (2014), contained studies in a large number of type 1 patients. The referenced publications used to support 'Successful reductions in HbA1c' (Rodbard *et al* 2013 and Bode *et al* 2013) were also for type 1 diabetics although the messages seemed to be related only to type 2 diabetics. In addition it was not clear what was meant by the claim 'Successful reductions' and what comparison it was trying to make. The complainant stated that in his practice, over 90% of diabetic patients had type 2 diabetes and therefore the material should be relevant to that patient type and not be misleading by including in type 1 patients; in the complainant's view this seemed very underhand and manipulative of Novo Nordisk.

When writing to Novo Nordisk the Authority asked it to consider the requirements of Clauses 7.2, 7.3, 7.4, 9.1 and 9.9 of the Code.

RESPONSE

Novo Nordisk explained that the email was sent on 22 December 2016 by a third party mailing house. The recipients were health professionals who had given their consent to receive such emails and who had an interest in diabetes to include diabetologists/endocrinologists, GPs with a specialist interest in diabetes, diabetes specialist nurses, GPs and practice nurses. The email was re-sent on 19 January 2017 to those who had not opened the first email.

The database of recipients used by the mailing house was described. Recipients of the email had provided their consent to receive promotional emails from pharmaceutical companies via a robust 4 stage process:

1 A representative of the database company telephoned the health professional to verify contact details and to confirm if he/she would like to be a member of the database. The nature of the service described included receiving emails from its associated/affiliated companies and their products and services, which might include pharmaceutical promotional materials.

2 The health professional was then sent a registration email with an access code to complete the registration form online. When completing their online registration form, a statement clearly informed the health professional that by completing the form he/she was agreeing to the terms and conditions which were clearly accessible as part of the online registration process. The email stated the following: '[the database company] will from time to time send information by email about our associated/affiliated companies, and their clients' product and services. This may include updates on specialist services, conferences and seminars, diagnostic, medical and pharmaceutical promotional materials as well as official information'.

3 The terms and conditions included the opt-in policy, which clearly stated that information provided might include pharmaceutical promotional materials and that users could opt out of receiving such materials without losing the remainder of the service. The health professional had to tick a box to confirm agreement with the terms and conditions before registration could be completed. Once the registration form was complete, the health professional was sent a confirmation email.

4 Health professionals were telephoned annually to confirm and update (if required) the information held. During this process, they were reminded that they had consented to receive emails from the database company or its associated/affiliated companies, which included promotional information from pharmaceutical companies.

With regard to the complainant's concerns about the cost comparison chart, Novo Nordisk submitted that treatment cost of insulin therapy was affected by not just the acquisition cost but also the daily required dose of insulin. The purpose of the cost comparison chart was to demonstrate this. The actual required dose of any insulin was of course individualised, however, the World Health Organisation (WHO) defined daily dose (DDD) of 40 units was regularly used as the reference point.

Bolli *et al* (2015) compared Toujeo with Lantus and showed that patients receiving Toujeo required on average a dose of 0.62U/kg, whilst those on Lantus required a dose of 0.53U/Kg, equating to a 17% higher insulin dose requirement for Toujeo over Lantus. If the WHO DDD of 40 units of Lantus was used as the reference point, a 17% higher insulin dose equated to 46.8U/kg of Toujeo. The same methodology could be applied for Tresiba based on the pre-specified type 2 basal only meta-analysis of the BEGIN trials (Vora *et al*), where it was shown that on average, patients required a 10% lower insulin dose of Tresiba vs Lantus. Again if 40 units of Lantus was used as the reference point, this equated to 36 units of Tresiba. Tresiba U100 and U200 had been shown to have bioequivalence as had Lantus and Abasaglar, therefore the same doses had been applied to these respective insulins.

The comparison of Tresiba vs glargine U100 was supported by Vora *et al* and the comparison of Toujeo

vs glargine U100 was supported by Bolli *et al* and the Toujeo summary of product characteristics (SPC).

With regard to the complainant's concerns about the use of data from type 1 diabetics, Novo Nordisk stated that Vora *et al* and Bolli *et al* were used to reference the cost comparison chart; none of the other references used within the mailer related to the chart. While the meta-analysis by Vora *et al* included both type 1 and type 2 patient data, only type 2 basal only insulin data had been used to substantiate the information in the chart. Bolli *et al* referred to the EDITION 3 trial which only related to the type 2 basal only insulin population.

The claim 'Tresiba is now at a comparable treatment cost to glargine U100 (Lantus) and glargine U300 in type 2 diabetes patients treated with basal insulin alone therapy' was positioned to summarise the information presented within the first section of the mailer which related to the cost of basal insulins in the type 2 basal only market. The next section of the mailer was separated into two boxes, both of which related to the use of Tresiba in patients with type 1 or type 2 diabetes and provided information on the general 35% price reduction (left-hand box) and the approval status of Tresiba with the All Wales Medicines Strategy Group (AWMSG) and the Scottish Medicines Consortium (SMC) (right-hand box). The final statements provided the key messages for Tresiba which understandably for an insulin product related to patients with either type 1 or type 2 diabetes. As such Novo Nordisk submitted that it was appropriate to reference the first key claim ('Successful reductions in HbA1c') to both Rodbard *et al* (type 2 diabetes patients) and Bode *et al* (type 1 diabetes patients).

Novo Nordisk submitted that the claim 'Successful reductions' did not make any comparison but simply underlined the successful improvement in glycaemic control demonstrated by confirmatory trials. This claim was supported by treat-to-target trials used as reference. The very notion of treat-to-target trials for insulin implied no difference in glycaemic control between the two comparators; hence the overall improvement in HbA1c was the primary endpoint of confirmatory trials.

Based on the above, Novo Nordisk submitted that the content of the mailer and its distribution met the requirements of Clauses 7.2, 7.3, 7.4, 9.1 and 9.9.

PANEL RULING

The Panel noted that the complainant stated that he/she wished to remain anonymous. The case preparation manager had not asked the complainant for permission to identify him/her to Novo Nordisk so that the company could investigate the allegation that the complainant had not given Novo Nordisk permission to send promotional material by email. The Panel noted the explanation from Novo Nordisk about the database used to send the material and that recipients had provided consent to receive promotional emails from pharmaceutical companies. The Panel noted that recipients were also contacted annually to validate the information held. The Panel noted the circumstances and considered that on the information provided by Novo Nordisk, in the absence of an agreement from the complainant to be identified to Novo Nordisk, there was no evidence before the Panel to establish whether the complainant had given permission to receive promotional emails. The Panel thus ruled no breach of Clause 9.9 of the Code.

The Panel noted that the cost comparison table in the email was followed by an explanation of the doses used. It appeared that the primary messages from the email, which appeared in green font or against a prominent green background, were that there was a 35% price reduction across all Tresiba presentations and that this reduced treatment cost compared favourably to other insulins in relation to treatment of type 2 diabetes. The prominent cost comparison table stated an illustrative dose and invited readers to directly compare the monthly and annual costs of Tresiba U100, U200, Toujeo, Lantus and Abasaglar. In the Panel's view, the initial impression given to some readers might be that there was direct comparative data, as stated by the complainant, and that was not so. In the absence of such comparative data, the basis of the comparison should be made clear and be an integral part of the table or sufficiently prominent such that it was with the table's visual field. In this regard, text three paragraphs beneath the table read 'Assumed illustrative dose for IGlar of 40U/day. Comparable annual treatment costs calculated using dose ratios from the BEGIN meta-analysis, the EDITION 3 trial (for glargine U300), Toujeo SmPC and Abasaglar SmPC'. This was followed by further explanation of the costs etc and then the prominent claim 'Tresiba is now at a comparable treatment cost to glargine U100 (Lantus) and glargine U300 in type 2 diabetes patients treated with basal only therapy' referenced to Vora *et al*, Bolli *et al* and MIMS December 2016. Two highlighted boxes then followed, one referred to the 35% price reduction and the second to the Scottish Medicines Consortium (SMC) and the All Wales Medicines Strategy Group (AWMSG) approvals for use in type 1 and type 2 diabetics. Three bullet points concluded the email, the first read 'Successful reductions in HbA1c', referenced to Rodbard *et al* 2013 and Bode *et al* 2013.

Vora *et al* was a meta-analysis of Tresiba and glargine in type 1 and type 2 diabetes mellitus (basal-bolus treated type 1, insulin naïve type 2 and basal-bolus treated type 2). The conclusions included that insulin naïve type 2 patients treated with Tresiba needed lower total doses of insulin than those treated with glargine. The results showed that the total daily dose at the end of trial was 10% lower (p=0.0004) with Tresiba in type 2 diabetic insulin naïve patients (end of trial dose Tresiba 0.39U/kg and glargine 0.43U/kg). In basal-bolus type 2 diabetic patients the total daily insulin dose did not differ statistically between treatments (Tresiba 1.22U/kg and glargine 1.18U/kg). The units per kg were adjusted for covariates (estimated using ANOVA with treatment, sex, antidiabetic therapy at screening, age and baseline dose as covariates).

Bolli *et al* compared the safety and efficacy of glargine 300U with glargine 100U in insulin naïve patients with type 2 diabetes. Participants were

receiving oral glucose-lowering medicines for at least 6 months prior to screening. Insulin dose was adjusted once weekly.

The SPC for Toujeo stated in Section 4.2 that when switching from insulin glargine 100U to Toujeo this could be done on a unit-to-unit basis but a higher Toujeo dose (approximately 10-18%) might be needed to achieve target ranges for plasma glucose levels.

The Panel was concerned that the data in the cost comparison was from a number of trials. Tresiba was not compared with each medicine mentioned, for example the comparison with Toujeo was based on two comparisons between Toujeo and Lantus and the other between Tresiba and Lantus. Bolli *et al* aimed at achieving pre-breakfast plasma glucose 4.4-5.6mmol/L (80-100mg/di). Vora *et al* also used treat to target of self-measured blood glucose <5mmol/L.

The Panel noted that the data used in the comparison table were from type 2 patients only on basal insulin and derived from Vora *et al* and Bolli *et al*. In these circumstances, the Panel did not consider it was misleading to reference the comparisons in the table to Vora *et al* which also investigated type 1 patients. Thus the Panel ruled no breach of Clause 7.2 on this narrow point.

The Panel noted its comments above about the comparison chart. The first two paragraphs beneath the comparison table related to, and qualified, the dose claims above the table rather than the data in the table. The third paragraph which was in less prominent font than the two paragraphs that immediately preceded it sought to explain the data in the comparison table. In the Panel's view, the assumptions used for the illustrative doses were not sufficiently complete or prominent. The Panel considered that the comparison table was misleading and the Panel ruled breaches of Clauses 7.2 and 7.3 of the Code.

The claim 'Successful reductions in HbA1C' appeared beneath two highlighted boxes, one of which referred to type 1 and type 2 diabetes. Above the highlighted boxes was the prominent comparative claim about treatment costs for Tresiba in type 2 diabetes compared to glargine U100 and U300. It was not clear whether the following three bullet points including 'Successful reductions in HbA1c' related to type 1 and type 2 diabetes. However, Tresiba was indicated for use in both conditions and both conditions were referred to in the box immediately above. The referenced studies Rodbard *et al* was in type 2 diabetes patients and Bode *et al* 2013 was in type 1 diabetes patients. The Panel did not accept Novo Nordisk's submission that the prominent comparative claim vs Lantus and glargine U300 summarized the information presented in the first section. Visually it sat immediately above the highlighted boxes and, in the Panel's view, its prominence, position, green font and design gave the context for the claims beneath. The claim 'Successful reductions in HbA1c' might be read as applying to all three products others might read it as a benefit for Tresiba compared to Lantus and glargine U300. There was some relevant data in Rodbard *et al* and Bode *et al*. Nonetheless, and on balance, it was not sufficiently clear. A breach of Clauses 7.2 and 7.3 was ruled.

In relation to the allegation that it was not clear what was meant by 'Successful reductions in HbA1c', the Panel noted Novo Nordisk's submission about treat-to-target trials and their primary endpoints. The Panel did not consider the claim misleading on this point as alleged. No breach of Clause 7.2 was ruled. The Panel did not consider that it was misleading to reference the claim to studies on both type 1 and type 2 patients given the reference to such patients in the box immediately above. The Panel ruled no breach of Clauses 7.2 and 7.3 of the Code.

The Panel noted its rulings above and, on balance, considered that the company had not failed to maintain high standards. No breach of Clause 9.1 was ruled.

Complaint received **22 March 2017**

Case completed **21 July 2017**

CASE AUTH/2949/3/17

HOSPITAL DOCTOR v A. MENARINI

Yellow Card Scheme details missing from company website

A hospital doctor complained after he had accessed the A. Menarini corporate website to find out more about, and report an adverse event to, one of the company's medicines. The complainant submitted that a number of links on the website did not work including one promising 'more information on medicines licensed in the UK'. There were no adverse event reporting forms or information to be found nor a link to the Yellow Card Scheme. The website stated:

- **Adverse events should be reported. Reporting forms and information can be found at. Adverse events should also be reported to A. MENARINI FARMACEUTICA INTERNAZIONALE S.R.L. Phone no. 0800 085 8678'**

The complainant could not see when this section of the website was last updated but considered that it was very low standards to have so many broken links, particularly when it came to adverse event reporting. The complainant queried whether the company took adverse event reporting seriously.

The detailed response from A. Menarini is given below.

The Panel noted A. Menarini's submission that the complaint concerned the webpage which could be reached by clicking on the 'Products' tab on the homepage of the corporate website.

The Panel noted that the webpage was examined and approved in 2011. The Panel disagreed with A. Menarini's submission that the homepage and the Products/Welcome webpage were corporate advertising and did not contain information that required certification. The Panel noted that the Code required that, *inter alia*, educational material for the public or patients issued by companies which related to diseases or medicines but was not intended as promotion for those medicines must be certified.

The Panel noted A. Menarini's submission that the Products/Welcome webpage did not contain promotional information and neither did it contain material about a medicine intended for patients taking that medicine.

The Panel considered that the complainant had not established that the website was promotional. No breach of that part of the Code which required an adverse event reporting statement, including reference to the Yellow Card Scheme, to be included on promotional material was ruled.

The Panel noted that access to the website was not limited to health professionals and other relevant decision makers, and it was therefore a source of information for the public including patients taking the company's medicines. The page in question was the introductory page to a section which provided information about the company's products. In the Panel's view given its likely readership included patients taking the company's medicines the section therefore should include the statement below or similar:

> **'Reporting of side effects**
> **If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in the package leaflet.**
> **You can also report side effects directly via the Yellow Card Scheme at www.mhra.gov.uk/yellowcard.**
> **By reporting side effects you can help provide more information on the safety of this medicine'.**

The Panel noted that A. Menarini had originally decided that details about the Yellow Card Scheme ought to appear on the page in question but when it noticed the missing Yellow Card hyperlink it decided not to close the webpage since the company telephone number was included. The Panel considered that this was insufficient. The reference to the Yellow Card Scheme was missing. A breach of the Code was ruled.

The Panel was very concerned that despite discovering that the hyperlink to the Yellow Card Scheme had disappeared, and promptly notifying its parent company responsible for website maintenance, no action was apparently taken until three months later when A. Menarini was notified of the present complaint. This showed a disregard for patient safety issues. The Panel was similarly concerned about the disappearance of a hyperlink to the electronic medicines compendium. In the Panel's view high standards had not been maintained and a breach of the Code was ruled.

A hospital doctor complained about the adverse event reporting function on the A. Menarini UK website, (menarini.co.uk); he had wanted to find out more about, and report, an adverse event about Adenuric (febuxostat), marketed by A. Menarini.

COMPLAINT

The complainant explained that one of his patients who was being treated for gout had experienced an adverse reaction. As the complainant did not see many gout patients, he searched the manufacturer's website to get more information about Adenuric and was disappointed with its general quality and was surprised at the number of links that did not work. For instance, the 'Stamp out gout' link led nowhere and the link promising 'more information about licensed medicines in the UK' did not work either.

The complainant then tried to report the adverse event which appeared not to be possible on this website as the links did not work. There were no

reporting forms or information to be found nor a link to the Yellow Card Scheme. The website stated:

- **Adverse events** should be reported. Reporting forms and information can be found at. Adverse events should also be reported to A. MENARINI FARMACEUTICA INTERNAZIONALE S.R.L. Phone no. **0800 085 8678**'

The complainant could not see when this section of the website was last updated but considered that it was very low standards to have so many broken links, particularly when it came to adverse event reporting. The company should surely have this section working properly and check often to make sure it worked. The complainant stated that he could not believe this website was properly maintained with so many broken links. It did not look like the company took adverse event reporting seriously.

When writing to A. Menarini, the Authority asked it to consider the requirements of Clauses 4.9, 9.1 and 26.3 of the Code.

RESPONSE

A. Menarini noted that the complaint concerned the Products/Welcome webpage (www.menarini.co.uk/Products/Welcome) which could be reached by clicking on the tab 'Products' on the homepage of the corporate website (menarini.co.uk).

The corporate website went live on 20 July 2011. The Code in force then was the 2011 Code. The homepage (copy provided) and the Products/Welcome webpage (copy provided) were considered corporate advertising and as such did not contain information that required certification (as otherwise would have been required by Clauses 14.1, 14.2 or 14.3 of the Code). Hence, these webpages were examined to ensure that they did not contravene the Code or the relevant statutory requirements in line with the supplementary information to Clause 14.3 'Examination of Other Material'. The webpages were approved on 20 July 2011.

A. Menarini noted that Clause 4.9 required that 'All promotional material must include the prominent statement "Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to [relevant pharmaceutical company]'. Since the Products/Welcome webpage did not contain promotional information, Clause 4.9 did not apply and so A. Menarini denied a breach of that clause.

Clause 26.3 required that:

> 'Any material which relates to a medicine and which is intended for patients taking that medicine must include the statement below or a similar one:
>
> > "Reporting of side effects
> > If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in the package leaflet. You can also report side effects directly via the Yellow Card Scheme at www.mhra.gov.uk/yellowcard. By reporting side effects you can help provide more information on the safety of this medicine"'.

Since the Products/Welcome webpage did not contain material about a medicine intended for patients taking that medicine, Clause 26.3 did not apply and so the company also denied a breach of that clause.

Clause 9.1 required high standards to be maintained at all times.

A. Menarini submitted that despite the fact that a statement on adverse event reporting was not required by the Code, it decided, before the website went live, to add such a statement to the Products/Welcome webpage. The statement read:

> 'Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to A. MENARINI FARMACEUTICA INTERNAZIONALE S.R.L. Phone no. 0800 085 8678.'

However, as reported by the complainant, the hyperlink to the Medicines and Healthcare products Regulatory Agency (MHRA) Yellow Card website was missing. The disappearance of that hyperlink was discovered by the local safety manager on 31 January 2017 and promptly communicated to A. Menarini's parent company, which provided technical support and maintenance of the site. The cause of this technical problem had not been identified and was under investigation. In the meantime, the company decided not to close the webpage since the statement included a company telephone number that could be called to report adverse events.

The 'Stamp out gout' website was under construction and the link did not lead to any further information or entity.

The sentence 'Information about licensed medicines in the UK may be found at (*)' previously read: 'Information about licensed medicines in the UK may be found at www.medicines.org.uk/emc (*)'. That the hyperlink to the electronic medicines compendium (eMC) was no longer there was also discovered on 31 January 2017 by the local safety manager, and was promptly communicated to the parent company. The technical causes for this were being investigated.

A. Menarini stated that it endeavoured to maintain the highest standards in all of its activities and communications, including its corporate website. Technical issues were difficult to avoid entirely, and it had undertaken to correct any issues following the internal discovery by the local safety manager.

A. Menarini stated that the website had been examined and would be corrected within one working week. That being said, and due to the time that had elapsed and the fact that at least one health professional had complained about the website, it

agreed that it should have acted more quickly and that a higher standard could have been achieved as required by Clause 9.1.

A. Menarini apologised for the confusion that might have been caused for the complainant and possibly for other website users. The company had implemented corrective actions and was committed to creating more robust systems to ensure that these technical problems did not resurface.

PANEL RULING

The Panel noted A. Menarini's submission that the complaint concerned the webpage which could be reached by clicking on the tab 'Products' on the homepage of the corporate www.menarini.co.uk website.

The Panel noted that the webpage was examined and approved, against the 2011 Code, on 20 July 2011 before going live the same day. The Panel disagreed with A. Menarini's submission that the homepage and the Products/Welcome webpage were considered corporate advertising and as such did not contain information that required certification. The Panel noted that Clause 14.3 required that, *inter alia*, educational material for the public or patients issued by companies which related to diseases or medicines but was not intended as promotion for those medicines must be certified in advance in a manner similar to that provided for by Clause 14.1.

The supplementary information to Clause 26.2 allowed for the provision of non-promotional information about prescription only medicines to the public by means of, *inter alia*, reference information made available by companies on their websites or otherwise as a resource for members of the public. Pharmaceutical companies were not obliged to provide reference information but it was considered good practice to provide, as a minimum, the regulatory information comprising the summary of product characteristics (SPC), the package leaflet (PIL) and the public assessment report (PAR) (UK or European) where such a document existed.

The Panel noted A. Menarini's submission that Clause 4.9 did not apply because the Products/ Welcome webpage did not contain promotional information and that Clause 26.3 did not apply either as the webpage did not contain material about a medicine and which was intended for patients taking that medicine.

The Panel noted that Clause 4.9 only required the adverse event reporting statement to be included on promotional material and considered that the complainant had not established that the website was promotional. No breach of Clause 4.9 was ruled.

The Panel noted that access to the website was not limited to health professionals and other relevant decision makers, and it was therefore a source of information for the public including patients taking the company's medicines. The page in question was the introductory page to a section which provided information about the company's products. In the Panel's view, given that its likely readership included patients taking the company's medicines the requirements of Clause 26.3 were triggered. The section therefore should include the statement below or similar:

> **'Reporting of side effects**
> If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in the package leaflet. You can also report side effects directly via the Yellow Card Scheme at www.mhra.gov.uk/yellowcard. By reporting side effects you can help provide more information on the safety of this medicine'.

The Panel noted that A. Menarini had originally decided that details about the Yellow Card Scheme ought to appear on the page in question. The Panel noted A. Menarini's submission that on noticing the missing Yellow Card hyperlink it decided not to close the webpage since the statement included a company telephone number that could be called to report adverse events. The Panel considered that this was insufficient. The reference to the Yellow Card Scheme was missing. A breach of Clause 26.3 was ruled.

The Panel was very concerned that despite discovering on 31 January 2017 that the hyperlink to the MHRA Yellow Card Scheme had disappeared, and promptly notifying its parent company responsible for website maintenance, no action was apparently taken until A. Menarini was notified of the present complaint on 27 March 2017. This showed a disregard for patient safety issues. The Panel was similarly concerned about the disappearance of the hyperlink to the electronic medicines compendium. In the Panel's view high standards had not been maintained and a breach of Clause 9.1 was ruled.

During its consideration of this case, the Panel was concerned to note A. Menarini's submission that the webpage in question had been examined in accordance with the supplementary information to Clause 14.3 of the 2011 Code. It appeared not to have been reviewed in accordance with the requirements of the Code since. The Panel noted that the complainant queried when the webpage was last updated. Clause 14.5 stated that material which was still in use must be recertified at intervals of no more than two years to ensure that it continued to conform with the relevant regulations relating to advertising and the Code. A. Menarini had not been asked to comment on Clause 14.3 or 14.5 and the Panel could therefore make no rulings in that regard. The Panel requested that A. Menarini be advised of its concerns.

Complaint received **24 March 2017**

Case completed **7 June 2017**

CASE AUTH/2953/4/17

TILLOTTS v DR FALK

Promotion of Salofalk Granules

Tillotts alleged that the headline claim in a journal advertisement, that Salofalk Granules (mesalazine, prolonged release) represented a 'step change' in the treatment of ulcerative colitis (UC), implied new features and superiority over other mesalazine products and other UC treatments when such was not so.

Tillotts noted that the advertisement also described how the sachets of granules might be taken once daily and that this might result in patients having a simpler routine. The granule format and once daily posology were not unusual in the mesalazine market and therefore this claim appeared to exaggerate the properties of Salofalk Granules. Further, the language used in the claim, '… even have a tasty vanilla flavour' was not in keeping with the high standards expected of a pharmaceutical company or the health professionals to whom the advertisement was directed.

With regard to the claim, 'if the inflammation is in the distal colon, the granules are pretty good at getting there too', Tillotts submitted that whilst this might be true, it implied an advantage for Salofalk Granules in this area compared with other mesalazine products, which was not supported by evidence. The supporting reference (Leifeld *et al*, 2011) was a pooled analysis of Salofalk Granules vs Salofalk tablets in induction therapy and provided no evidence that Salofalk Granules were superior to mesalazine tablets offered by other manufacturers, particularly those which released mesalazine further down the gastrointestinal tract. As above, this claim appeared to exaggerate the properties of Salofalk Granules. The language used in the claim, 'the granules are pretty good at getting there', was neither clear in its description of the product's properties, nor in keeping with the high standards expected of a pharmaceutical company or the health professionals to whom the advertisement was directed.

Finally, Tillotts noted that the claim 'Optimisation with Salofalk Granules for patients inadequately maintained on previous mesalazine resulted in: 69% fewer days off work, 87% fewer hospital visits due to [UC] flare up, 45% fewer GP visits due to [UC] flare ups, 50% fewer steroid courses used' was referenced to Aldulaimi *et al* (2016a). The reference did not explain what 'optimisation' meant, nor whether patients were previously treated with mesalazine tablets, granules, rectal preparations or brands of mesalazine from other manufacturers. Thus, this reference did not support the claims and also appeared to exaggerate the properties of Salofalk Granules.

Tillotts submitted that in summary, the advertisement appeared to contain a number of claims that were not supported by robust evidence and were therefore potentially inaccurate and exaggerated; might provide misleading comparisons; might not be capable of substantiation; might not encourage rational use of medicines containing mesalazine and potentially disparaged other manufacturers' mesalazine products. Tillotts also alleged that the advertisement demonstrated a failure to uphold high standards.

The detailed response from Dr Falk is given below.

The Panel noted the headline claim 'An oral ulcerative colitis treatment that's a step change, not a step up' followed in more prominent font by 'Now that's progress' and Tillotts' allegation that 'step change' implied new features and superiority over other mesalazine products and other UC treatments which could not be substantiated. Beneath a picture of a granules sachet text in a much smaller typeface stated 'When mesalazine doesn't seem to be working, stepping up to immunosuppressants might not be the only option'. Followed by 'For those patients who could benefit from a simpler routine, Salofalk Granules come in a convenient little sachet, only need to be taken once a day and even have a tasty vanilla flavour' and finally 'Oh, and if the inflammation is in the distal colon, the granules are pretty good at getting there too'.

The Panel noted Dr Falk's submission that it was 'justified to inform health professionals of the option of changing mesalazine rather than moving up to immunosuppressants or biologics' but considered that the claim in question went beyond this. The Panel considered that by describing Salofalk Granules as a step change, followed by the prominent claim 'Now that's progress', some readers might assume that Salofalk Granules represented a significant and progressive change in the treatment of UC compared with other available mesalazines and that was not so. In addition the Panel noted that the qualification 'When mesalazine doesn't seem to be working, stepping up to immunosuppressants might not be the only option' appeared in a separate paragraph and in much smaller white font beneath the depiction of a sachet and bold headline claims. In the Panel's view it would not be immediately obvious that this separate paragraph was meant to qualify the claims above. It also misleadingly implied that changing to Salofalk Granules was the only option to avoid stepping up to immunosuppressants which was not so. The Panel considered that the description of Salofalk Granules as a 'step change' was misleading; the claim exaggerated the effects of Salofalk Granules and could not be substantiated. Breaches of the Code were ruled.

The Panel noted Tillott's allegation that as granules and once daily dosing were not unusual in the mesalazine market the claim 'For those patients who could benefit from a simpler routine, Salofalk

Granules come in a convenient little sachet, only need to be taken once a day and even have a tasty vanilla flavour' exaggerated the properties of Salofalk Granules. The Panel noted Dr Falk's submission that the claim related solely to Salofalk Granules, it was not comparative and was a statement of fact. The Panel noted that 'simpler' was a comparative term and referred to dosing regimens other than once daily. However in the Panel's view the claim did not state or imply that Salofalk Granules were the only mesalazine that could be taken once daily as alleged; it presented Salofalk Granules as an option for those patients who would benefit from a simpler once daily routine. The Panel did not consider that the claim was exaggerated as alleged. No breach of the Code was ruled.

The Panel disagreed with Tillotts' concern that the language used in the claim, including the phrase 'even have a tasty vanilla flavour', was not in keeping with high standards. The advertisement adopted a conversational style which was not unacceptable *per se* so long as the content otherwise complied with the Code. The Panel noted that Tillotts had not explained why it considered high standards had not been maintained and it bore the burden of proof in this regard. No breach of the Code was ruled.

The Panel disagreed with Tillotts' view that the claim '… if the inflammation is in the distal colon, the granules are pretty good at getting there too' implied that Salofalk Granules had an advantage in this area compared with other mesalazine products. The Panel did not consider that the claim was an express or implied comparison. There was no implication that other mesalazine products did not deliver medicine to the distal colon or that Salofalk Granules otherwise had an advantage in this area as alleged. The Panel thus ruled no breach of the Code. The supporting reference, Leifeld *et al*, stated that the favourable effects of mesalazine granules in distal colitis were plausible since the extended release system allowed more 5-ASA to reach the distal parts of the colon. The Panel considered that the claim could be substantiated and ruled no breach of the Code. Further the Panel did not consider that the claim exaggerated the properties of Salofalk Granules as alleged and ruled no breach of the Code.

The Panel noted the allegation that the language used in the claim 'the granules are pretty good at getting there too' was neither clear in its description of the product's properties, nor in keeping with the high standards expected of a pharmaceutical company. The Panel considered that its comments above in relation to the conversational style of the advertisement were relevant here. The Panel also noted its comments above in relation to Leifeld *et al* and rulings of no breach of the Code in relation to the claim in question. The Panel had some concerns about the phrase 'pretty good' but on balance considered that Tillotts had not demonstrated that in using it Dr Falk had failed to maintain high standards. The Panel ruled no breach of the Code.
In relation to the claim 'Optimisation with Salofalk Granules for patients inadequately maintained on previous mesalazine resulted in: 69% fewer days off work, 87% fewer hospital visits due to [UC] flare up, 45% fewer GP visits due to [UC] flare ups, 50% fewer steroid courses used', Tillotts alleged that Aldulaimi *et al* (2016a), did not support the claim as it did not explain what optimisation with Salofalk Granules meant, nor whether the patients involved in the study were previously treated with mesalazine tablets, granules, rectal preparations or brands of mesalazine from other manufacturers. The Panel noted Dr Falk's submission that Tillotts had referred to an incorrect reference; the correct reference, which included additional data was Aldulaimi *et al* (2016b). The Panel noted that the correct reference was cited on the advertisement in question. The Panel noted that Aldulaimi *et al* (2016b) stated that patients were previously treated with various mesalazine therapies; dosing frequencies were provided. The Panel did not consider that the claim in question was incapable of substantiation on the narrow ground alleged. No breach of the Code was ruled.

In relation to the term 'optimisation' the Panel noted that contrary to Dr Falk's submission it was not defined in either study. The only reference to the term was in the introduction to Aldulaimi *et al* (b) which stated 'We have previously reported that optimising oral mesalazine maintenance therapy improved patient and disease outcomes in primary care.' The reference for the previous report was not cited. There was no further reference to the term. Dr Falk had provided a copy of a paper which appeared to be the case study referred to in Aldulaimi *et al* (b) and examined cost reduction and improvements in patient care by improvement of adherence to therapy and patient education. Neither 'optimisation' nor its derivatives were referred to although there was a general reference to dosing frequency in relation to improving adherence and outcomes. The Panel noted the definition of optimisation was 'the act of making the best of something; the state or condition of being optimal' (The New Shorter Oxford English Dictionary). The Panel noted that Aldulaimi *et al* (a and b) evaluated the effect of changing patients inadequately controlled on their current mesalazine therapy to once daily Salofalk Granules. Few details were given in either paper including details of dosages used. The Panel noted that a once daily dose was licensed for treatment of acute episodes of UC. The licensed dosing frequency for maintenance of remission was three times daily although in certain patients the dosing schedule for Salofalk Granules could be adapted to a single daily dose. The title of Aldulaimi *et al* (a and b) referred to maintenance therapy. The position regarding dosage was unclear. The Panel considered that some readers might assume that optimisation meant more than a straightforward switch to a once daily dose. Others might interpret it as a description of the outcomes achieved and described in the claim in relation to days off work etc. The Panel noted that optimisation was however referred to in Taylor and Irving (2011), a review which was not cited in the advertisement in relation to the claim in question: optimisation of conventional

therapy of patients with irritable bowel disease included patient-related factors (adherence and acceptability of treatment) and medicine-related factors (formulation, dose and drug related factors) which could be adjusted to enable successful treatment. The Panel noted that this matter was further complicated as the complainant did not have Aldulaimi *et al* (b) when it made the complaint. The complainant bore the burden of proof. Whilst the Panel had concerns about the claim and data these were not the subject of complaint. The Panel considered that Tillotts had not established that the failure of the study to define optimisation meant that the claim was not capable of substantiation and on the very narrow ground of that allegation it ruled no breach of the Code.

In relation to the allegation that the reference appeared to exaggerate the properties of Salofalk Granules, Tillotts mentioned its failure to detail patients' previous therapies and failure to define optimisation. The Panel noted its rulings above in this regard. The Panel noted it would not rule on the study *per se* but whether given the study the claim was exaggerated for the reasons cited. The Panel noted its comments above about the burden of proof. The Panel noted that at the outset of the study patients were assessed in relation to disease activity (Walmsley Index), use of steroids, days off work, GP and hospital visits. A subgroup of patients were switched to Salofalk Granules once daily maintenance therapy and all patients were reviewed 6 months later. Patient and disease outcomes were compared between those who switched to Salofalk Granules and those retained on their current mesalazine treatment. The Panel noted that Aldulaimi *et al* (a) as provided by Tillotts' stated that patients changing to Salofalk Granules had a higher baseline disease activity Walmsley Index (2.78 vs 1.99 p<0.01) vs those who remained on their mesalazine treatment. The Panel noted that disease activity Walmsley Index was 2.78 vs 1.97 in Aldulaimi *et al* (b) as provided by Dr Falk. Neither Tillotts nor Dr Falk commented on this or the effect if any this might have on the change from baseline of this index and other reported outcomes.

The Panel noted that Tillotts had the burden of proving its complaint on the balance of probabilities; the matter would be judged on the evidence provided by the parties. The Panel did not consider that Tillott's had proven that because the reference did not explain what optimisation with Salofalk granules meant or state the previous therapies that the claim 'Optimisation with Salofalk Granules for patients inadequately maintained on previous mesalazine resulted in: 69% fewer days off work, 87% fewer hospital visits due to [UC] flare up, 45% fewer GP visits due to [UC] flare ups, 50% fewer steroid courses used' exaggerated the properties of Salofalk granules as alleged. The correct reference provided by Dr Falk, Aldulaimi *et al* (b) included additional data. Based on the very narrow allegation, the Panel ruled no breach of the Code.

The Panel did not consider that Tillotts had established that Dr Falk had disparaged other manufacturers' mesalazine products as alleged. No breach of the Code was ruled.

Tillotts Pharma UK Limited complained about an advertisement (ref DrF 17/041) for Salofalk (mesalazine, prolonged release) Granules placed by Dr Falk Pharma UK Ltd and published in Frontline Gastroenterology. The headline claim was 'An oral ulcerative colitis treatment that's a step change, not a step up. Now that's progress'.

Salofalk was indicated for the treatment of acute episodes and the maintenance of remission of ulcerative colitis.

Tillotts marketed Octasa (mesalazine, modified release) tablets which was indicated for the treatment of mild to moderate acute exacerbations and the maintenance of remission of ulcerative colitis.

For the treatment of acute episodes of ulcerative colitis Salofalk Granules were licensed for once daily dosing although it was also possible to take the prescribed daily dose in three divided doses if this was more convenient to the patient. For the maintenance of remission of ulcerative colitis the standard treatment was three times daily. For patients known to be at increased risk of relapse for medical reasons or due to difficulties to adhere to the application of three daily doses the dosing schedule could be adapted to a single daily dose.

COMPLAINT

Tillotts alleged that the statement in the advertisement that Salofalk Granules represented a 'step change' in the treatment of ulcerative colitis implied new features and superiority over other mesalazine products and other treatments for ulcerative colitis. This was not so and was not supported by any evidence. No reference was cited to support the claim and despite a request for such evidence from Dr Falk, none was received. The Cochrane review of mesalazine products used in the treatment of ulcerative colitis (Wang *et al*, 2016) described a meta-analysis of all available clinical data and concluded that 'there do not appear to be any differences in efficacy or safety among the various 5-ASA [mesalazine] formulations'. Tillotts considered that this contradicted the key claim made in the advertisement.

Tillotts noted that the advertisement also described how the sachets of granules might be taken once daily and that this might result in patients having a simpler routine. The granule format and once daily posology were not unusual in the mesalazine market and therefore this claim appeared to exaggerate the properties of Salofalk Granules. Furthermore, the language used in the statement, for example, '… even have a tasty vanilla flavour' was not in keeping with the high standards expected of a pharmaceutical company or the health professionals to whom the advertisement was directed.

Tillotts noted that it was further stated in the advertisement that 'if the inflammation is in the distal colon, the granules are pretty good at getting there too'. Whilst this might be true, it implied that Salofalk Granules had an advantage in this area compared with other mesalazine products, which

was not supported by evidence. The reference cited to support this claim (Leifeld *et al*, 2011) referred to a pooled analysis study in which Salofalk Granules were compared with Salofalk tablets in induction therapy only. Therefore it did not provide evidence that Salofalk Granules were superior to mesalazine tablets offered by other manufacturers, particularly those which might release mesalazine later in the gastrointestinal tract. This point was important, as the majority of oral mesalazine products relied on a pH-dependent modified release mechanism for release of the active ingredient once the tablet or granules reached a certain point in the gastrointestinal tract (the colon was most relevant to those with ulcerative colitis). A higher trigger pH meant the tablet would travel further into the gastrointestinal tract before it released mesalazine, which might result in more mesalazine being available in the distal colon. For example, Asacol (marketed by Allergan) and Octasa tablets began to release at a higher pH than Salofalk tablets, so the results of Leifeld *et al* could not be considered to apply in a comparison between Salofalk Granules and other oral mesalazines. Furthermore, Leifeld *et al* did not provide any evidence of superiority of Salofalk Granules vs Salofalk tablets beyond 8 weeks' treatment and in this regard Tillotts noted that ulcerative colitis was a lifelong condition with mesalazine (or an alternative medicine) being taken for many years. As above, this claim appeared to exaggerate the properties of Salofalk Granules. The language used in the claim, 'the granules are pretty good at getting there', was neither clear in its description of the product's properties, nor in keeping with the high standards expected of a pharmaceutical company or the health professionals to whom the advertisement was directed.

Finally, Tillotts noted the following claim in the advertisement, 'Optimisation with Salofalk Granules for patients inadequately maintained on previous mesalazine resulted in: 69% fewer days off work, 87% fewer hospital visits due to [ulcerative colitis] flare up, 45% fewer GP visits due to [ulcerative colitis] flare ups, 50% fewer steroid courses used' referenced to Aldulaimi *et al* (2016a), a poster displayed at a scientific congress on which Dr Falk's medical director was an author. The reference did not explain what 'optimisation with Salofalk Granules' meant, nor whether the patients involved in the study were previously treated with mesalazine tablets, granules, rectal preparations or brands of mesalazine from other manufacturers. Therefore, this reference did not provide the necessary detail to support the claims and also appeared to exaggerate the properties of Salofalk Granules.

Tillotts submitted that in summary, the advertisement appeared to contain a number of claims that were not supported by robust evidence and were therefore potentially inaccurate and exaggerated; might provide misleading comparisons; might not be capable of substantiation; might not encourage rational use of medicines containing mesalazine and potentially disparaged other manufacturers' mesalazine products. Tillotts also contended that the advertisement demonstrated a failure to uphold high standards. Breaches of Clauses 7.2, 7.3, 7.4, 7.10, 8.1 and 9.1 amongst others were alleged.

RESPONSE

Dr Falk noted the allegation that the term 'step change' 'implied new features and superiority …' and Tillotts' reference to the Cochrane review, which stated that 'there does not appear to be any difference in efficacy or safety among the various [mesalazine] formulations'. Dr Falk submitted that the Cochrane review concluded this on the basis that there were no head-to-head trials between the different mesalazine products. Tillotts alleged that the advertisement contradicted this statement. Dr Falk stated that it agreed with the Cochrane review. The advertisement did not claim or imply differences in efficacy or safety.

Dr Falk recognised that mesalazine products were equally efficacious and safe but noted that the release mechanisms of the various products were different and so they were not considered interchangeable. Dr Falk explained that all mesalazine products were modified release, with the mesalazine being released at different locations within the gastrointestinal tract (pH dependant) due to the different coatings used. The British National Formulary stated that '… the delivery characteristics of oral mesalazine preparations may vary …' and this statement was used in an advertisement by Tillotts which demonstrated its awareness of this fact. In a review of available therapies, Taylor and Irving (2011) stated that 'In any event, swapping to a different formulation might be worth considering in people who are not responding to their current [mesalazine] therapy'. Therefore, whilst in general terms mesalazine products were equally efficacious and safe, patients responded differently depending on the location of disease and might find one product more beneficial than another. Dr Falk concluded that in the advertisement there was no contradiction of the Cochrane review, no statement or implication of superiority or new features and that it was justified to inform health professionals of the option of changing mesalazine rather than moving up to immunosuppressants or biologics.

Dr Falk denied any breach of Clauses 7.2, 7.3, 7.4, 7.10 and 8.1.

Dr Falk noted Tillotts' submission that the claim that Salofalk granules came in a sachet and could be taken once daily for a simpler routine 'appeared to be an exaggeration'. However, it was a statement of fact as the granules did come in a sachet and were taken once daily. There was no claim that Salofalk granules were different to, or better than, any other mesalazine. Dr Falk also noted the allegation that the claim that the granules had a tasty vanilla flavour did not meet high standards. Again, this was a statement of fact, it was not a superlative. Dr Falk considered the statement to be standard English, not in poor taste and that it did not fail to meet the high standards expected.

Dr Falk denied any breach of Clauses 7.2, 7.3, 7.4, 7.10, 8.1 and 9.1.

Dr Falk further noted the allegation that the claim that granules reached the distal colon implied that the granules had an advantage, but Tillotts also admitted that the statement was true, as shown by the reference to Leifeld *et al*. Dr Falk submitted that no comparison was made and there was no claim of superiority and that the language of the factual statement did not fall below the standards expected.

Dr Falk noted that Tillotts discussed the scope of Leifeld *et al* which showed that Salofalk Granules reached the distal region as the study used Salofalk Granules and Salofalk tablets and concluded, 'This pooled analysis supports the hypothesis that mesalazine granules are superior to mesalazine tablets in induction of remission in distal colitis and should be taken once daily' (emphasis added). Consequently, the advertisement correctly stated that Salofalk Granules reached the distal region. It was irrelevant what product Leifeld *et al* compared Salofalk Granules against as the fact remained that Salofalk Granules were shown to reach the distal area as claimed. Other scintigraphic studies confirmed this (Brunner *et al* 2003). The advertisement did not make comparisons with any other product, there was no claim of superiority nor could this be read into the claim. Tillotts then discussed duration of treatment. The advertisement did not mention or allude to duration of treatment; the complaint on this point was therefore not relevant. Dr Falk denied any breach of Clauses 7.2, 7.3, 7.4, 7.10, 8.1 and 9.1.

Dr Falk trusted that, in commenting that the medical director of Dr Falk Pharma UK Ltd was a co-author on Aldulaimi *et al* (2016a), Tillotts had not suggested that the integrity of any author had been compromised but it found it difficult to otherwise understand the point to that comment as the Code did not prevent declared, transparent, authorship. With regard to what 'Optimisation with Salofalk Granules' meant, Dr Falk noted that optimisation was not a new concept and was explained within the referenced paper.

Finally, Dr Falk noted that Tillotts had commented that there was no mention of the products involved in Aldulaimi *et al* (2016a) but in that regard Tillotts had referred to an incorrect reference. The correct reference, which included the data alleged to be missing was Aldulaimi *et al* (2016b). Dr Falk submitted that it was not relevant what mesalazine treatment patients in the study received; standard, validated, assessment methods were used to identify any patients that were inadequately maintained and those patients were offered an alternative treatment. It was not necessary to identify products on which patients were not adequately maintained and no such comparisons were made. Dr Falk did not accept the logic of Tillotts' comment that meant the properties of Salofalk Granules had been exaggerated. The claims in the advertisement were as described by Aldulaimi *et al* (2016b) and represented the outcome from the study, which was an extension to a previous study which was the only quality, innovation, productivity and prevention (QIPP) approved project in lower gastrointestinal disease (Palin 2014). The properties of Salofalk granules had not been exaggerated. The reference provided the necessary detail to support the claims.

Dr Falk denied any breach of Clauses 7.2, 7.3, 7.4, 7.10 and 8.1.

In conclusion, Dr Falk stated that no proof of the complaint had been given and in that regard Tillotts had only alleged that the advertisement might breach Clauses 7.2, 7.3, 7.4, 7.10, 8.1 and 9.1 amongst others. Dr Falk considered that this was not sufficient to prove the complaints and that it had not breached the Code.

PANEL RULING

The Panel noted the headline claim 'An oral ulcerative colitis treatment that's a step change, not a step up' followed in more prominent font by 'Now that's progress' and Tillotts' allegation that 'step change' implied new features and superiority over other mesalazine products and other ulcerative colitis treatments which could not be substantiated. Beneath a picture of a granule sachet followed three paragraphs in a much smaller typeface. The first paragraph stated 'When mesalazine doesn't seem to be working, stepping up to immunosuppressants might not be the only option'. Followed by 'For those patients who could benefit from a simpler routine, Salofalk Granules come in a convenient little sachet, only need to be taken once a day and even have a tasty vanilla flavour' and finally 'Oh, and if the inflammation is in the distal colon, the granules are pretty good at getting there too'.

The Panel noted Dr Falk's submission that the advertisement did not claim or imply differences in efficacy or safety and that whilst in general terms mesalazine products were equally efficacious and safe, patients responded differently depending on the location of the disease and might find one product more beneficial than another. A review of available therapies, Taylor and Irving, noted that there did not appear to be any difference in efficacy between the various formulations of oral 5-ASA and stated that 'In any event, swapping to a different formulation might be worth considering in people who are not responding to their current [5-aminosalicylate] therapy'. The authors further noted that if once daily dosing offered any clinical advantage it probably related to improved adherence. The Cochrane review, Wang *et al*, a meta-analysis noted that there were no differences in efficacy between once daily and conventional dosing for the induction of remission. The authors noted that adherence did not appear to be enhanced by once daily dosing in the clinical trial setting. It was unknown whether adherence was enhanced by once daily dosing in a community based setting. The Panel noted Tillotts' comment that once daily dosing was not unusual in the mesalazine market.

The Panel noted that Taylor and Irving stated that tolerance was rarely a problem with mesalazines, except for sulfasalazine in patients who could not tolerate it and changing to a different mesalazine normally enabled successful treatment. It went on to state that remarkably little evidence supported swapping between 5-aminosalicylates to improve efficacy. The trials reviewed suggested that 5-aminosalicylate dose escalation might be worthwhile in some patients with ulcerative

colitis. Unfortunately, 5-aminosalicylate therapy was often dismissed before maximal doses were reached. A further trial suggested that increasing the duration of therapy might avoid the need to switch to corticosteroids or immunosuppressive drugs. Conversely, a subgroup analysis of data from the ASCEND trials suggested that extending the duration of treatment was worth considering in patients with mild ulcerative colitis, whereas treatment escalation should not be delayed in those with active, severe disease.

The Panel noted Dr Falk's submission that it was 'justified to inform health professionals of the option of changing mesalazine rather than moving up to immunosuppressants or biologics' but considered that the claim in question went beyond this. The Panel noted that 'step change' was defined as a significant change in policy especially one that results in an improvement or increase (on-line English Oxford dictionary). The Panel considered that by describing Salofalk Granules as a 'step change' followed by the prominent claim 'Now that's progress' some readers might assume, not unreasonably, that Salofalk Granules represented a significant and progressive change in the treatment of ulcerative colitis compared to other available mesalazine medicines and that was not so. In addition the Panel noted that the qualification 'When mesalazine doesn't seem to be working, stepping up to immunosuppressants might not be the only option' appeared in a separate paragraph and in much smaller white font beneath the depiction of a sachet and bold headline claims. In the Panel's view it would not be immediately obvious that this separate paragraph beneath was meant to qualify the claims above. It also misleadingly implied that changing to Salofalk Granules was the only option to avoid stepping up to immunosuppressants which was not so. The Panel considered that the description of Salofalk Granules as a 'step change' within the claim 'An ulcerative colitis treatment that's a step change, not a step up. Now that's progress' was misleading and ruled a breach of Clauses 7.2 and 7.3. The Panel considered that the claim in question exaggerated the effects of Salofalk Granules and could not be substantiated. A breach of Clauses 7.4 and 7.10 was ruled.

The Panel noted Tillott's allegation that as the granule format and once daily posology were not unusual in the mesalazine market the claim 'For those patients who could benefit from a simpler routine, Salofalk Granules come in a convenient little sachet, only need to be taken once a day and even have a tasty vanilla flavour' exaggerated the properties of Salofalk Granules. The Panel noted Dr Falk's submission that the claim related solely to Salofalk Granules, it was not comparative and was a statement of fact. The Panel noted that 'simpler' was a comparative term and referred to dosing regimens other than once daily. However in the Panel's view the claim in question did not state or imply that Salofalk Granules were the only mesalazine product that could be taken once daily as alleged. It merely presented Salofalk Granules as an option to consider for those patients who would benefit from a simpler once daily routine. The Panel did not consider that the claim was exaggerated as alleged. No breach of Clause 7.10 was ruled.

The Panel disagreed with Tillotts' concern that the language used in the statement, including the phrase 'even have a tasty vanilla flavour', was not in keeping with the high standards expected of a pharmaceutical company or the health professionals to whom the advertisement was directed. The Panel noted that the advertisement adopted a conversational style, indeed the headline claims were in quotation marks. This was not unacceptable *per se* so long as the content otherwise complied with the Code. The Panel noted that Tillotts had not explained why it considered high standards had not been maintained. Tillotts bore the burden of proof in this regard and had provided no evidence to demonstrate that in using such language Dr Falk had failed to maintain high standards. No breach of Clause 9.1 was ruled in that regard.

The Panel disagreed with Tillotts' view that the claim '... if the inflammation is in the distal colon, the granules are pretty good at getting there too' implied that Salofalk Granules had an advantage in this area compared with other mesalazine products. The Panel noted that the reference cited to support this claim (Leifeld *et al*, 2011) was a pooled analysis in which Salofalk Granules were compared with Salofalk tablets in induction therapy. Whilst the study concluded that its analysis supported the hypothesis that mesalazine granules were superior to mesalazine tablets in the induction of remission in distal colitis, the Panel did not consider that the claim at issue was an express or implied comparison. There was no implication that other mesalazine products did not deliver medicine to the distal colon or that Salofalk Granules otherwise had an advantage in this area as alleged. The Panel therefore ruled no breach of Clause 7.3. Leifeld *et al* stated that the favourable effects of mesalazine granules in distal colitis were plausible and consistent with the galenical properties of this formulation, since the extended release system allowed more 5-ASA to reach the distal parts of the colon. The Panel considered that the claim could be substantiated and ruled no breach of Clause 7.4. Further the Panel did not consider that the claim exaggerated the properties of Salofalk Granules on this point as alleged and ruled no breach of Clause 7.10.

The Panel noted the allegation that the language used in the claim 'the granules are pretty good at getting there too' was neither clear in its description of the product's properties, nor in keeping with the high standards expected of a pharmaceutical company. The Panel considered that its comments above in relation to the phrase 'tasty vanilla flavour' and its conversational style were relevant here. The Panel also noted its comments above in relation to Leifeld *et al* and rulings of no breach of Clauses 7.3, 7.4 and 7.10 in relation to the claim in question. The Panel had some concerns about the phrase 'pretty

good' but on balance considered that Tillotts had not provided evidence to demonstrate that in using such language Dr Falk had failed to maintain high standards. The Panel therefore ruled no breach of Clause 9.1.

In relation to the claim 'Optimisation with Salofalk Granules for patients inadequately maintained on previous mesalazine resulted in: 69% fewer days off work, 87% fewer hospital visits due to [ulcerative colitis] flare up, 45% fewer GP visits due to [ulcerative colitis] flare ups, 50% fewer steroid courses used', Tillotts alleged that what it considered to be the reference, Aldulaimi *et al* (2016a), did not support the claim as it did not explain what optimisation with Salofalk Granules meant, nor whether the patients involved in the study were previously treated with mesalazine tablets, granules, rectal preparations or brands of mesalazine from other manufacturers. The Panel noted Dr Falk's submission that Tillotts had referred to an incorrect reference Aldulaimi *et al* (2016a); the correct reference, which did include some additional data was Aldulaimi *et al* (2016b). The Panel noted that the correct reference (DRF16/057) was cited on the advertisement in question. The Panel noted the narrow nature of the allegation. The Panel noted that Aldulaimi *et al* (2016b) stated that patients were previously treated with mesalazine therapies: Asacol, Pentasa, Mezavant, Octasa and Salofalk. Dosing frequencies were provided. The Panel did not consider that the claim in question was incapable of substantiation on the narrow ground alleged. Details of previous therapies were provided. No breach of Clause 7.4 was ruled.

In relation to the term 'optimisation' the Panel noted that contrary to Dr Falk's submission it was not defined in either study. The only reference to the term was in the introduction to Aldulaimi *et al* (b) which stated 'We have previously reported that optimising oral mesalazine maintenance therapy improved patient and disease outcomes in primary care.' The reference for the previous report was not cited. There was no further reference to the term. Dr Falk had provided a copy of Quality and Productivity:Proven Case Study – A pharmacist-led ulcerative colitis review service: Improving medicines adherence in general practice (Palin). This appeared to be the case study referred to in Aldulaimi *et al* (b) and examined cost reduction and improvements in patient care by improvement of adherence to therapy and patient education. The word 'optimisation' and its derivatives were not referred to although there was a general reference to dosing frequency in relation to improving adherence and outcomes. The Panel noted the definition of optimisation was 'the act of making the best of something; the state or condition of being optimal' (The New Shorter Oxford English Dictionary). The Panel noted that the aim of Aldulaimi *et al* (a and b) was to evaluate the effect of changing to once daily Salofalk Granules in patients inadequately controlled on their current mesalazine therapy. Few details were given in either Aldulaimi *et al* (a and b) including details of dosages used. The Panel noted that a once daily dose was licensed for treatment of acute episodes of ulcerative colitis. The licensed dosing frequency for maintenance of remission was three times daily although in certain patients the dosing schedule for Salofalk Granules could be adapted to a single daily dose. The title of Aldulaimi *et al* (a and b) referred to maintenance therapy. The position regarding dosage was unclear. The Panel considered that some readers might assume that optimisation meant more than a straightforward switch to a once daily dose. Others might interpret it as a description of the outcomes achieved and described in the claim in relation to days off work etc. The Panel noted that optimisation was however referred to in the Taylor and Irving review which was not cited in the advertisement in relation to the claim in question: optimisation of conventional therapy of patients with irritable bowel disease included patient-related factors (adherence and acceptability of treatment) and medicine-related factors (formulation, dose and drug related factors) which could be adjusted to enable successful treatment. The Panel noted the very narrow nature of the allegation: that the reference did not explain what optimisation meant and therefore did not support the claims made. The Panel noted that this matter was further complicated as the complainant did not have Aldulaimi *et al* (b) when it made the complaint. Tillotts bore the burden of proof. Whilst the Panel had concerns about the claim and data these were not the subject of complaint. The Panel considered that Tillotts had not established that the failure of the study to define optimisation meant that the claim was not capable of substantiation and on the narrow ground alleged ruled no breach of Clause 7.4.

In relation to the allegation that the reference appeared to exaggerate the properties of Salofalk Granules, Tillotts mentioned its failure to detail patients' previous therapies and failure to define optimisation. The Panel noted its rulings above in this regard. The Panel noted it would not rule on the study *per se* but whether given the study the claim was exaggerated for the reasons cited. The Panel noted its comments above about the burden of proof. The Panel noted that at the outset of the study patients were assessed in relation to disease activity (Walmsley Index), use of steroids, days off work, GP and hospital visits. A subgroup of patients were switched to Salofalk Granules once daily maintenance therapy and all patients were reviewed 6 months later. Patient and disease outcomes were compared between those who switched to Salofalk Granules and those retained on their current mesalazine treatment. The Panel noted that Aldulaimi *et al* (2016a) as provided by Tillotts' stated that patients changing to Salofalk Granules had a higher baseline disease activity Walmsley Index (2.78 vs 1.99 $p<0.01$) vs those who remained on their mesalazine treatment. The Panel noted that disease activity Walmsley Index was 2.78 vs 1.97 in Aldulaimi *et al* (2016b) as provided by Dr Falk. Neither Tillotts nor Dr Falk commented on this or the effect if any this might have on the change from baseline of this index and other reported outcomes.

The Panel noted that Tillotts had the burden of proving its complaint on the balance of probabilities; the matter would be judged on the evidence provided by the parties. The Panel did not consider

that Tillott's had proven that because the reference did not explain what optimisation with Salofalk granules meant or state the previous therapies that the claim 'Optimisation with Salofalk Granules for patients inadequately maintained on previous mesalazine resulted in: 69% fewer days off work, 87% fewer hospital visits due to [ulcerative colitis] flare up, 45% fewer GP visits due to [ulcerative colitis] flare ups, 50% fewer steroid courses used' exaggerated the properties of Salofalk granules as alleged. The correct reference provided by Dr Falk, Aldulaimi *et al* (2016b) did include some additional data. Based on the very narrow allegation, the Panel ruled no breach of Clause 7.10.

The Panel did not consider that Tillotts had established that Dr Falk had disparaged other manufacturers' mesalazine products as alleged. The Panel thus ruled no breach of Clause 8.1.

Complaint received **18 April 2017**

Case completed **17 August 2017**

CASE AUTH/2954/4/17

HEALTH PROFESSIONAL v ASTRAZENECA

Conduct of a representative

A health professional from a clinical commissioning group (CCG) complained about the conduct of a named representative (representative A) from AstraZeneca. AstraZeneca had sponsored a practice nurse forum meeting at which the complainant alleged that representative A had falsely stated that AstraZeneca had a special arrangement with the CCG and the CCG was in favour of Symbicort (formoterol plus budesonide).

The complainant noted that the CCG was part of the area prescribing committee and subscribed to, and promoted, the area's management guidelines for asthma and COPD (chronic obstructive pulmonary disease); neither Symbicort nor Turbohaler appeared in those guidelines. AstraZeneca knew this because at a meeting in 2016 to discuss the promotion of Symbicort locally various approaches were agreed including that:

- **for patients stabilised on Symbicort Turbohaler the CCG did not proactively encourage a review and a switch**
- **all new patients/prescriptions for inhaled budesonide and formoterol combination would be started on DuoResp Spiromax, in accordance with local guidelines;**
- **all inhalers should be prescribed by brand name, in accordance with best practice to avoid confusion at dispensing; and**
- **AstraZeneca representatives were not to promote Symbicort locally as it was not covered by the current guidelines.**

The detailed response from AstraZeneca is given below. AstraZeneca explained that representative A had attended the practice nurse forum in question. Representative B had been at the 2016 meeting during which the promotion of Symbicort locally was discussed along with his/her regional business manager (RBM).

The Panel noted AstraZeneca's submission that representative A promoted Symbicort for asthma and COPD at the practice nurse forum and although he/she did not discuss the CCG guidelines specifically, as the delegates had generally discussed costs he/she read out the following in-call statement in relation to the CCG's position on Symbicort:

'[The] CCG recommends a formoterol/budesonide combination as one of the options on the asthma/COPD formulary. The specific product choice is down to the prescribers' discretion, and should be decided upon after discussion and agreement with the patient/carer. The CCG does however recommend that all prescribing of inhaled corticosteroids/long-acting beta agonist combinations should be done by brand name, and due to a commercial agreement between the CCG and AstraZeneca, cost should not be a barrier to prescribing Symbicort. For further information contact [named individual].'

The Panel noted that this statement was first emailed by the RBM to, *inter alia*, representative B in early October 2016 with an instruction that it should be shared with customers in every call in the CCG. The email which advocated the statement's proactive use stated that its further use was subject to discussion at an account level. That same day, representative B emailed recipients of the RBM's email advising that the statement should not be used until a meeting with the CCG clarified matters. Representative B subsequently clarified the position by email following a meeting with the RBM and the CCG advising that the statement should only be used verbally and reactively if cost came up as a barrier to prescribing Symbicort and that it was 'specifically in relation to maintaining patients on Symbicort as opposed to new patients'. The email stated that the CCG supported continuing Symbicort in patients who were stable and well controlled (as opposed to new patients). The email then made it clear that the guidelines applied to new patients only, not existing, and a switch from existing therapies should only occur as part of a CCG driven review initiative. Whilst the email described when the in-call statement could be used it did not unambiguously reflect the company's overall local promotional strategy in relation to Symbicort. This was a significant omission given that, according to AstraZeneca, it had been discussed at the meeting with the CCG and representative B understood that Symbicort could only be promoted locally in certain patients. The Panel noted that the complainant's recollection of the meeting differed: he/she stated that it was agreed that, locally, Symbicort would not be promoted to health professionals. It was difficult in such circumstances to determine where the truth lay.

The Panel also noted the apparent confusion within the CCG about the status of the guidelines. Representative B's email stated that the guidelines had not yet been launched within the CCG and there was still confusion around the class and products that sat within it. The RBM's unsigned account of the investigation interview referred to the author of the guidelines who stated that 'the guidelines were just that and it was up to the prescriber what they prescribed'. The RBM did, however, state that it was AstraZeneca's strategy for the CCG to maintain patients on Symbicort rather than target new patients.

Representative A who ran the nurse forum meeting at issue did not receive the RBM's October 2016 email nor the emails from representative B. Representative A's signed account of the investigation interview referred to a document which contained in-call statements for a number

of CCGs which was emailed by the RBM to representatives in January 2017. The Panel noted that representative A recalled that when the in-call statement email was sent, he/she was also told that the statement in relation to the CCG at issue only applied to patients established on Symbicort rather than new patients. The Panel queried why this was not included in the email in question and the accompanying table of in-call statements. Whilst the covering email did state 'All of these statements are reactive' the table of in-call statements included a column headed 'Can I raise proactively or reactively?' and was marked as 'TBC' for the CCG statement in question. Further, 3 in-call statements in the table were listed for proactive use which directly contradicted the covering email. Whilst the company's local plan for the CCG referred to reactive use of the in-call statement, the Panel considered that the table of in-call statements should be capable of standing alone. The Panel considered that the email sent by the RBM in January 2017 regarding in-call statements when considered with the accompanying table was not clear about the CCG in-call statement's reactive or proactive use, nor was there any clarity about the company's local promotional strategy and therefore it advocated a course of action likely to be in breach of the Code. A breach of the Code was ruled.

The Panel noted that representative A knew that the in-call statement only related to patients established on Symbicort but did not make this clear at the nurse forum meeting in question. In the Panel's view this omission meant that the use of the in-call statement at the meeting was misleading. The Panel ruled a breach of the Code. The impression that it applied to all patients, including new patients, could not be substantiated and a further breach of the Code was ruled. In the Panel's view, to mislead the audience in this regard meant that the representative had not maintained a high standard of ethical conduct and a breach of the Code was ruled.

The Panel noted that the parties' understanding of the agreement reached in 2016 differed in relation to whether, and if so how, Symbicort would be promoted within the CCG. It was beholden upon the company to be clear in such circumstances about the agreement reached and in this regard it was of concern that the outcome had not been agreed in writing between the parties. It was of the utmost importance that such agreements were clearly and unambiguously communicated to the field force. The complainant's understanding was that AstraZeneca representatives were not to promote Symbicort to local health professionals as it was not covered by the current guidelines. The Panel accepted that the complainant must have felt strongly about this matter to be moved to complain. The Panel noted that the complainant did not comment on the in-call statement but noted that many patients were stabilised on Symbicort Turbohaler and the local CCG did not proactively encourage a review and a switch to another product. Representative A was sure he/she was told that the in-call statement only applied to established patients but did not refer to such patients being stable and well-controlled. The Panel noted AstraZeneca's submission that given the in-call statement was not clear about which patients within the CCG Symbicort could be used in, it advocated a course of action which was contrary to local arrangements and the Panel thus ruled a breach of the Code.

The Panel noted its comments and rulings above and considered that high standards had not been maintained. The Panel considered that the failure to give clear and unequivocal instructions to representative A was compounded by the fact that the company's stated local promotional strategy was not reflected in the local plan for the CCG and the failure to confirm the outcome of the 2016 meeting in writing. A breach of the Code was ruled.

A health professional from a clinical commissioning group (CCG), complained about the conduct of a named representative from AstraZeneca UK Limited. AstraZeneca had sponsored a local practice nurse forum meeting in April at which the complainant alleged that the representative had made false claims about the use of Symbicort Turbohaler (formoterol plus budesonide) within the local CCG. Symbicort was indicated for use in relevant patients with asthma or chronic obstructive pulmonary disease (COPD).

COMPLAINT

The complainant stated that the representative promoted Symbicort at the meeting in question and claimed that AstraZeneca had a special arrangement with the CCG and that the CCG was in favour of Symbicort.

The complainant noted that the CCG was part of an area prescribing committee and subscribed to, and promoted, the area's management guidelines for asthma and COPD; neither Symbicort nor Turbohaler appeared in those guidelines. AstraZeneca knew this because at a meeting in October 2016 to discuss the promotion of Symbicort locally, various approaches were agreed including that:

- many patients were stabilised on Symbicort Turbohaler, the CCG did not proactively encourage a review and a switch;
- all new patients/prescriptions for inhaled budesonide and formoterol combination would be started on DuoResp Spiromax, in accordance with local guidelines;
- all inhalers would be prescribed by brand name, in accordance with best practice to avoid confusion at dispensing; and
- AstraZeneca representatives were not to promote Symbicort to local health professionals as it was not covered by the current guidelines.

When writing to AstraZeneca, the Authority asked it to consider the requirements of Clauses 7.2, 7.4, 15.2, 15.4, 15.9 and 9.1 of the Code.

RESPONSE

AstraZeneca stated that it was extremely disappointed to receive the complaint. After conducting a thorough investigation, including

a review of call notes as well as speaking to the representatives involved, the company considered that the situation arose due to misunderstandings by a number of AstraZeneca representatives (due in part to inadequate briefing) as well as by the complainant.

AstraZeneca submitted that it had interviewed representative A who had attended the practice nurse forum in April 2017, representative B who had been at the meeting in 2016 and his/her line manager, the regional business manager (RBM), who was also present at that meeting. The meeting in 2016 was with the CCG's senior clinical commissioning pharmacist and was initiated by representative B. There were no other attendees. AstraZeneca provided notes from interviews with its two employees.

AstraZeneca submitted that there were a number of objectives for the 2016 meeting, including a discussion as to how it could assist in the roll-out of the CCG's recently issued guidelines about the prescription of respiratory medicines. A week before the meeting the RBM had emailed a statement to representative B and two other local, relevant field-based staff in relation to a commercial agreement that the local commercial account manager had negotiated with the CCG. The email stated:

> 'In light of a commercial agreement between [the CCG] and AstraZeneca, please ensure the below statement is shared with customers in every call in this CCG;
>
> *"The CCG recommends a formoterol/budesonide combination as one of the options on the asthma/COPD formulary. The specific product choice is down to the prescribers' discretion, and should be decided upon after discussion and agreement with the patient/carer. The CCG does however recommend that all prescribing of [inhaled corticosteroids/long active beta-agonist] ICS/LABA combinations should be done by brand name, and due to a commercial agreement between the CCG and AstraZeneca, cost should not be a barrier to prescribing Symbicort. For further information contact [the complainant]."'*

Representative B responded to all recipients of this email to state that he/she understood that the statement should only be used reactively and that he/she would clarify this with the local senior commissioning pharmacist.

AstraZeneca submitted that this statement was then subsequently discussed a week later at the 2016 meeting and it was clarified that it should only be used reactively if cost came up as a barrier to prescribing Symbicort in the CCG for patients already established on the medicine who were stable and well controlled (as opposed to new patients). It was also agreed that Symbicort should not be promoted in the CCG for new patients, given that it was not included in the CCG guidelines. Representative B's understanding of the impact of this on the promotion of Symbicort in the CCG was that Symbicort could still be promoted for patients established and well controlled on the medicine and that AstraZeneca would be transparent if health professionals asked if Symbicort was on the CCG guidelines for new patients and state that it was not. AstraZeneca submitted that contrary to the complainant's understanding, the agreement and the CCG guidelines did not mean that Symbicort could not be promoted in the CCG at all, rather that it could only be promoted for certain patients.

On the same day, immediately following the 2016 meeting, representative B summarised what was agreed with the CCG in an email to the RBM and to the local primary care representatives (copy provided).

The nurse forum in April 2017 was organised by a number of local practices and was attended by nurses from those practices. Representative A provided lunch and was given a 10-15 minute slot at the beginning of the meeting to present. AstraZeneca did not have an agenda for the meeting; the list of attendees was included in the meeting notes (copy provided).

Representative A stated that he/she did not discuss the CCG guidelines specifically but at the end of his/her presentation he/she read out the in-call statement noted above in relation to the CCG's position on Symbicort because there had been general discussion about cost amongst the delegates at the meeting.

The statement was provided to representative A by the RBM in January 2017 as part of a wider document that contained in-call statements for several CCGs (copies provided). The representative was 'pretty sure' that he/she was also told at the time that the in-call statement in relation to the CCG only applied to patients established on Symbicort rather than new patients. This did not appear to be covered in the RBM's email in January 2017 but the email did note that the statement was to be used reactively. At the nurse forum, representative A did not consider it necessary to clarify that the statement only referred to certain patients and did not recall anyone asking for clarification.

When interviewed as part of the investigation in to this complaint, the RBM stated that he/she received the in-call statement from the commercial account manager for the region at the time. The RBM did not know whether the statement had been certified; the commercial account manager would have agreed the statement with the CCG but as he/she was no longer with AstraZeneca this could not be confirmed.

When questioned about his/her understanding of the agreement with the CCG and whether the statement meant that Symbicort could only be promoted locally for patients established on the medicine, the RBM stated that that was not his/her understanding. However, it was the strategy that had been adopted by AstraZeneca in the CCG. This strategy was not stated in the RBM's email as the attachment contained in-call statements for a number of CCGs, but it was reflected in the account plan in place when the nurse forum took place. This account plan noted

that the objective for the CCG was to protect and maintain Symbicort by communicating the CCG in-call statement.

AstraZeneca submitted that given the above, it appeared that the statement provided to representatives A and B in relation to the position of Symbicort in the CCG was misleading; as a stand-alone item it did not clarify that Symbicort should not be promoted in the CCG for new patients, given that it was not included in the CCG guidelines. Thus, the statement that representative A read out at the nurse forum was misleading and could not be substantiated. AstraZeneca acknowledged a breach of Clauses 7.2 and 7.4.

Further, given that the in-call statement was not clear as to which patients within the CCG could be prescribed Symbicort, it advocated a course of action which was contrary to the current arrangements in place at the CCG and thus would be likely to lead to a breach of the Code. AstraZeneca acknowledged a breach of Clauses 15.4 and 15.9 in that regard.

AstraZeneca submitted that as representative B clarified the use of the in-call statement with the CCG and representative A was provided with an inadequate brief, the conduct of neither amounted to a failure to maintain high standards; the company thus refuted a breach of Clause 15.2 in that regard. However, the provision of such a briefing to the two representatives did amount to such a failure, and AstraZeneca acknowledged that the actions of the commercial account manager who provided the statement for circulation, were in breach of Clause 15.2.

Finally, it appeared that the in-call statement regarding the promotion of Symbicort in the CCG was not certified, in breach of Clause 15.9. AstraZeneca considered that this was a failure by the company to maintain high standards, in breach of Clause 9.1.

AstraZeneca apologised for the failures noted above and would act to address these as a matter of priority.

PANEL RULING

The Panel noted AstraZeneca's submission that representative A presented an overview of Symbicort and its use in asthma and COPD at a practice nurse forum in April 2017 and left a number of leavepieces behind at the end of the meeting. Representative A did not discuss the CCG guidelines specifically but at the end of his/her presentation read out the following in-call statement in relation to the CCG's position on Symbicort as there had been a general discussion about costs amongst the delegates:

> 'The CCG recommends a formoterol/budesonide combination as one of the options on the asthma/COPD formulary. The specific product choice is down to the prescribers' discretion, and should be decided upon after discussion and agreement with the patient/carer. The CCG does however recommend that all prescribing of ICS/LABA combinations should be done by brand name, and due to a commercial agreement between the CCG and AstraZeneca, cost should not be a barrier to prescribing Symbicort. For further information contact [named individual].'

The Panel noted that this statement was first emailed by the RBM to representative B and two other local, field-based staff in October 2016 with an instruction that the recipients should 'ensure that it was shared with customers in every call' in the CCG. The email which advocated the statement's proactive use stated that its further use was subject to discussion at account level. That same day, representative B emailed recipients of the RBM's email advising that the statement should not be used until a meeting with the CCG clarified matters. Representative B subsequently clarified the position by email a week later following a meeting earlier that day with the RBM and the CCG's clinical commissioning pharmacist advising that the statement should only be used verbally and reactively if cost came up as a barrier to prescribing Symbicort and that it was 'specifically in relation to maintaining patients on Symbicort as opposed to new patients'. The email stated that the clinical commissioning pharmacist supported continuing Symbicort in patients who were stable and well controlled (as opposed to new patients). The email then made it clear that the guidelines applied to new patients only, not existing, and a switch from existing therapies should only occur as part of a CCG driven review initiative. Whilst the email described when the in-call statement could be used it did not unambiguously reflect the company's overall local promotional strategy in relation to Symbicort. This was a significant omission given that, according to AstraZeneca, it had been discussed at the meeting with the CCG clinical commissioning pharmacist and representative B's understanding was that Symbicort could only be promoted locally in certain patients. The Panel noted that the complainant's recollection of the meeting differed: he/she stated that it was agreed that Symbicort would not be promoted to health professionals in the CCG. It was difficult in such circumstances to determine where the truth lay.

The Panel also noted the apparent confusion within the CCG about the status of the guidelines as evidenced in the material provided by AstraZeneca. Representative B's email a week after the meeting in October 2016 stated that the guidelines had not yet been launched effectively in the CCG and there was still confusion around the class and products that sat within it. The RBM's unsigned account of the investigation interview referred to the local formulary pharmacist who was the author of the guidelines who stated that 'the guidelines were just that and it was up to the prescriber what they prescribed'. The RBM did, however, state that it was AstraZeneca's strategy for the CCG to maintain patients on Symbicort rather than target new patients.

Representative A who ran the nurse forum meeting did not receive any of the 2016 emails from the RBM or representative B outlined above. Representative A's signed account of the investigation interview referred to a document which contained in-call statements for a number of CCGs which was emailed by the RBM to representatives in January 2017.

The Panel noted that representative A recalled that when the in-call statement email was sent, he/she was also told that the statement in relation to the CCG at issue only applied to patients established on Symbicort rather than new patients. The Panel queried why this was not included in the email in question and the accompanying table of in-call statements. Whilst the covering email did state 'All of these statements are reactive' the table of in-call statements included a column headed 'Can I raise proactively or reactively?' and was marked as 'TBC' for the CCG statement in question. Further, 3 in-call statements in the table were listed for proactive use which directly contradicted the covering email. Whilst the company's local plan for the CCG referred to reactive use of the in-call statement, the Panel considered that the table of in-call statements should be capable of standing alone. The Panel considered that the email sent by the RBM in January 2017 regarding in-call statements when considered with the accompanying table was not clear about the CCG in-call statement's reactive or proactive use, nor was there any clarity about the company's local promotional strategy and therefore it advocated a course of action likely to be in breach of the Code. A breach of Clause 15.9 was ruled.

The Panel noted that according to the signed account of the investigation interview, representative A knew that the in-call statement only related to patients established on Symbicort but he/she did not make this clear at the nurse forum meeting in April 2017. In the Panel's view this omission meant that the use of the in-call statement at the meeting was misleading. The Panel ruled a breach of Clause 7.2. The impression that it applied to all patients, including new patients, could not be substantiated and a breach of Clause 7.4 was ruled. In the Panel's view, to mislead the audience in this regard meant that the representative had not maintained a high standard of ethical conduct and a breach of Clause 15.2 was ruled.

The Panel noted that the parties had a different understanding of the agreement reached at the meeting in October in relation to whether and if so how Symbicort would be promoted within the CCG. It was beholden upon the company to be clear in such circumstances about the agreement reached and in this regard it was disappointing and of concern that the outcome had not been agreed in writing between the parties. It was also of the utmost importance that any such agreements were clearly and unambiguously communicated to the field force. The complainant's understanding was that AstraZeneca representatives were not to promote Symbicort to local health professionals as it was not covered by the current guidelines. The Panel accepted that the complainant must have felt strongly about this matter to be moved to complain. The Panel noted that the complainant did not comment on the in-call statement but noted that many patients were stabilised on Symbicort Turbohaler and the CCG did not proactively encourage a review and a switch to DuoResp Spiromax. Representative A was sure he/she was told that the in-call statement only applied to established patients but did not refer to such patients being stable and well-controlled. The Panel noted AstraZeneca's submission that given the in-call statement was not clear about which patients within the CCG Symbicort could be used in, it advocated a course of action which was contrary to the arrangements in place at the CCG and the Panel thus ruled a breach of Clause 15.4.

The Panel noted its comments and rulings above and considered that high standards had not been maintained. The Panel considered that the failure to give clear and unequivocal instructions to representative A was compounded by the fact that the company's stated local promotional strategy was not reflected in the local plan for the CCG and the failure to confirm the outcome of the meeting of October in writing. A breach of Clause 9.1 was ruled.

Complaint received **18 April 2017**

Case completed **12 July 2017**

ANONYMOUS NON-CONTACTABLE EMPLOYEE v BOEHRINGER INGELHEIM

Call rates

An anonymous, non-contactable employee of Boehringer Ingelheim complained about representatives' call rates and numbers of target customers. The complainant was concerned that a number of representatives had been managed out of the company for failing to hit their call rate targets; in that regard the complainant queried how representatives with fewer target customers could meet their daily call rates and still comply within the Code. The complainant referred to a culture of bullying and fear and that he/she could not discuss the matter with his/her first line manager for fear of being let go.

The detailed response from Boehringer Ingelheim is given below.

The Panel noted that as the anonymous complainant was non-contactable, it was not able to go back to him/her for further and better particulars.

The Panel noted that supplementary information to the Code stated, *inter alia,* that the number of calls made on a doctor or other prescriber by a representative each year should not normally exceed three on average. This did not include attendance at group meetings and the like, a visit requested by the doctor or other prescriber or a visit to follow up a report of an adverse reaction, all of which could be additional to the three visits allowed.

Based on the quoted activity rates, Boehringer Ingelheim assumed that the complainant had referred to a general medicine role. The Panel noted Boehringer Ingelheim's submission that the call rates per day cited by the complainant were not target call rates but overall target contact rates for individual primary care specialists (PCS) and therapy area specialists (TAS) respectively. The Panel noted Boehringer Ingelheim's explanation that as the minimum target list lengths in 2017 were 120 and 180 for the PCS and TAS roles respectively, and as the majority of interactions for general medicine were group meetings, these target list sizes were easily sufficient to ensure representatives were not required to breach the Code.

The Panel further noted Boehringer Ingelheim's submission that the average contact rate for a TAS was 76% of the target contacts/day and for a PCS 77% of the target contacts/day. The Panel noted Boehringer Ingelheim's calculations which showed an average of 0.83 and 1.28 unsolicited contacts per health professional per year for a PCS and TAS respectively. In the area with the smallest target list the maximum number of unsolicited calls would be 1.19 for a PCS and 1.92 for a TAS.

The Panel noted Boehringer Ingelheim's submission that whenever told about contact rates representatives were also reminded about the limit of 3 unsolicited calls per year under the Code. The Panel also noted that this reminder was not included in management forms which set performance objectives for 2017 and referred to the required contact rates. The Panel noted that the key account manager (KAM) performance objectives provided by Boehringer Ingelheim incorrectly referred to a minimum number of calls based on customer-facing days instead of the number of contacts and this document did not refer to the requirements of the Code.

The Panel noted that one incident of overcalling in general medicine was due to a failure to accurately record the nature of interactions namely that contacts at a group meeting were not correctly categorised. Whether a second incident of apparent overcalling was an error in recording or a genuine incident of overcalling could not be confirmed as the individual had left the company.

The Panel noted the complainant's comments about representatives being managed out of the company. The Code did not govern contractual matters such as general terms and conditions including the decision to invoke disciplinary proceedings and dismissal. The Panel also considered that if a company had created an environment where there was a clear unequivocal pressure to overcall, that environment might be relevant to matters potentially within the scope of the Code irrespective of the acceptability of briefing material. The Panel noted Boehringer Ingelheim's submission that no representatives had been managed out for failure to achieve a certain call rate, because Boehringer Ingelheim did not set call rate as a target. Nor had any representatives been managed out either for failure to achieve target contact rate or activity volumes. The Panel considered that in the particular circumstances of this case the complainant's narrow allegation about representatives being managed out of the company and a bullying culture were outside the scope of the Code; no breach of the Code was ruled.

Whilst the Panel had concerns regarding some matters outlined above, it noted the narrow allegation and that the complainant bore the burden of proof. The Panel did not consider that the complainant had established on the balance of probabilities that some representatives had only 60 target customers and a 'hit' rate of 4 per day which was likely to lead to a breach of the Code. Nor was the complainant's concern about target lists combined with call rates reflected in the briefing material. Based on the narrow allegation, the Panel ruled no breach of the Code including of Clause 2.

An anonymous, non-contactable employee of Boehringer Ingelheim complained about call rates and the number of target customers at the company.

COMPLAINT

The complainant was concerned about the number of representatives who had been managed out of the company because they had not hit their call rate per day in primary care or secondary care (details were provided). In that regard the complainant referred to at least 10 people in the last year in one particular region.

The complainant stated that he/she knew of some representatives who only had about 60 target customers; with a call rate of 4 per day, the complainant queried how they could comply with the Code in terms of activity.

The complainant referred to a bullying culture and a fear culture which made people ill. The complainant was saddened that good, honest representatives had lost their jobs because of call rates.

The complainant submitted that there was no point discussing the matter with his/her first line manager as it would be escalated up through the company and would result in the person who complained being subsequently no longer employed.

When writing to Boehringer Ingelheim, the Authority asked it to consider the requirements of Clauses 2, 9.1, 15.4 and 15.9.

RESPONSE

Boehringer Ingelheim explained that its sales force teams were divided into general medicine and specialty medicine. General medicine comprised the respiratory, cardiovascular and metabolic (diabetes) therapy areas, while specialty medicine comprised lytics (comprising Actilyse and Cathflo), idiopathic pulmonary fibrosis (referred to as IPF or Ofev) and oncology.

Customer-facing sales roles within general medicine comprised primary care specialists (PCS), therapy area specialists (TAS) and key account managers (KAM) within 22 defined geographic areas. TAS and KAM roles covered both primary and secondary care health professionals.

In specialty medicine, the customer-facing role was a key account specialist (KAS) or senior key account specialist (S-KAS). The number of geographic areas in specialty medicine varied by therapy area. KAS and S-KAS roles tended to be largely (but not exclusively) focussed on secondary care health professionals given the nature of the therapy area. The sales teams in lytics and IPF were much smaller than the other sales teams given the nature of these therapy areas.

When considering sales activity/activity rates/coverage, Boehringer Ingelheim explained that it used a defined target list for a given therapy area within a given geographic area. Target lists represented individual health professionals, in primary or secondary care, identified by a process of data analysis and input from local representatives as relevant to the therapy area and appropriate for promotional discussion. The local representatives had the final say on who was allocated to a target list based on their local insights. Boehringer Ingelheim submitted that it ensured that the target list was sufficiently long to ensure individuals could achieve the required activity levels without being under pressure to exceed the call limits set by the Code.

1 Clause 15.4: Frequency of calls

a) Call rate

Boehringer Ingelheim noted that although the complainant referred to target call rates per day these were not target call rates but overall target contact rates for individual general medicine representatives. 'Contact rate' was defined in accordance with in-house guidance issued in June 2016 on Clause 15 as:

i) those contacts that are speculative or appointments, which must not exceed 3 per year as clearly stated within the Code,

ii) those that are additional to the speculative call rate which includes: attendance at meetings (including audio-visual presentations), a visit which is requested by a doctor for example requested meeting interactions (contracting and follow ups) or contacts that are in response to an enquiry.'

Boehringer Ingelheim explained that contacts falling within i) above were classified as 'unsolicited' (ie not requested) and those which fell within ii) above as 'solicited' (ie requested by a health professional) and in this regard referred to an email to the sales force dated 3 June 2016.

Boehringer Ingelheim noted that the template performance measures (MAG) for a PCS and TAS clearly stated the required rate was a contact rate not a call rate.

Boehringer Ingelheim submitted that in general medicine, it measured its sales force on an overall activity volume, which was an aggregate of contact rates and expected days per year in the field to see health professionals. This could be achieved against any target health professional and included unsolicited and solicited contacts in an individual or a group meeting setting. Boehringer Ingelheim noted that the majority of contacts occurred in group meetings.

b) Target lists

Boehringer Ingelheim noted the complainant's reference to a representative with a target customer list of 60 individuals. Based on the quoted activity rates, the company assumed that the complainant had referred to a general medicine role. However, no representative in general medicine had such a small target customer list.

General medicine

In order to ensure that representatives had ample opportunity to achieve their target contact volumes within the Code requirements, Boehringer Ingelheim explained that it set minimum target list lengths for the PCS and TAS role. For example, in 2017 the minimum target list length for a PCS was 120; in 2016 it was 115. Typically, however, target lists were longer than this, for example the average list length for a PCS in general medicine was 173. As the majority of interactions for general medicine (on average 67.9% for PCS) were group meetings, target list sizes were easily sufficient to ensure representatives were not required to breach the Code.

By way of example, details of average target call rate and the number of working days giving an average contact rate for unsolicited contacts per year were given for PCS and TAS:

Boehringer Ingelheim noted that even in the area with the smallest target list size, the maximum of unsolicited calls would be 1.19 per health professional per year for a PCS or 1.92 for a TAS.

Boehringer Ingelheim submitted that the two worked examples given were conservative as other non-group meeting activities could also be classed as solicited by a health professional (requested visits, response to a specific enquiry, follow-up of an adverse event report).

The company provided the 2015-2017 target list analysis (2017 with full geographic breakdown) and examples of 2016 and 2017 targeting exercises which demonstrated minimum list length.

Boehringer Ingelheim submitted that whilst KAMs had a contact rate of 2 per day, they did not have a target list, so any contact with any health professional qualified as a contact. They were also only expected to spend three days a week in contact with customers. A copy of the KAM performance objectives was provided. Boehringer Ingelheim had identified that although the 2017 objectives for a KAM referred to a minimum number of calls based on customer-facing days, this was incorrect terminology and should refer to contacts. The company would ensure this was corrected but since KAMs did not have a target list and therefore could achieve this call rate by reference to any health professional, this would not advocate a breach of the Code.

Boehringer Ingelheim noted that while these contact rates were measured by the company, in practice the majority of representatives did not achieve them, therefore the above examples represented the worst case scenario in terms of call rate.

Specialty medicine

Although Boehringer Ingelheim did not believe that the complainant had referred to a specialty medicine role given the quoted contact rates, in the interests of completeness it nonetheless detailed the targeting process for each specialty medicine therapy area (IPF, lytics and oncology).

In specialty medicine a target list of customers (either at health professional or organisation level) was defined by the representatives and objectives were set in relation to coverage of those targets (where coverage meant there had been at least one interaction with that customer). An analysis of unsolicited contact rates (see section below on overcalling data) confirmed that no representative in specialty medicine had exceeded the limit of three per year.

- Idiopathic pulmonary fibrosis (IPF)

  In both 2016 and 2017, the incentive scheme implemented for the KAS and S-KAS IPF team set expectations of coverage of target customers. The key performance indicators set for a KAS/S-KAS in 2016 were 90% coverage of target A customers by April 2016 and 80% of target B customers by June 2016. Target A customers were health professionals that could prescribe Ofev ie clinical specialists, whereas target B customers were health professionals that could influence a choice of IPF therapy. In 2017, the target coverage rate for a KAS was 85%. IPF was an orphan indication and only treated in specialist centres in the UK, so the target list for different geographical areas varied.

  For the first half of 2017 additional guidance was communicated to the KAS team at the January sales conference 'At least 1 Platinum and 1 Silver/ Gold customer call per day on territory (daily unique health professionals >2) in 1:1/ group call'. This could be achieved against any target health professional within an organisation classified as Platinum, Silver or Gold and could include unsolicited and solicited contacts in an individual and a group meeting setting. This guidance did not form part of the formal performance management objectives for the IPF team as it was recognised that some of the representatives had smaller territories. The primary performance objective was the 85% coverage rate. Boehringer Ingelheim noted that the slide at issue also specifically included a reminder to the IPF team to comply with Clause 15.

- Lytics

  In the lytics therapy area, the targets were set in relation to coverage (which meant any contact with a customer) with reference to a target list of customers. There was no call rate or contact rate expectation. In 2017, the annual target for a KAS was 85% coverage on the target list. There was no minimum target customer list length set, but in 2016, representatives were encouraged to aim for at least a certain number of customers. Details of the 2017 total target list and the average was per representative were provided). Since the only target that Boehringer Ingelheim set was that a KAS should have one contact with 85% of their target list, this would not put them under any pressure to exceed the call rate limit.

- Oncology

  In oncology, the target customer coverage was 80% per six months (ie a maximum of 2 contacts per year) with local frequency key performance indicators of between 2 and 3 contacts per day for A and B target customers. Target A customers were prescribers and target B customers were clinical nurse specialists in lung cancer. The average target list length for an oncology KAS was provided as was the target customer-facing days per year, the size of the target lists was easily sufficient to ensure representatives were not put under pressure to breach the Code requirements to achieve activity targets.

  Boehringer Ingelheim noted that it had identified that the template performance requirements for an oncology KAS incorrectly referred to a requirement of 3 calls per day. This should refer to 3 contacts per day in line with the Boehringer Ingelheim definition, but the company understood from the sales operations manager for this team that this requirement was communicated correctly verbally, with a reminder about the requirements of Clause 15. Boehringer Ingelheim stated that it would ensure this was corrected although its data analysis revealed that no oncology KAS had called upon a health professional more than three times in a year.

c) Records of overcalling

Boehringer Ingelheim noted that within its customer relations management (CRM) system representatives could indicate whether a contact was solicited (ie requested by a health professional) or unsolicited (ie not requested by a health professional). Training on how to do this was provided to all new employees in their initial week's training programme.

Boehringer Ingelheim submitted that this complaint had triggered a detailed review of its CRM database over the last 24 months of contact history. It had run a report on all unsolicited interactions – which under the Code and consistent with in-house definitions must not exceed 3 per year – and identified instances where a representative had exceeded this frequency on a given health professional. The company provided the data and submitted that of these interactions, only 4% were considered to be unsolicited. One of the key drivers for this low figure was the high dependence that the company had on group meeting contacts, with over two thirds of interactions being this.

Analysis of the unsolicited interactions had identified one individual in general medicine who had recorded four unsolicited visits to one particular health professional. These interactions took place over two calendar years, but fell within a rolling twelve month period. Unfortunately, Boehringer Ingelheim could not establish if this was a genuine occurrence of overcalling, or a failure to accurately record the nature of interactions as the representative in question was currently on annual leave. An analysis of the interactions recorded as unsolicited by this representative highlighted some inaccuracies which required validation with the individual, for example he/she had recorded a number of group meeting contacts as unsolicited which was inappropriate. Boehringer Ingelheim undertook to investigate the case with the representative upon their return and provide the final findings to the Panel.

For completeness, Boehringer Ingelheim had also analysed the historic activity of a number of individuals who were no longer active users and had left the organisation. This figure was driven beyond normal staff turnover by a large organisational restructuring that took place in late 2015. Within this population a second individual was identified who saw a single doctor five times within both a calendar year and a rolling 12 month period. The representative held a multi-portfolio role working across four brands. Boehringer Ingelheim was unable to confirm whether this was an error in recording or reflected a genuine incident of overcalling.

The analysis of unsolicited activity had identified a training need for a small number of individuals to ensure that they were confident to accurately record contacts with health professionals in line with the company's definitions of solicited and unsolicited contacts. The potential for overcalling was limited to 0.225% of past and present representatives or 0.00049% of unsolicited activity.

Whilst the level of potential overcalling was extremely low, Boehringer Ingelheim submitted that it would ensure that:

1 Information was obtained from the current representative about the level of unsolicited contacts to confirm if overcalling had taken place. The outcome of this would follow.
2 Retraining was provided to the individuals identified as having recording inaccuracies, particularly in relation to classification of group meeting contacts.
3 The sales force activity dashboard was updated to allow easier monitoring of unsolicited contacts. Currently the report provided an overview of contacts with health professionals based on frequency which allowed managers to flag high frequencies of contacts and run further reports if necessary. However this included all contact types. Boehringer Ingelheim would add in the functionality to show this information by individual for health professionals and to distinguish between unsolicited and solicited contacts.

d) Managing representatives out for failure to meet call rates

Boehringer Ingelheim submitted that the complainant's statement that 10 people had left a particular region in the last year for failure to achieve call rates was not correct. No representatives had been managed out for failure to reach call rate, because Boehringer Ingelheim did not set call rates as a target. Although 7 people had left the named region in the last year, no representatives had been managed out either for failure to achieve target

contact rate or activity volumes. In fact, the majority of the field force did not achieve their target contact rates, so it would be impractical to operate in this manner. The average contact rate for a TAS was 76% of the target contacts/day and for a PCS 77% of the target contacts/day.

2 Clause 15.9: Briefing material

Boehringer Ingelheim provided copies of all documents sent to representatives in the last two years in relation to call/contact rates, split by therapy area. The company noted that it had described above the contact rate and target list process and submitted that none of the briefing materials provided advocated a course of action which would be likely to lead to a breach of the Code.

3 Clauses 9.1 and 2

Boehringer Ingelheim submitted that contrary to the complainant's assertion, it did not set a call rate for its representatives but did set a contact rate in the majority of its therapy areas. This varied between 2-4 per day.

Contact rates were clearly defined and included solicited and unsolicited interactions. When contact rates were communicated to representatives, they were reminded about the limit of 3 unsolicited calls per year under the Code. No documents advocated a course of action which would be likely to lead to a breach of the Code. Boehringer Ingelheim submitted that it had not managed out any representatives for failure to meet either expected call rates or expected contact rates. Target lists were set by a 'bottom-up' process with extensive input from representatives. These lists were of a sufficient size that representatives were not required to breach the Code in order to achieve their expected contact rate.

Boehringer Ingelheim submitted that it had not failed to maintain high standards nor had it brought the pharmaceutical industry into disrepute, it thus denied breaches of Clauses 9.1 and 2.

Summary

Boehringer Ingelheim submitted that the contact rates mentioned by the complainant applied to a PCS and a TAS in general medicine. However, the complainant had incorrectly represented this as a call rate rather than a contact rate. Boehringer Ingelheim had a clear definition of contacts and regularly reminded representatives that the limit of three calls should not be exceeded. In general medicine the smallest target list length per representative was 121 which, given the high rate of group meetings in primary care, would not put pressure on a representative to breach the limits under the Code (see worked examples above). Data showed that in practice representatives rarely even achieved the target contact rate. Accordingly, there had been no breach of the Code.

On analysis of its CRM records for the last 24 months, Boehringer Ingelheim had identified only two instances where the call rate limit of 3 might have potentially been exceeded. This represented an extremely small percentage of the overall number of unsolicited contacts. The company stated that it would be able to confirm or eliminate one of these when the relevant representative returned from annual leave, but would be unable to assess the remaining instance as it no longer employed the individual in question. A need for re-training in a small number of cases on how to accurately record customer interactions had been identified and new functionality would be added to its activity dashboard to facilitate easier monitoring of the unsolicited call rate by managers.

Further information

Boehringer Ingelheim noted that as detailed above, one of its representatives had called (unsolicited) four times on one health professional within a twelve month rolling period. Following that representative's return to work after annual leave, Boehringer Ingelheim conducted an investigation to ensure that the records of his/her interactions to date accurately reflected the nature of the interaction that occurred and that he/she was consistent with the company's definitions of contact type, which was in accordance with guidance on Clause 15 as:

i) Those that are speculative or appointments requested by a representative (which must not exceed 3 per year as clearly stated within the Code).

These types of contacts were classified as 'unsolicited' in the CRM system unless the appointment fell within the category below.

ii) Those that were additional to the unsolicited call rate which included:

- Attendance at group meetings (included audio-visual presentations),
- a visit which was requested by a doctor, for example requested meeting interactions (contracting and follow-ups), or contacts that were in response to a specific enquiry, or
- a visit to follow up a report of an adverse reaction.

These types of contacts were classified as 'solicited' in the CRM system.

Boehringer Ingelheim submitted that an exercise whereby the employee was provided with a file extract from the CRM system and asked to review his/her classification of interactions against the above definitions and to make any corrections if necessary, showed that the apparent overcalling was due to a failure to accurately record the nature of interactions. Specifically this was caused by contacts at a group meeting not being correctly categorised. The individual had confirmed the true nature of the interactions and the CRM system was being updated as appropriate. The individual had also been issued with training models aligned to CRM use for completion.

Boehringer Ingelheim was confident that the findings of the investigation were accurate, that the intervention was appropriate for the individual and

would prevent future errors of this nature. As noted above, the position with regard to the employee who had left the company could not be clarified.

PANEL RULING

The Panel noted that the complainant was anonymous and non-contactable. The Constitution and Procedure stated that anonymous complaints would be accepted, but that like all complaints, the complainant had the burden of proving his/her complaint on the balance of probabilities. The Panel was not able to go back to the complainant for further and better particulars.

The Panel noted that the supplementary information to Clause 15.4 stated, *inter alia*, that the number of calls made on a doctor or other prescriber by a representative each year should not normally exceed three on average. This did not include attendance at group meetings and the like, a visit requested by the doctor or other prescriber or a visit to follow up a report of an adverse reaction, all of which could be additional to the three visits allowed.

The Panel noted the complainant's concern that a number of representatives had been managed out of the company because they had not hit their call rate and that he/she queried how representatives with only 60 target customers could comply with the Code in terms of activity based on the required call rate.

Based on the quoted activity rates, Boehringer Ingelheim assumed that the complainant had referred to a general medicine role. The Panel could not contact the complainant for further information. The Panel noted Boehringer Ingelheim's submission that the call rates per day referred to by the complainant were not target call rates but overall target contact rates for individual primary care specialists (PCS) and therapy area specialists (TAS) respectively. The Panel noted Boehringer Ingelheim's explanation that it set minimum target list lengths for the PCS and TAS role. For example, in 2017 the minimum target list length for a PCS was 120 and in 2016 it was 115. Comparable figures for a TAS were 180 and 162. The Panel noted Boehringer Ingelheim's submission that actual target lists were typically longer than this. As the majority of interactions for general medicine were group meetings, target list sizes were easily sufficient to ensure representatives were not required to breach the Code.

The Panel further noted Boehringer Ingelheim's submission that the average contact rate for a TAS was 76% of the target contacts/day and for a PCS 77% of the target contacts/day. The Panel noted Boehringer Ingelheim's calculations which showed an average of 0.83 and 1.28 unsolicited contacts per health professional per year for a PCS and TAS respectively. In the area with the smallest target list the maximum number of unsolicited calls would be 1.19 for a PCS and 1.92 for a TAS.

The Panel noted Boehringer Ingelheim's submission that it ensured that the target list length was of a sufficient size to ensure individuals could achieve the required activity levels without being under pressure to exceed the call limits set by the Code and that local representatives had the final say on who was allocated to a target list. In that regard the Panel also noted Boehringer Ingelheim's submission that as the majority of interactions for general medicine were group meetings, target list sizes were easily sufficient to ensure representatives were not required to breach the Code.

The Panel noted Boehringer Ingelheim's submission that whenever contact rates were communicated to representatives, they were reminded about the limit of 3 unsolicited calls per year under the Code. The Panel also noted that this reminder was not included in the MAG & Talent Management forms 2017 which set performance objectives and referred to the required contact rates. The Panel noted that the KAM performance objectives provided by Boehringer Ingelheim incorrectly referred to a minimum number of calls based on customer-facing days instead of the number of contacts and this document made no reference to the requirements of Clause 15.

The Panel noted that one incident of overcalling in general medicine was due to a failure to accurately record the nature of interactions namely that contacts at a group meeting were not correctly categorised. Boehringer Ingelheim was unable to confirm whether a second incident of apparent overcalling was an error in recording or reflected a genuine incident of overcalling as the individual who held a multi-portfolio role had left the company.

The Panel noted Boehringer Ingelheim's submission that with regard to idiopathic pulmonary fibrosis (IPF) the incentive scheme implemented for the KAS and S-KAS team set expectations of coverage of target customers; the target coverage rate for a KAS in 2017 was 85%. Similarly in the lytics therapy area the targets were set in relation to coverage and the target for a KAS was 85%. There was no call or contact rate expectation. There was no minimum target customer list length set but in 2016 representatives were encouraged to aim for at least 80 customers which was similar to 2017.

The Panel noted Boehringer Ingelheim's submission that in oncology, the target customer coverage was 80% per six months (ie a maximum of 2 contacts per year) with local frequency key performance indicators of between 2 and 3 contacts per day for A and B target customers. Target A customers were prescribers and target B customers were clinical nurse specialists in lung cancer. The average target list length for an oncology KAS was provided and the number of customer-facing days per year. The Panel noted Boehringer Ingelheim's submission that the size of the target lists was easily sufficient to ensure representatives were not put under pressure to breach the Code requirements to achieve activity targets.

The Panel further noted Boehringer Ingelheim's submission that it had identified that the template performance requirements (MAG and Talent Management Form 2017) for an oncology KAS incorrectly referred to a requirement for 3 calls per

day and should have referred to 3 contacts per day in line with the Boehringer Ingelheim definition. The Panel noted Boehringer Ingelheim's submission that it understood from the sales operations manager of this team that this requirement was verbally communicated correctly, with a reminder about the requirements of Clause 15.

The Panel noted the complainant's comments about representatives being managed out of the company. The Code did not govern certain contractual matters between a representative and a pharmaceutical company such as general terms and conditions including the decision to invoke disciplinary proceedings and dismissal. The Panel also considered that if a company had created an environment where there was a clear unequivocal pressure to overcall, that environment might be relevant to matters potentially within the scope of the Code irrespective of the acceptability of briefing material. The Panel noted Boehringer Ingelheim's submission that no representatives had been managed out for failure to achieve a certain call rate, because Boehringer Ingelheim did not set call rate as a target. Nor had any representatives been managed out either for failure to achieve target contact rate or activity volumes. The Panel considered that in the particular circumstances of this case the complainant's narrow allegation about representatives being managed out of the company and a bullying culture were outside the scope of the Code; no breach of the Code was ruled.

Whilst the Panel had concerns regarding some matters outlined above, it noted the narrow nature of the allegation and that the complainant bore the burden of proof. The Panel did not consider that the complainant had established on the balance of probabilities that some representatives had only 60 target customers and a 'hit' rate of 4 per day which was likely to lead to a breach of the Code. Nor was the complainant's concern about target lists combined with call rates reflected in the briefing material. Based on the narrow allegation, the Panel ruled no breach of Clauses 15.4, 15.9, 9.1 and 2.

During its consideration of this case the Panel was concerned about the briefing material with regard to the varying explanations of calls and contacts. It was important that instructions to representatives about contact and call rates were consistent, clear and unambiguous across all communications to representatives and reflected the requirements of the Code as set out in the supplementary information to Clause 15.4.

The Panel was further concerned to note Boehringer Ingelheim's submission that while contact rates were measured by the company, in practice the majority of representatives did not achieve them. The Panel queried if by setting the activity targets so high in relation to contact rates it could be argued that they advocated a course of action which would be likely to lead to a breach of the Code. The Panel was also concerned to note that the requirements of Clause 15.4 were not referred to in all key documents that discussed call and contact rates.

The Panel asked that Boehringer Ingelheim be advised of its concerns.

Complaint received **25 April 2017**

Case completed **1 August 2017**

EX-EMPLOYEE v NAPP

Flutiform promotional practices

An ex representative, previously employed by Napp through a third party agency, complained about various promotional practices within Napp.

Napp's detailed response to each allegation is given below.

The complainant stated that one of his key performance indicators (KPIs) was to get ten target GP practices to 'switch' a percentage of asthma patients on GlaxoSmithKline's Seretide Evohaler (salmeterol plus fluticasone) to the equivalent doses of Napp's Flutiform metered dose inhaler (MDI) within a specified timeframe. The complainant noted, however, that the prescribing particulars (age range and indications) of Seretide Evohaler and Flutiform were different and so the two were not wholly interchangeable. Further, the percentage switch conversion was unrealistic as there were no financial incentive schemes in named local clinical commissioning groups (CCGs) to switch. This, together with rebates from GlaxoSmithKline on Seretide Evohaler and from other manufacturers on other inhalers meant that some of the cost savings claimed by Napp for a switch to Flutiform were inaccurate. The complainant stated that he was under significant and sustained pressure to deliver on business outcomes. The complainant was further concerned that emailing surgery prescribing data could potentially breach data protection.

The complainant noted that Napp's marketing material did not refer to asthma patients prescribed Seretide Evohaler who were also diagnosed with asthma-chronic obstructive pulmonary disease (COPD) overlap syndrome (ACOS); Flutiform was not licensed for COPD. Napp's marketing message of a simple switch was misleading. Even in Napp's own marketing material there were a number of differences between Seretide Evohaler and Flutiform, which meant that the medicines were not like-for-like formulations. A simple switch should not be taken as like-for-like dose changes, but the actual process of making changes which was rather more involved and required firm commitment from the practice.

The complainant stated that practices could do the switches themselves or via one of two services offered by Napp which were seen as independent non-promotional services but were set up to switch inhaler medicines to Flutiform. The complainant stated that he was briefed about this service via Napp's intranet site but that specific in-house, face-to-face training and validation were lacking. The complainant also stated that he did not know when these service were being provided within his target surgeries and that he could order non-promotional materials despite not having been trained. The complainant alleged that, in pursuit of sales, compliance towards switches and Napp's briefing on switches from his manager (the area business manager (ABM)) was very lax. As Napp was driving switches, the non-promotional service should not have been used as the introduction was linked to Flutiform as a commitment from the customer to make changes through quality outcomes framework (QOF) and patient review in the first call and to then sign up to the service in the second call.

The Panel noted that the parties' accounts differed; it was difficult in such circumstances to determine precisely what had happened. A judgement had to be made on the available evidence whilst noting that the complainant bore the burden of proof and had to establish his case on the balance of probabilities.

The Panel noted that the complainant's concern was that the percentage switch conversion from Seretide Evohaler to Flutiform, as set out in his KPIs, was unrealistic. The Panel noted that it appeared that the KPIs had been agreed by the complainant and that he was required to achieve a stated switch success rate within ten target GP practices within 6-8 months. It was stated that a switch should be 50% or more of a surgery's Seretide Evohaler marketshare to the equivalent dose of Flutiform. The Panel considered that the absence of incentive schemes in the CCGs did not necessarily mean that a switch would be unrealistic. Much would depend on whether health professionals considered that the benefits of a switch outweighed the work required to action it. The Panel did not consider that the complainant had proven that, on the balance of probabilities, the percentage switch was unrealistic for the reasons alleged. Nor that Napp in setting this KPI advocated, either directly or indirectly, any course of action which would be likely to lead to a breach of the Code. No breach of the Code was ruled.

The Panel further noted the complainant's concern that there were rebates in place in the three named CCGs for Seretide Evohaler and another inhaler Sirdupla and therefore the cost saving figures in the leavepiece concerning medicines optimisation for one of the named CCGs were inaccurate and misleading. The Panel noted Napp's submission that the leavepiece compared NHS list prices and national prescribing data to ensure licensed age ranges were taken into account when calculating the potential cost savings. The Panel noted Napp's submission that the complainant had been briefed on the leavepiece and confirmed that he understood how to use it. The Panel considered that although discounts etc might make it possible to buy medicines at less than the NHS list price, it was not unreasonable for companies to base price comparisons on the NHS list price when this was made clear. The Panel did not consider that the complainant had proven that, on the balance of

probabilities, the leavepiece was misleading in that regard. On the narrow grounds alleged the Panel ruled no breach of the Code.

The Panel reviewed two emails provided by the complainant in support of his allegation that he was under pressure to get practices to switch and the allegation that discussing surgery prescribing data and patient switches in emails could potentially breach data protection laws. The Panel noted Napp's submission that the content of the first email displayed the manager's concern that the likelihood of a switch in the named GP practice was low thus calling into question the complainant's sales abilities. The second email predated the first and provided details of a business review held between the complainant and his ABM. The email highlighted the complainant's progress against his mutually agreed KPIs.

The Panel did not consider that it was necessarily unacceptable for ABMs to require weekly progress updates provided that such did not contravene the requirements of the Code. The Panel did not consider that the complainant had proven that he had been under sustained pressure from the ABM to deliver on business outcomes that did not comply with the Code as alleged. No breach of the Code was ruled. Nor had the complainant proved that that the ABM requesting weekly updates would advocate directly or indirectly any course of action that would be likely to breach the Code. No breach of the Code was ruled.

The Panel noted Napp's submission that the emails provided by the complainant did not contain any patient specific data and the information sought was anonymous in nature. The Panel further noted Napp's submission that to the extent that the emails mentioned individual health professionals, this publicly available information was used for legitimate business purposes and was subject to appropriate safeguards. The Panel was concerned about activities in relation to the Code. It was not for the Panel to determine whether Napp's activities were in line with data protection requirements *per se*.

Clause 1.11, however, stated that companies must comply with all applicable codes, laws and regulations to which they were subject. This clause had not been raised and the complainant had not provided evidence that the companies had been found in breach of data protection requirements. Given the circumstances the Panel therefore considered that there was no evidence that high standards had not been maintained and it ruled accordingly.

With regard to the use of the medicine for asthma overlap syndrome (AOS) and COPD as Flutiform was not licensed for COPD, the Panel noted Seretide Evohaler's SPC and Napp's submission that Seretide Evohaler was not licensed to treat ACOS or COPD and therefore there was no need for such a consideration within its materials which referred to switching including the leavepieces. Seretide Accuhaler was licensed to treat both asthma and COPD. The Panel did not consider that the material was misleading in that regard and no breach of the Code was ruled.

The Panel noted that the complainant provided the incomplete front page of a document which stated 'A simple switch to Flutiform Real Difference' and an extract from another leavepiece which included a table highlighting differences between Seretide Evohaler and Flutiform. The Panel noted the complainant's allegation that describing the switch as 'simple' was misleading as making changes was more involved and required significant time investment from practices. The Panel noted that under the Code, a company could promote a simple switch from one product to another but could not assist in implementing that switch. The Panel noted that it would take time to review patients who potentially could be switched but considered that the reference to 'a simple switch' in the supplementary information to the Code referred to switching from one medicine to another in relevant patients. The Panel noted that the complete document provided by Napp was titled 'A simple switch to Flutiform can make a real difference to your patients'. The leavepiece discussed some of the features of Flutiform followed by study results from patients switched from Seretide Evohaler to Flutiform.

The Panel further noted Napp's submission that 'simple' was used to describe the switch from Seretide Evohaler to Flutiform as both products were similarly licensed for asthma maintenance and differences in licensed age ranges were clearly stated; both were MDI's; and both contained the same inhaled corticosteroid, so no steroid dose conversion was necessary.

The Panel noted that the leavepiece referred to the licensed indication of Flutiform including the age range for the various strengths and that it was for patients 12 years and older (low and medium strengths) and adults (all dosage strengths). The leavepiece stated that patients previously controlled on Seretide Evohaler 250mcg could be switched to Flutiform 250mcg and maintain good asthma control. A bullet point below in less prominent font stated that this was based on a 12-week study in 225 adult asthma patients. The leavepiece did not include the licensed indication for Seretide including the age range or the differences in licensed age ranges between Flutiform and Seretide as stated by Napp. The Panel queried why the leavepiece did not state that patients aged 5 to 12 could not be switched from Seretide Evohaler to Flutiform. The second leavepiece referred to by the complainant, entitled 'Do you have a medicines optimisation plan to switch asthma patients from Seretide Evohaler? Why choose Flutiform', included the claim 'A simple switch can make a real difference' and asked the reader what was important to them when switching patients from Seretide Evohaler to Flutiform. The leavepiece compared various features of Flutiform, Seretide Evohaler and Fostair including change in steroid from Seretide Evohaler, patient-facing dose indicator and refrigeration required prior to dispensing. Page 3 compared Flutiform and Fostair

in terms of dose delivery and steroid percentage at the lowest daily dose. Whilst the leavepiece stated the licensed indication of Flutiform including the age range for the various strengths, it did not refer to the licensed indications of Seretide or Fostair including the age range. There would be patients who could simply be changed from Seretide to Flutiform. Notwithstanding its comments about the two leavepieces above, the Panel did not consider that the complainant had proved that describing the switch in the leavepiece as simple was misleading due to the time investment required by surgeries. Based on this very narrow allegation the Panel ruled no breach of the Code.

The Panel noted the complainant's concerns about the services offered by Napp to assist surgeries to switch from Seretide Evohaler to Flutiform. The Panel did not consider that there was any evidence before it to demonstrate that the service as implemented was included in individual sales targets or was only offered where a switch was guaranteed as alleged. No breaches of the Code were ruled.

The Panel considered the service in relation to the allegations about the promotional materials which focussed on switching patients to Flutiform. The Panel noted Napp's submission that account managers, including the complainant, were only allowed to introduce the service briefly and in accordance with the approved briefing. In October 2016, the complainant received live, 1 hour, on-line training on the new pharmacist-led review service and a follow-up briefing document to further clarify the process which specified the dos and don'ts for account managers in terms of non-promotional vs promotional calls and to which was attached the service introduction document. Napp noted that the complainant acknowledged that he had read and understood the briefing document. The Q&A stated that once a therapeutic review was in progress in a practice, account managers were not allowed to discuss the asthma review service with any of the health professionals in that practice. The briefing included relevant requirements from the Code. The Panel noted Napp's submission that the complainant was not informed about services within his target surgeries because there had been none whilst he was employed. The Panel further noted that the complainant had been instructed not to introduce the therapy review service.

The Panel noted that a briefing document, the training slides for account managers and the material provided by the complainant set out what discussions could take place in a promotional call and a non-promotional call. The promotional call flow diagram covered situations for customers who had agreed to switch either with no assistance or where assistance was requested. In both situations no therapeutic review would be offered. The flow diagram for the non-promotional call whereby the health professional had an interest in therapeutic review, the service introduction document was to be used and the practice referred to the ABM/ healthcare development manager (HDM). The Panel did not consider the training materials were sufficiently clear given that the main promotional message was for a switch to take place. In addition, leavepieces promoting the switch were to be left at the end of the call. There was no flow diagram or other instructions in the training material for the situation when the service was briefly introduced during a promotional call. It was not clear from the briefing documents for account managers that if a practice had agreed to switch, the service could not be offered in that practice even in a subsequent non-promotional call by the account manager or an ABM/HDM. However, this did not necessarily mean that the therapy review service offered by Napp was linked to the promotion of Flutiform as alleged. The Panel noted its comments and rulings above and although concerned about the relationship between the promotional messages about switching and the service which provided resource to change patients' medication including to Napp's product Flutiform, it did not consider that the complainant had shown on the balance of probabilities that the arrangements failed to meet the requirements of the Code. The Panel therefore ruled no breach of the Code. The Panel did not consider that the complainant had provided evidence that in pursuit of sales, Napp's compliance and briefing on switches from the ABM were very lax as alleged. The Panel consequently ruled no breach of the Code including Clause 2.

The complainant noted that he was pressurised to increase sales and call and contact rate via emails from Napp and the contract agency but that these communications did not refer to the Code regarding solicited/unsolicited and the frequency of calling and remaining Code compliant.

The Panel noted that the email provided by the complainant was sent by the third party agency and it discussed the complainant's progress in terms of improvement in his call rates and an increase in the number of 1:1 appointments confirmed. The Panel noted Napp's submission that the complainant was urged to increase his activity; he had only seen around one target GP surgery every 5 weeks. The Panel considered that whilst it might be preferable to refer to the requirements of the Code whenever calls or contacts were discussed with representatives, given the complainant's call rates there was no evidence to show that Napp, in encouraging him to increase his activity, had advocated either directly or indirectly any course of action which was likely to breach the Code. The Panel noted Napp's submission that all of its account managers were trained on the Code including its requirements regarding call and contact rates. The Panel ruled no breach of the Code. There was no evidence that Napp had failed to maintain high standards in this regard nor that the company had brought discredit upon or reduced confidence in the pharmaceutical industry. The Panel ruled no breach of the Code including of Clause 2.

The complainant noted that Napp organised an external speaker through a series of meetings as a tactic to access health professionals at and after the meeting, however Napp did not provide any briefing about whether the speaker was only to be offered at nurse meetings and not GP meetings. The complainant provided an email which showed that his ABM was reluctant to sponsor a meeting for a

particular group of GPs because previous experience showed that they were 'not of particular value'. The complainant considered his AMB's comments derogatory and unprofessional. The complainant further stated that the contract agency suggested in its communication with him that such a meeting was linked to a return on investment. The complainant was not sure if Napp was copied into this communication. The contract agency briefing to the complainant was simple and in breach with no written reference to the Code to protect itself as an organisation.

The Panel noted that Napp did not comment on the complainant's allegation that Napp had used the promotional meetings as a tactic to gain access to health professionals at and after the meetings. The Panel considered that it was not necessarily unacceptable for meetings to be a means of interacting with health professionals. Noting the complete absence of evidence, the Panel considered that the complainant had failed to show that there had been a breach of the Code with regard to the use of the meetings and so it ruled no breach of the Code including Clause 2. In its response Napp had cited a clause of the Code which was not relevant to the matter; no breach of that clause was ruled.

The Panel did not consider that in referring to a group of GP's as being 'not of particular value' the ABM had been derogatory as alleged; it was not necessarily unacceptable for a company to decide which health professionals to promote to based on a return of investment provided that requirements of the Code were met. The Panel did not consider that Napp had failed to maintain high standards; no breach of the Code was ruled.

An ex-employee, previously employed via a third party contract agency by Napp Pharmaceuticals Limited, complained about various practices within Napp.

The complaint included concerns about the promotion of Flutiform (fluticasone propionate/ formoterol). Flutiform indications included the regular treatment of asthma where a combination product (an inhaled corticosteroid (ICS) and a long action B2 agonist (LABA)) was appropriate. Flutiform 50mcg fluticasone/5mcg formoterol and Flutiform 125mcg fluticasone/5mcg formoterol were indicated in adults and adolescents aged 12 years and above. Flutiform 250mcg fluticasone/10mcg formoterol was indicated in adults only.

When writing to Napp, attention was drawn to the requirements of Clauses 2, 7.2, 7.4, 9.1, 15.9 and 19.2. Attention was also drawn to the supplementary information to Clause 15.4.

Napp noted that the complainant had his sales role contract terminated early due to unacceptable performance. Napp added that the complainant had passed the ABPI representatives examination some years ago and was employed by Napp in an area where he had worked previously and would thus be expected to know the local NHS environment and health professionals. With a number of years' experience selling, Napp considered that the complainant should have clearly known about the role of a primary care representative and the Code.

1 Switches to Flutiform

COMPLAINT

The complainant stated that one of his key performance indicators (KPIs) set by his area business manager (ABM) was to get ten target GP practices to 'switch' a percentage of asthma patients on GlaxoSmithKline's Seretide Evohaler (metered dose inhaler (MDI)) (salmeterol plus fluticasone) to the equivalent doses of Flutiform also an (MDI) within a specified timeframe.

Seretide Evohaler and Flutiform differed in their licensed indications and age range and so a 100% switch conversion could not be achieved which was referenced in Napp's leavepiece. Some of the practices that were chosen were not overspent on their respiratory prescribing budgets, which was just recently known to the complainant. The complainant stated that the percentage switch conversion was very unrealistic as there were no specific incentive schemes in place in three local, named clinical commissioning groups (CCG) to switch exclusively to Flutiform. The complainant stated that in addition GlaxoSmithKline gave a stated rebate in those three CCGs with Seretide Evohaler which meant that one of the named CCGs would only potentially save £114,396 by changing to Flutiform and not £142,995 as misleadingly stated in the leavepiece. The complainant believed that there was also a rebate in place for Sirdupla (salmeterol plus fluticasone, marketed by Generics UK) and the cost savings of Flutiform vs Sirdupla were also inaccurate. The complainant stated that the pressure from his ABM to convince practices was significant as he had to email his progress within his target practices weekly. The complainant referred to the sustained pressure to deliver on business outcomes and provided two in-house emails. The complainant further stated that emailing surgery prescribing data and patient switches could potentially breach data protection which was not noted and corrected by the ABM.

The complainant stated that Napp's marketing communication was to switch asthma patients from Seretide Evohaler to Flutiform, however, no reference was made to differentiate those asthma patients prescribed Seretide Evohaler who were also diagnosed with asthma-chronic obstructive pulmonary disease (COPD) overlap syndrome (ACOS); Flutiform was not licensed for COPD. The complainant stated that Napp's marketing message of a simple switch was misleading as administrative and/or clinic based reviews still required the surgery to invest significant time to audit appropriate patients, exclude those not within the licensed indications of Seretide Evohaler, explain the change, check inhaler technique and inform local community pharmacists to run down stocks of Seretide Evohaler. Even in Napp's own marketing communication, there were a number of differences between Seretide Evohaler and Flutiform, which meant that the medicines were not like-for-like formulations. A simple switch should not be taken

as like-for-like dose changes, but the actual process of making changes which was rather more involved and required firm commitment from the practice.

The complainant stated that switches could be achieved either by influencing practices to make the switch in-house and/or introducing a nurse (ORCA) and/or a pharmacist service, to practices if resource was required, which was seen as an independent non-promotional service but was set up in such a way to use this service to switch inhaler medicines to Flutiform. The complainant stated that he was briefed about this service via Napp's intranet site but received no specific in-house, face-to-face training from Napp and no validation of a promotional call and a non-promotional service call with customers. The complainant also stated that he was not informed when these service nurses and pharmacists would be present within his target surgeries. He could order non-promotional materials, despite not having been trained by the training department and ABM. The complainant alleged that, in pursuit of sales, compliance towards switches and Napp's briefing on switches from the ABM was very lax during discussions in the field. As Napp was driving business outcomes for switches, the non-promotional service should not have been used as the introduction was linked to Flutiform as a commitment from the customer to make changes through quality outcomes framework (QOF) and patient review in the first call and to then sign up to the service in the second call.

RESPONSE

Napp noted the complainant's statement that one of his KPIs set by his ABM/Napp was to get 10 target GP practices to 'switch' a percentage of asthma patients on repeats from Seretide Evohaler to the equivalent doses of Flutiform within a specified time frame. In that regard, Napp noted that the complainant's KPI document referred to his mutually agreed KPIs. For Flutiform sales, the document referred to achieving firstly, a stated switch success rate within 10 identified GP surgeries selected jointly with his ABM within 6-8 months of his 12 month contract. It was also stated that 'A switch success should be 50% or more of the Seretide Evohaler (an asthma inhaler) market share'. Napp stated that this was clearly not a 100% switch as alleged.

The second point of the KPI document was about the complainant calling on 80% (ie coverage) of at least 1 decision maker (GP, practice nurse or practice manager) in these top 10 GP surgeries within 4 months of being trained by to sell Flutiform in asthma. Napp stated that it would return to this point when addressing point 2 of the complaint concerning call and contact rate below.

Napp submitted that the complainant was almost correct in that there was one difference between the Seretide Evohaler and Flutiform in that Flutiform was not licensed for the treatment of asthma patients below the age of 12 years, whereas Seretide Evohaler was licensed for children from 5 years and up. Napp noted that a recently introduced cost-saving generic alternative to Seretide Evohaler, Sirdupla, could be a switch choice as part of medicines optimisation by a CCG. Sirdupla was only licensed for the treatment of asthma patients aged 18 years or over. The leavepiece provided by the complainant, concerned medicines optimisation for a named CCG, ie one of the three CCGs identified within his Flutiform KPI. Scrutiny of this document clearly highlighted in several areas the age differences when comparing Seretide Evohaler with Sirdupla or Flutiform as potential cost-saving asthma inhalers. Indeed, boxed text at the top of a page stated 'This document outlines the points to consider when discussing Flutiform or Sirdupla as alternatives to Seretide Evohaler for patients with asthma across [a named] CCG'. Also within this box the first bullet point stated in a balanced and factual way that 'Moving *appropriate* patients onto either Flutiform or Sirdupla can produce significant cost savings' (emphasis added). The use of 'appropriate' referred to patients identified within the licensed indications of each of the medicines. This contrasted markedly with the complainant's assertion that the document was all about 100% switch conversion from Seretide Evohaler to Flutiform MDI. The first table compared Seretide Evohaler with Sirdupla and Flutiform. The middle row of the table highlighted the age comparisons in the licensed indications for each of the 3 medicines: both Seretide Evohaler and Flutiform had a 'medium strength licensed for children > 12 years', whereas the Sirdupla column stated with a red cross to indicate that it was not licensed for this age range, and stated in the table that it was for 'adults > 18 years'. This fact was also reinforced in the orange box to the right of the middle of the page as it posed the question 'If switching to Sirdupla rather than Flutiform what about patients aged 12-17?'.

The second table of the leavepiece was entitled 'Potential annual cost savings in [a named] CCG'. Cost calculation information was provided to highlight how the doses and age ranges within the licensed indications for the three medicines was calculated. The final column provided again the numbers of appropriate patients for switch to Flutiform or Sirdupla. This did not imply or mislead to draw a conclusion that Napp advocated a 100% switch to Flutiform and for all ages. The cost calculation information explained that not all ages could be switched from Seretide Evohaler to Sirdupla because of the doses and licensed age range of >18 years for Sirdupla. The second bullet point of the cost calculation information stated that 'The number of Seretide Evohaler patients appropriate for Flutiform had been modelled from prescribing data using national patient data *to account for the licensed indication and age range for Flutiform*' (emphasis added). A bold orange background box further emphasised the licensed indication of Flutiform running along the bottom of the page but in bold clear font of the text 'flutiform is licensed for asthma maintenance therapy for patients 12 years and older) low and medium strengths), adults (all strengths)'. Napp firmly disagreed with the complainant that this material advocated a 100% switch from Seretide Evohaler to Flutiform. Napp submitted that the information, claims and comparisons within the

leavepiece were accurate, balanced, fair, objective and unambiguous for the reasons provided. They did not mislead either directly or by implication, by distortion, exaggeration or undue emphasis. The information and comparisons were substantiated by the accompanying references within the material. Furthermore, a health professional could just as easily decide to switch patients to Sirdupla rather than Flutiform. Napp asserted that the promotion of Flutiform relevant to the complainant's first allegation was not in breach of Clauses 7.2 or 7.4. High standards had been maintained and thus Napp denied a breach of Clause 9.1. Napp submitted that the complainant was briefed on the material by his manager and his mentor and had confirmed that he understood how to use it appropriately and with the right customers (ie GP respiratory/prescribing leads, not necessarily nurses). Napp therefore denied a breach of Clause 15.9. Napp submitted that the briefing document offered the complainant direct contact with a Napp market access manager or a brand assistant if he had any questions. Napp was not aware that the complainant had contacted either of these two people or his manager to discuss any concerns. Napp noted that the last bullet point of the briefing document in the 'Actions' section stated 'Please make sure you are clear on the data and its assumptions before using it with your customers'. Napp queried why the complainant did not raise any issues he had with Napp whilst contracted to it?

Napp noted the rebates stated by the complainant but queried how and from where such data had been obtained given that rebate percentages were confidential. Although price rebates might be offered to local CCGs, they were confidential contractual arrangements between the pharmaceutical company and the NHS payors and were therefore not publicly available. It would be inappropriate for Napp to speculate on the potential rebate percentages offered by its competitors, as this might be inaccurate, misleading and therefore not a fair comparison in breach Clauses 7.2 and 7.4. Hence the leavepiece used to compare prices had been modelled on national prescribing data to ensure licensed age ranges were taken into account. The table was clearly labelled as such and NHS list prices were used to ensure accuracy and fair representation of the published prices, upholding Clauses 7.2, 7.4 and 9.1.

Napp submitted that it was normal for business managers to set clear expectations and put good communications in place with their reports. The complainant had been supported by his manager with regular email correspondence, monthly face-to-face meetings and field visits. The complainant's ABM had, *inter alia*, stated when interviewed by Napp and the senior compliance manager that as the complainant was new in the role it was not unreasonable to suggest weekly reports if possible. The ABM, however, reported concerns about the quality of that feedback (details were provided).

Napp noted that the complainant was allocated a fellow representative as a mentor to provide help, advice and support. Such contacts would also highlight areas for development or improvement especially if KPIs were not being met or selling methods were inappropriate. It was therefore surprising that the complainant felt under significant pressure to do his job which was to sell in a responsible, ethical and professional manner. The complainant had provided two example emails to highlight 'sustained pressure to deliver on business outcomes'. One was a follow-up email from his manager after accompanying him to a GP practice lunchtime meeting. Within the email it was the complainant who was quoted by his manager in paragraph 2: 'I have a lunch meeting at the practice on [date] and [a named doctor] will tell me when in April and how many Seretide Evohaler patients switched to Flutiform'. Such information would form part of the agreed KPI that a successful switch would be at least 50% of the surgery's Seretide Evohaler market share – which was publicly available non-confidential information. Napp fundamentally disagreed that the emails relied upon by the complainant were in breach of data protection legislation. In particular, the emails did not contain any specific data about individual identifiable patients and the information sought was entirely anonymous in nature. To the extent that the emails mentioned individual health professionals, this information was a matter of public record and was being used by Napp for entirely legitimate business purposes and was subject to appropriate safeguards. Napp therefore refuted any breach of data protection for these reasons, and considered that it had maintained high standards consistent with Clause 9.1. It was also clear from the contents of the email from the analysis of the complainant's manager that the likelihood of switch occurring in this practice was low, calling into question the complainant's sales abilities. Finally, the email highlighted the complainant's selling skills by suggesting what questions he should ask the GP. It was therefore not surprising that the complainant's manager wished to be updated and importantly the email concluded with a closing sentence which stated 'You did say that you agreed with all of these points, please do let me know your plans for moving this forward'. If the complainant agreed, then Napp now concluded that he had since changed his opinion and provided it as an example of sustained pressure as subsequent events unfolded and he lost his job.

Turning to the second email, this was dated 10 days earlier than the email discussed above. The email was from the complainant's manager to provide written details of a business review meeting held 3 days earlier. The email first discussed the complainant's progress against his mutually agreed KPIs 5.5 months (22 weeks) after he had begun selling for Napp. Out of 30 GP surgeries (accounts) the complainant had only managed to see four ie around 1 surgery every 5 weeks.

The second email referred to practice level data of patients switching. This information would form part of the agreed KPI that a successful switch would be at least 50% of the surgery's Seretide Evohaler market share – which was publicly available non-confidential information.

Napp submitted that the complainant was factually incorrect in that neither Seretide Evohaler nor Flutiform were licensed to treat ACOS or COPD.

There was therefore no need for such a consideration within its materials. It was actually Seretide Accuhaler, a dry powder inhaler, that was licensed to treat both asthma and COPD. Napp submitted that it was aligned with the supplementary information to Clause 19.1 in promoting a simple switch from Seretide Evohaler to Flutiform in appropriate asthma patients. Napp also did not pay for such switches either directly or indirectly. Documents provided by the complainant had been extracted from complete documents, and so were incomplete and out of context. Napp provided copies of the complete documents and briefing documents. One document was entitled 'A simple switch to Flutiform'. The switch to Flutiform from Seretide Evohaler could be considered simple as both products:

- had very similar licensed indications for asthma maintenance therapy (Seretide had a paediatric licence, whereas Flutiform was for 12 years and older).
- any differences in licensed age ranges were clearly stated.
- in all Flutiform promotional materials the therapeutic indication was stated in the prescribing information and COPD/ACOS were never mentioned. Napp only promoted Flutiform in accordance with the licensed indication.
- were pressurised aerosol metered dose inhalers (MDIs) (some inhalers were dry powder devices requiring a different inhalation technique)
- contained the same inhaled corticosteroid, so no steroid dose conversion was necessary, unlike other asthma inhalers, eg Fostair (formoterol fumarate/beclometasone dipropionate marketed by Chiesi).

Napp submitted that a leavepiece (ref UK/FLUT-16007), promoted a switch to Flutiform and included the licensed indication, plume data and data from Kemppinen *et al* (2016). Notably, when discussing the results of Kemppinen *et al* on page 3 of the leavepiece, it was clearly stated that patients who changed treatment from Seretide Evohaler to Flutiform were controlled asthma patients. This statement had been included to ensure the nature of the patients in the study was clear to health professionals to allow for informed clinical decisions and ensure patient safety was not jeopardised.

Any switch between medicines required administrative and practical effort on the part of the health professionals. The statement 'A simple switch' was intended to reinforce the similarities between the products which enabled a change of medicine to be as simple as the health professional chose to do so. It was also in line with the Code (Clause 19.1, supplementary information) which stated that 'it would be acceptable for a company to promote a simple switch from one product to another'. Napp did not facilitate the switch as implementing this change was the clinical decision of the health professional. The complainant failed to be specific when presenting his arguments about an extract from a full leavepiece (ref UK/FLUT-16063a) about the differences between Flutiform and Seretide Evohaler. The table highlighted that Flutiform had a different long-acting beta agonist (formoterol) and a colour coded, patient facing dose counter. Napp submitted that these did not lead to a conclusion that a switch from Seretide Evohaler to Flutiform was complicated. Napp noted the complainant's comments about the nurse (ORCA) and/or the pharmacist service and explained that whilst the complainant worked for Napp there were no therapy review services undertaken in the business region in which he was employed. The complainant confused the promotion of switch services with the non-promotional therapy review service that Napp provided as a service to medicine. Napp strongly refuted the assertion that its therapy review service was actually a switch activity which would be a clear and serious breach of the Code. Napp noted that in Case AUTH/2808/12/15 the full details of the nurse-led ORCA therapy review service were scrutinised and the service was not found to be a promotional activity. Napp also provided full and complete details of the pharmacist-led asthma therapy review service including the criteria for selecting practices. The service was offered through a third party. Napp used two providers because feedback showed that some GP practices preferred therapy reviews to be undertaken by nurses whilst others preferred them to be led by a pharmacist. Both therapy review services were designed, organised and conducted in the same way, differing only by the use of either pharmacists or nurses to deliver the service.

Napp did not monitor any sales uplift in areas where the pharmacist-led or ORCA therapy review services had been conducted. Neither were representatives' bonuses based on Interface service to the NHS. A senior scientific advisor oversaw the service, as this was a non-promotional role and sat within the medical department, and had regular contact with the Interface head of clinical services, along with provision of a management report to discuss any operational issues.

Napp submitted that the sales teams, including their managers, did not have access to the Interface client reporting metrics as this was a non-promotional activity. The report was discussed within the medical and Code compliance department which allowed Napp to ensure with Interface that it offered the service in accordance to the provision of medical and educational goods and services (MEGS) as set out in Clause 19.2.

Napp set sales targets but pharmacist-led asthma therapy reviews were not included in the calculation that it used to determine what growth a region could deliver.

The number of therapeutic reviews by region/area were not included at any point in the calculation of the targets and were not monitored in relation to measuring success against that target. Napp did not include any planned or future Interface asthma reviews in the calculations used to determine the sales targets and Napp did not incentivise staff based on these reviews and no individual sales person's target was affected by the asthma reviews.

Napp submitted that the complainant's statement that he was briefed on the pharmacist-led review

service via Napp's intranet site but received no specific in-house, face-to-face training from Napp and no validation of a promotional call and non-promotional service call with customers was incorrect. Account managers, including the complainant, were only allowed to introduce the service briefly as allowed by the Code and in accordance with the briefing document (ref UK/RES-16082c). Napp submitted that the complainant received (along with other account managers) a live 1 hour, on-line WebEx training on the new pharmacist-led review service and process from. This was a 'virtual' face-to-face training to avoid field-based account manager needing to travel to head office. The training included a Q&A session and a follow-up briefing document to further clarify the process (ref UK/RES-16082c) to which was attached the service introduction document. Napp noted that the complainant acknowledged that he had read and understood this briefing document.

The briefing document (ref UK/RES-16082c) specified the dos and don'ts for account managers in terms of non-promotional vs promotional calls as represented by the flow diagram on page 2. The Q&A section of this document specified that once a therapeutic review was in progress in a practice, account managers were not allowed to discuss the asthma review service with any of the health professionals in that practice. It also detailed the requirements of the therapeutic review service in accordance with the Code (MEGS and therapeutic review).

Napp's ABMs and healthcare development managers (HDMs) were the only people allowed to discuss the therapeutic review service in detail in a non-promotional call once a practice had expressed interest following the brief introduction.

The ABMs and HDMs were all trained face-to-face according to the detailed information in the training slide (ref UK/RES-16082h) including a specific briefing document for the ABMs/HDMs (ref UK/RES-16082b) clearly stating some of the requirements such as below:

> 'You may introduce the service by giving a brief description of the service during the promotional call but may not instigate a detailed description about the service at the same time as a call when products are being promoted, this should be done in a non-promotional call.
>
> **You should ensure the following is adhered to:**
>
> - Napp support of this review must **NOT** be dependent on the customer prescribing a Napp product. This must be neither the fact in practice nor the impression given either verbally or in any documents connected with the project, internal or external
> - The prescribing of specific products must **NOT** be linked to the service either in conversation, or in writing, with any customer
> - Detailed discussion about the service must **NOT** be initiated at the same time as a call at which products are promoted.'

In addition, following the comprehensive training, the ABMs/HDMs had to score 100% in a validation test before any introduction of this service to practices (ref UK/RES-16082i).
Napp submitted that the complainant was specifically informed by his manager not to introduce the therapy review service and if he did so this was against instruction. The complainant's ABM when interviewed was critical about the complainant's understanding of the difference between a promotional and a non-promotional call and his selling skills (details were provided).

Napp submitted that neither the complainant nor anyone in his team introduced the asthma therapy review service. He was not therefore engaged in any form of validation training in call with a customer. He was not informed when these service nurses or pharmacists would be within his target surgeries because there never were any therapy review services within his entire region during the time he was employed. Theoretically as he had been trained on introducing the pharmacist-led asthma therapy review service then he could have access to the document. Yet again, if he did so this was against his manager's specific instructions and guidance. Napp would be interested to ask the complainant whether he did introduce a therapy review service to any of his target practices. Napp absolutely refuted the complainant's allegation that in pursuit of sales, compliance towards switches and Napp's briefing on switches from his manager was very lax during discussions within the field. Napp queried where the evidence for this was. Napp agreed that it was driving for business outcomes by the legitimate use of promoting switch, but did not confuse this with that of a *bona fide*, comprehensive asthma therapy review service. The complainant asserted that a health professional 'customer is encouraged to make changes through QOF and patient review in the first call and then to sign up the service in the second call'. Napp completely rejected this and challenged the complainant to provide any substantive evidence that this was the case.

In conclusion, Napp strongly disagreed with all of the complainant's allegations; it had provided comprehensive evidence that it had robust and compliant processes and training to implement a genuine non-promotional therapeutic review service via its third party supplier. In addition, a previous Napp case had been scrutinised by the Panel and no breaches of the Code were ruled in relation to Napp's ORCA service. Integral to this non-promotional service to the NHS, Napp had paid particular focus on Clause 19.2. Napp submitted that it had always maintained high standards as per Clause 9.1, and this activity had not brought discredit upon, or reduced confidence in the pharmaceutical industry as per Clause 2.

In response to a request for further information, Napp provided references from the leavepiece concerning medicines optimisation for a named CCG (ref UK/FLUT-15163) together with an explanation of each as follows:

- *MIMS Online [Accessed March 2016] Respiratory Asthma, COPD, Beta2 agonists, long-acting corticosteroids.* This referenced the three MIMS online resource to support the prices quoted in the leavepiece. Napp submitted that all prices were correct and no prices had changed since March 2016 for flutiform, Seretide Evohaler or Sirdupla.

- *GP Prescribing Data Extract, Health and Social Care Information Centre (HSCIC), 2015.* Napp submitted that this data provided the annual spend for many CCGs. Highlighted was the annual spend in the named CCG on the three strengths of Seretide Evohaler. The values were used as a starting point to derive patient numbers (see reference 8 below).

- *Patient Data, IMS Information Solutions UK Ltd, May 2015.* The data (under tab labelled 'calculation') took the annual spend on Seretide Evohaler in the named CCG (from reference 7 HSCIC data above, highlighted in pale orange) and what this translated into was actual patient numbers for each strength. The patient numbers were highlighted in yellow. Those numbers appeared in the table within the leavepiece. The potential cost savings were calculated by only taking those eligible Seretide Evohaler patients who would be within the licence for flutiform (because Seretide also had a paediatric licence). It then applied the flutiform and Sirdupla prices and subtracted that number from the cost of Seretide Evohaler to derive a cost saving, if there was a 100% switch of those patients within the flutiform and Sirdupla licences.

- *Methods for calculating flutiform appropriate patients from Seretide Evohaler Prescribing Data UK/FLUT-15142c.* Napp submitted that this reference provided detailed methodology for calculating the number of flutiform appropriate patients from Seretide Evohaler prescribing data. All caveats which were specified in reference 9 were included next to the table in the leavepiece. This clearly explained the methodology and the maths. The document included a worked example of calculations used for a different named CCG.

- *Methods for calculating Sirdupla appropriate patients from Seretide Evohaler Prescribing Data UK/FLUT-15142d.* Napp submitted that this reference substantiated the information in the leavepiece and provided the methodology for calculating number of Sirdupla appropriate patients from Seretide Evohaler. As above all mandatory caveats were included on the leavepiece.

PANEL RULING

The Panel noted that the parties' accounts differed; it was difficult in such circumstances to determine precisely what had happened. A judgement had to be made on the available evidence whilst noting that the complainant bore the burden of proof and had to establish his case on the balance of probabilities.

In relation to the complaint made to the PMCPA, the Panel was only able to consider matters within the scope of the Code. It considered the complaint as follows.

The Panel did not consider that the complainant alleged that Napp was advocating a 100% switch from Seretide Evohaler to Flutiform MDI; the complainant clearly stated that the fact that a 100% switch conversion could not be achieved was referenced in Napp's leavepiece.

The Panel noted that the complainant's concern was that the percentage switch conversion as set out in his KPIs by his ABM was unrealistic as there was no specific incentive schemes in place in any of the three named CCGs to switch exclusively to Flutiform MDI from Seretide Evohaler. The Panel noted that it appeared that the KPIs had been agreed by the complainant and his ABM and required the complainant to achieve a stated switch success rate within ten target GP practices within 6-8 months. It was stated that a switch should be 50% or more of a surgery's Seretide Evohaler marketshare to the equivalent dose of Flutiform. The Panel considered that the absence of incentive schemes in the CCGs did not necessarily mean that a switch would be unrealistic. Much would depend on whether health professionals considered that the benefits of a switch outweighed the work required to action it. The Panel did not consider that the complainant had proven that, on the balance of probabilities, the percentage switch was unrealistic for the reasons alleged. Nor that Napp in setting this KPI advocated, either directly or indirectly, any course of action which would be likely to lead to a breach of the Code. No breach of Clause 15.9 was ruled.

The Panel further noted the complainant's concern that there was a stated rebate in place in the three named CCGs for GlaxoSmithKline's Seretide Evohaler and Sirdupla and therefore the cost saving figures in the leavepiece concerning medicines optimisation for one of the named CCGs (ref UK/FLUT-15163) were inaccurate and misleading. The Panel noted Napp's submission regarding the confidentiality of rebate percentages. The Panel further noted Napp's submission that the leavepiece compared NHS list prices and national prescribing data to ensure licensed age ranges were taken into account when calculating the potential cost savings. The Panel noted Napp's submission that the complainant had been briefed on the leavepiece and confirmed that he understood how to use it. The Panel considered that although it might be possible to buy medicines at less than the NHS list price due to the availability of discounts etc, it was not unreasonable for companies to base price comparisons on the NHS list price when this was made clear. The Panel did not consider that on the material before it the complainant had proven that, on the balance of probabilities, the leavepiece was misleading in that regard. On the narrow grounds alleged the Panel thus ruled no breach of Clauses 7.2, 7.4 and 9.1.

The Panel noted the complainant's allegation that he was under significant pressure from his ABM to convince practices to switch; the complainant was required to communicate his progress in each target practice on a weekly basis. The Panel reviewed two

emails provided by the complainant in support of this allegation and the allegation that discussing surgery prescribing data and patient switches in emails could potentially breach data protection laws. The first email was a follow-up email to the complainant from the ABM following the ABMs attendance at one of the complainant's GP practice meetings. The Panel noted Napp's submission that the email content displayed the ABM's concern that the likelihood of a switch in the named GP practice was low and this called into question the complainant's sales abilities. This email further highlighted the complainant's selling skills and suggested questions that he should be asking the GP. The second email predated the first and provided details of a business review held between the complainant and his ABM. The email highlighted the complainant's progress against his mutually agreed KPIs.

The Panel did not consider that it was necessarily unacceptable for ABMs to require weekly progress updates provided that it was done in a way that did not contravene the requirements of the Code. The Panel did not consider that the complainant had proven that the area business manager had applied sustained pressure on the complainant to deliver on business outcomes that did not comply with the Code as alleged. No breach of Clause 9.1 was ruled. Nor had the complainant proved that that the ABM requesting weekly updates would advocate directly or indirectly any course of action that would be likely to breach the Code. No breach of Clause 15.9 was ruled.

The Panel noted Napp's submission that the emails provided by the complainant did not contain any specific data about individual identifiable patients and the information sought was entirely anonymous in nature. The Panel further noted Napp's submission that to the extent that the emails mentioned individual health professionals, this information was a matter of public record and was being used by Napp for entirely legitimate business purposes and was subject to appropriate safeguards. The Panel was concerned about activities in relation to the Code. It was not for the Panel to determine whether Napp's activities were in line with data protection requirements *per se*.

Clause 1.11, however, stated that companies must comply with all applicable codes, laws and regulations to which they are subject. This clause had not been raised and the complainant had not provided evidence that the companies had been found in breach of data protection requirements. Given the circumstances the Panel therefore ruled no breach of Clause 9.1.

With regard to the use of the medicine for asthma overlap syndrome (AOS) and COPD as Flutiform MDI was not licensed for COPD, the Panel noted Seretide Evohaler's SPC and Napp's submission that Seretide Evohaler was not licensed to treat ACOS or COPD and therefore there was no need for such a consideration within its materials which referred to switching including the leavepieces (ref UK/FLUT-15163, UK/FLUT-16063a, and UK/FLUT-16007). Seretide Accuhaler was licensed to treat both asthma and COPD. The Panel did not consider that the material was misleading in that regard and no breach of Clause 7.2 was ruled.

The Panel noted that the complainant provided the incomplete front page of a document which stated 'A simple switch to Flutiform Real Difference' and an extract from another leavepiece which included a table highlighting differences between Seretide Evohaler and Flutiform. The Panel noted the complainant's allegation that describing the switch as simple was misleading as a simple switch should not be taken as like for like dose changes but should take into consideration the process of making changes which was more involved and required significant time investment from practices. The Panel noted that under the Code it would be acceptable for a company to promote a simple switch from one product to another but not to assist a health professional in implementing that switch. The Panel noted that it would take time to review patients who potentially could be switched but considered that the reference to 'a simple switch' in the supplementary information to Clause 19.1 Switch and Therapy Review Programmes referred to switching from one medicine to another in relevant patients. The Panel noted that the complete document provided by Napp (ref UK/FLUT-16007) was titled 'A simple switch to Flutiform can make a real difference to your patients'. The leavepiece discussed some of the features of Flutiform followed by the results of a study in which patients were switched from Seretide Evohaler to Flutiform.

The Panel further noted Napp's submission that 'simple' was used to describe the switch from Seretide Evohaler to Flutiform as both products had very similar licensed indications for asthma maintenance therapy and any differences in licensed age ranges were clearly stated; both were pressurised aerosol MDIs; and both contained the same inhaled corticosteroid, so no steroid dose conversion was necessary.

The Panel noted that the leavepiece (ref UK/FLUT-16007) referred to the licensed indication of Flutiform including the age range for the various strengths and that it was for patients 12 years and older (low and medium strengths) and adults (all dosage strengths). The leavepiece stated that patients previously controlled on Seretide Evohaler 250mcg could be switched to Flutiform 250mcg and maintain good asthma control. A bullet point below in less prominent font stated that this was based on a 12-week pragmatic, open-label, randomised, controlled, non-inferiority trial in 225 adult patients with asthma. The leavepiece did not include the licensed indication for Seretide including the age range or the differences in licensed age ranges between Flutiform and Seretide as stated by Napp. The Panel queried why the leavepiece made no reference to the fact that patients aged 5 to 12 could not be switched from Seretide Evohaler to Flutiform. The second leavepiece referred to by the complainant (ref UK/FLUT-16063a) which was titled 'Do you have a medicines optimisation plan to switch asthma patients from Seretide Evohaler? Why choose Flutiform' included the claim 'A simple switch can make a real difference'. This leavepiece

asked the reader what was important to them when switching patients from Seretide Evohaler to Flutiform. The leavepiece compared Flutiform to Seretide Evohaler and Fostair in relation to a number of features including change in steroid from Seretide Evohaler, patient-facing dose indicator and refrigeration required prior to dispensing. Page 3 compared Flutiform and Fostair in terms of dose delivery and steroid percentage at the lowest daily dose. Whilst the leavepiece stated the licensed indication of Flutiform including the age range for the various strengths, it made no reference to the licensed indications of Seretide or Fostair including the age range. There would be patients who could simply be changed from Seretide to Flutiform. Notwithstanding its comments about the two leavepieces above, the Panel did not, however, consider that the complainant had proved that describing the switch in the leavepiece as simple was misleading due to the time investment required by surgeries in auditing patients appropriate for switching as alleged. Based on this very narrow allegation the Panel ruled no breach of Clause 7.2.

The Panel noted the complainant's statement that switches could be achieved either by influencing practices to make the switch in-house and/or introducing a nurse (ORCA) and/or pharmacist service, to practices if resource was required. The complainant alleged that although seen as an independent non-promotional service it was set up in such a way to switch inhaler medicines to Flutiform. The complainant stated that he was briefed about this service via Napp's intranet site but received no specific in-house, face-to-face training from Napp and no validation of a promotional call and non-promotional service call with customers. The complainant also stated that he was not informed when these service nurses and pharmacists would be present within his target surgeries. He could order non-promotional materials despite not having been trained by the training department and ABM. The complainant alleged that, in pursuit of sales, compliance towards switches and Napp's briefing on switches from the ABM was very lax during discussions in the field. As Napp was driving business outcomes for switches, the non-promotional service should not have been used as the introduction, was linked to Flutiform as a commitment from the customer to make changes through quality outcomes framework (QOF) and patient review in the first call and to then sign up the service in the second call.

The Panel noted Napp's submission that in a previous Napp case the OCRA service had been scrutinised by the Panel and no breaches of the Code were ruled in relation to the service. The Panel noted that it could only rule based on the evidence provided by both parties in relation to the allegations made. Each case was considered on its own merits. The Panel's ruling in Case AUTH/2808/12/15 in relation to the OCRA therapy review service stated that 'Whilst some concerns were outlined the Panel did not consider that the complainant in that case had proved his complaint on the balance of probabilities. The Panel did not consider that there was any evidence before it to demonstrate that the service as implemented was included in individual sales targets or was only offered where a switch was guaranteed as alleged. The Panel thus ruled no breach of Clauses 18.1 and 19.1. Subsequently no breach of Clauses 9.1 and 2 were also ruled'.

Turning back to Case AUTH 2956/5/17, the Panel noted there were differences since it considered the previous case. The current documents provided were dated between September and December 2016. There was no indication whether the materials had simply been changed to reflect the new pharmacist-led service or other changes had been made. The Panel had to consider the service in relation to the allegations about the promotional materials which focussed on switching patients to Flutiform. The Panel noted Napp's submission that account managers, including the complainant, were only allowed to introduce the service briefly and in accordance with the briefing document (ref UK/RES-16082c). Napp had further submitted that the complainant received a live 1 hour, on-line WebEx training on the new pharmacist-led review service and process. This was a 'virtual' face-to-face training which included a Q&A session and a follow-up briefing document to further clarify the process (ref UK/RES-16082c) which specified the dos and don'ts for account managers in terms of non-promotional vs promotional calls and to which was attached the service introduction document. Napp noted that the complainant acknowledged that he had read and understood the briefing document. The Q&A stated that once a therapeutic review was in progress in a practice, account managers were not allowed to discuss the asthma review service with any of the health professionals in that practice. The briefing included relevant requirements from the Code. The Panel noted Napp's submission that the complainant was not informed when these service nurses or pharmacists would be within his target surgeries because there were no therapy review services within his entire region during the time he was employed. The Panel further noted that the complainant was informed by his manager not to introduce the therapy review service and if he did so it was against instruction.

The Panel noted that a briefing document (ref UK/RES-16082c), the training slides for account managers and the material provided by the complainant set out what discussions could take place in a promotional call and a non-promotional call. The promotional call flow diagram covered two possible situations for customers which had agreed to switch, firstly where there was no request for assistance and secondly where assistance was requested. In both situations no therapeutic review would be offered. The flow diagram for the non-promotional call whereby the health professional had an interest in therapeutic review, the service introduction document was to be used and the practice referred to the ABM/HDM. The Panel did not consider the training materials were sufficiently clear given that the main promotional message for account managers was for a switch to take place. In addition, leavepieces promoting the switch (refs UK/FLUT-16007, UK/FLUT-16063a and UK/FLUT-15163) were to be left at the end of the call. There was no

flow diagram or other instructions in the training material for the situation when the service was briefly introduced during a promotional call. It was not clear from the briefing documents for account managers (ref UK/RES-16082c) or ABMs/HDMs (ref UK/RES/16082b) that if a practice had agreed to switch, the service could not be offered in that practice even in a subsequent non-promotional call by the account manager or an ABM/HDM. However, this did not necessarily mean that the therapy review service offered by Napp was linked to the promotion of Flutiform as alleged. The Panel noted its comments and rulings above and although concerned about the relationship between the promotional messages about switching and the service which provided resource to change patients' medication including to Napp's product Flutiform, it did not consider that the complainant had shown on the balance of probabilities that the arrangements failed to meet the requirements of Clause 19.2. The Panel therefore ruled no breach of Clause 19.2. The Panel did not consider that the complainant had provided evidence that in pursuit of sales, Napp's compliance and briefing on switches from the ABM were very lax as alleged. The Panel consequently ruled no breach of Clauses 9.1 and 2.

2 Call rates

COMPLAINT

The complainant pointed out that a Napp and contract agency communication which required for him to increase his call and contact rate did not reference Clause 15.4 of the Code relating to solicited/unsolicited and the frequency of calling and remaining Code compliant. The pressure to increase sales and call rate without referencing the Code was written freely in email communications both from Napp and the contract agency email. The complainant understood that the contract agency was not a member of the ABPI, however the instruction to increase his call rate was made by it as well and therefore there was an issue of responsibility from the agency to promote the Code on behalf of its client, Napp, which did not happen.

RESPONSE

Napp submitted that it did not require a call rate number from any of its account managers but did expect relevant and compliant customer contact to make sales in order to be a profitable business. All account managers were trained as part of Code compliance training and updates on the requirements of the Code with regards to frequency/the number of calls made on a doctor or other prescriber by a representative which should not exceed three on average per year. It was thus therefore highly surprising that the complainant felt surprised that he was put under pressure by his manager and contract agency to increase his contacts and calls with relevant health professionals. Napp stated that it was clear from the manager that the complainant was never asked to breach Clause 15.4; he was employed full time, working an average of 37.5 hours per week. Given that the complainant had seen only one target customer GP surgery per 5 weeks (=25 working days) when he was reviewed in 2016 Napp queried whether the complainant seriously proposed that that was acceptable.

Napp stated that this was further highlighted later in the email when discussing the sales activity which the complainant had recorded within the online customer relationship management (CRM) system. The email stated that 'In the period [in question] you appear to have seen around 20 GPs face-to-face, and just 4 practice nurse calls.' This was a period of 18 weeks and so was about 1 GP per week. A document provided by the complainant explained that he was asked to increase his call rates by the contract agency. There was no evidence in this email that the complainant was asked to breach Clause 15.4, either directly or indirectly.

Napp stated that it had interviewed the complainant's manager in detail and corresponded with the contract agency in order to establish his activity. The contract agency had stated that 'During legitimate performance management, [the complainant] was urged by [his] manager to increase [his] general activity, which was abnormally low. At no time did the agency ask or encourage [the complainant] to breach [the Code], either Clause 15.4 or any other provision. In particular, [he] was not asked or encouraged to increase frequency of calls on the same health professionals, nor to override such health professionals' wishes or cause inconvenience to them. [The agency] is well aware of the provisions of the [Code] and takes reasonable steps to ensure that they are not breached by its representatives'.

Napp followed up this response by asking what was meant by 'abnormally low' activity and was informed that this was with reference to the health professional calls recorded by the complainant in the CRM system. Napp also asked about what 'reasonable steps' were taken by the contract agency concerning the Code and received the following response:

> 'For experienced representatives, we ensure that we see a valid ABPI certificate prior to joining. In addition, we take and keep a copy of the ABPI certificate on file. We ensure employment references are requested and checked. We offer further support and training where required (for example if knowledge gaps are identified) working in conjunction with the client manager.'

Napp submitted that the complainant's ABM gave a very poor summary of the complainant's performance which led to the decision to terminate his contract early (details were provided).

Napp stated that, in conclusion, it was very clear that it had not breached Clause 15.9 (together with the supplementary information to Clause 15.4), it had maintained high standards at all times (not in breach of Clause 9.1) and that its employees had not undertaken any activities that would bring discredit upon the pharmaceutical industry and therefore was not in breach of Clause 2.

PANEL RULING

The Panel noted the email provided by the complainant as evidence that he was pressurised to increase his call and contact rate without reference to Clause 15.4 and remaining Code compliant. This email, sent by the third party agency discussed the complainant's progress in terms of improvement in his call rates and an increase in the number of 1:1 appointments confirmed. The Panel noted Napp's submission that the complainant was urged to increase his activity. The complainant had only seen someone from 4 out of his 30 accounts in five and a half months which equated to around one target GP surgery every 5 weeks. The Panel considered that whilst it might be prudent and good practice to refer to the requirements of Clause 15.4 whenever calls or contacts were discussed with representatives, given the complainant's call rates there was no evidence to show that Napp in encouraging the complainant to increase his activity had advocated either directly or indirectly any course of action which was likely to breach the Code. The Panel noted Napp's submission that all of its account managers received training with regard to the Code including the frequency/ number of calls made on a health professionals per year. The Panel ruled no breach of Clause 15.9. There was no evidence that Napp had failed to maintain high standards in this regard nor that the company had brought discredit upon or reduced confidence in the pharmaceutical industry. The Panel ruled no breach of Clauses 9.1 and 2.

3 Speaker meetings

COMPLAINT

The complainant noted that Napp organised an external speaker through its Chest Sounds meetings as a tactic to access health professionals and follow-ups with the attendees after the meeting, however Napp did not provide any briefing about whether the speaker was only to be offered at nurse meetings and not GP meetings. The complainant provided documents where his ABM was reluctant to sponsor a meeting for a GP, writing in an email that a previous representative on the territory had 'suggested they were not of particular value'. The complainant was concerned that his ABM had been derogatory about a health professional and his GP group who were all prescribers, and was not offering a service based upon an interaction of a previous territory representative. The complainant alleged that Napp had shown unprofessional behaviour towards a health professional and his GP group. The complainant further stated that the contract agency suggested in its communication with him that such a meeting was linked to a return on investment. The complainant was not sure if Napp was copied into this communication. The contract agency briefing to the complainant was simple and in breach with no written reference to the Code to protect itself as an organisation.

RESPONSE

Napp noted the complainant's comments about speaker meetings and that his manager had been reluctant to support one meeting with a health professional because the GP was 'not of particular value'. Napp also noted the complainant's reference to the contract agency that meetings were linked to a return on investment. In that regard Napp stated that as part of its promotional activity within asthma it had found that, within the region covered by the complainant, asthma nurses in particular valued education on how to listen to and understand respiratory chest sounds. This had become a popular speaker meeting and was also a promotional meeting for Flutiform (examples provided). The speaker was a respiratory consultant physician. Napp submitted that from discussion with the complainant's manager it was clear that there was no need for a briefing on the target nurse audience; his manager had verbally agreed with the complainant that he would arrange such a meeting to interact with practice nurses interested in asthma. The complainant's manager had explained that what was missing from the complainant's letter was that despite several reminders he did not arrange the meeting, which he was supposed to do via a GP practice manager. The complainant's manager found this unprofessional and frustrating as dates and organisation with the consultant physician speaker were potentially damaging the relationship as the speaker would travel some distance to deliver the presentation. Finally, following several reminders from his manager, the complainant suggested an alternative 'quick fix' solution for the Chest Sounds meeting to be delivered to a well-known group of local GPs. This was referred to in an email from his manager to the contract agency. A particular sentence was highlighted within the email '([representative] who worked this territory previously suggested they were not of particular value)'. Napp noted that the complainant alleged that this was a derogatory comment about a GP and his GP group 'who were all prescribers.' In actual fact the feedback that the complainant's manager had had was that this group of GPs were known informally locally as the 'middle-aged doctor' group which had existed for some years and that around half were retired and hence this would be inappropriate, ie 'not of particular value'. Retired GPs could be perceived as members of the public if not in active NHS employment, and so it would be in breach of the Code to promote to them. This was why the complainant's manager was right to cancel the promotional meeting. The manager commented on this point that:

> 'In our last discussion around this ….., I specifically asked [the complainant] not to approach the GP lead for this group as I was keen to ensure we did this meeting for the right reasons, with the right customers, and not just for the sake of doing it. [The complainant] went ahead and approached [his] customer despite being asked not to.'

Napp submitted that this was clearly at odds with the complainant's allegations and it suggested that he was asked to elaborate further. The manager's comment was not derogatory and had been taken out of context. Napp denied a breach of Clause 9.1.

The Chest Sounds meeting would have been a promotional meeting and so did not come within the scope of Clause 19.2 of the Code. Napp therefore denied a breach of Clause 19.2, as well as of Clauses 9.1 and 2.

PANEL RULING

The Panel noted that the parties' accounts differed, it was extremely difficult in such cases to know exactly what had transpired. The complainant stated that Napp did not provide any briefing about whether the speaker was only to be offered at nurse meetings and not GP meetings. The Panel noted Napp's submission that it was verbally agreed by the complainant and his manager that the Chest Sounds meetings involving an external speaker would be arranged with practice nurses with an interest in asthma.

The Panel noted that Napp did not comment on the complainant's allegation that Napp had used the Chest Sounds promotional meetings as a tactic to gain access to health professionals and follow up with attendees after the meetings. The Panel considered that it was not necessarily unacceptable for meetings to be a means of interacting with health professionals. Noting its comments above and the complete absence of evidence, the Panel considered that the complainant had failed to show that there had been a breach of the Code with regard to the use of the Chest Sounds meetings. The Panel consequently ruled no breach of Clause 9.1 and 2. The Panel did not consider that Clause 19.2 was relevant as this applied to medical and educational goods and services and not to promotional meetings. No breach of Clause 19.2 was ruled.

The Panel noted that the complainant's ABM stated in an email to the third party agency that an account manager who worked the territory previously suggested they were not of particular value when referring to a group of GPs that the complainant suggested running a meeting with when the meeting with a group of nurses had not been confirmed. The ABM took the decision not to sponsor the meeting. The Panel noted Napp's submission that the feedback the ABM received from another account manager was that this group of GPs were known informally locally as the 'middle-aged doctor' group who had been around many years and half of whom were retired. Napp submitted that retired GPs were 'not of particular value' and could be perceived as members of the public and it would be in breach of the Code to promote to them which was why the meeting did not go ahead. The Panel did not consider that in referring to the group of GP's as being 'not of particular value' the ABM had been derogatory as alleged; it was not necessarily unacceptable for a pharmaceutical company to decide which health professionals to promote to based on a return of investment provided that requirements of the Code were met. The Panel did not consider that Napp had failed to maintain high standards and therefore ruled no breach of Clause 9.1.

Complaint received **8 May 2017**

Case completed **29 August 2017**

CASE AUTH/2957/5/17

VOLUNTARY ADMISSION BY ASTELLAS UK

Omission of prescribing information

Astellas Pharmaceuticals (Astellas UK) voluntarily admitted that promotional materials which referred to both Betmiga (mirabegron) and solifenacin (Vesicare) only contained prescribing information for Betmiga. In addition, promotional material which referred to both Advagraf (tacrolimus prolonged release capsules) and Prograf (tacrolimus capsules) did not contain prescribing information for the latter.

Whilst the voluntary admission was made under the self-regulatory system, given the potential impact on patient safety, the companies had informed the Medicines and Healthcare products Regulatory Agency (MHRA) which was advised that the PMCPA was dealing with the matter as a complaint under the Code.

As Paragraph 5.6 of the Constitution and Procedure required the Director to treat a voluntary admission as a complaint, the matter was taken up with Astellas UK.

Astellas UK explained that during its investigation of the issues with prescribing information in another case, Case AUTH/2939/2/17, its urology marketing team uncovered four promotional items for Betmiga, on 15 February 2017, which also referred to solifenacin but only contained prescribing information for Betmiga; all four items were withdrawn on the same day. A further item was subsequently discovered by the urology marketing team and withdrawn.

Astellas UK stated that the voluntary admission for Case AUTH/2939/2/17, submitted on 21 February 2017, should have included this additional issue. However, aside from an email to healthcare compliance on 17 February, the urology marketing team did not further raise the issue with the healthcare compliance team or those involved in drafting the voluntary admission for Case AUTH/2939/2/17 and the healthcare compliance team did not action the email from urology until May. Whilst there was no excuse for this, Astellas UK explained that the healthcare compliance team was extremely busy in February and March 2017 preparing for the April PMCPA audit.

Astellas UK submitted that it had identified a further 46 Betmiga items which also referred to solifenacin but only contained the prescribing information for Betmiga. These dated back to 2013 and were all withdrawn before the issue of lack of Vesicare prescribing information was identified. Astellas UK noted that many of these items were certified and recertified without this issue being identified.

In addition, during this investigation, a further 25 promotional items for Vesomni (tamsulosin/ solifenacin) were identified that referred to Vesicare (solifenacin), outside of it being a component of Vesomni, without inclusion of the Vesicare prescribing information. All of this material had already been withdrawn.

Astellas UK also submitted that a review of material produced by other brand teams had identified that detail aids for Advagraf (tacrolimus prolonged release capsules) which referred to Prograf (tacrolimus capsules) did not contain the prescribing information for the latter; the withdrawal of both items was initiated immediately on discovery of this issue.

Astellas UK considered that this issue constituted multiple breaches of the Code. In addition, given the potential to impact patient safety, Astellas UK considered that this matter reduced confidence in the industry and brought the industry into disrepute, in breach of Clause 2.

The detailed response from Astellas UK is given below.

The Panel agreed with Astellas UK that this matter should have been included in its voluntary admission, Case AUTH/2939/2/17. The Panel considered that given the importance of patient safety, this should have been an absolute priority. The amount of time between Astellas UK first discovering the problem on 15 February 2017 and the healthcare compliance team taking action on 8 May 2017 was totally unacceptable. The explanation that the healthcare team was extremely busy preparing for the April PMCPA audit did not justify the delay.

The Panel was very concerned to note that in addition to the five items in use, a further 46 Betmiga items, which referred to solifenacin but did not contain its prescribing information, were identified which dated back to 2013. A further 25 promotional items for Vesomni (tamsulosin/ solifenacin) were identified that referred to Vesicare (solifenacin) alone and failed to provide its prescribing information. All of these items had already been withdrawn before this matter was identified.

The Panel further noted that two detail aids for Advagraf (tacrolimus prolonged release capsules) which referred to Prograf (tacrolimus capsules) did not contain its prescribing information. These items were withdrawn upon discovery.

The Panel ruled breaches of the Code in relation to each item subject to the voluntary admission which did not include the requisite prescribing information.

Failing to provide the requisite prescribing information was a serious matter. The Panel was very concerned that the company's systems including certification and, in relation to some

materials, recertification had not picked up these errors sooner. Overall, high standards had not been maintained and a breach of the Code was ruled.

The Panel noted its comments above and the failure of the company to treat this matter as a priority and include these matters in its voluntary admission in Case AUTH/2939/2/17. These failures brought discredit upon and reduced confidence in the pharmaceutical industry. In particular, the Panel was concerned about the volume of materials involved and that this error had occurred across business units. It was very difficult to understand how, and of concern that, these matters had not been picked up previously. It was crucial that health professionals and others could rely completely upon the industry for up-to-date and accurate information about their medicines. A breach of Clause 2 was ruled.

The Panel noted that had the investigation been appropriately followed up, the matters in this case would have been included in the voluntary admission in Case AUTH/2939/2/17. The Panel noted its comments above and its ruling of a breach of Clause 2 which would mean that brief details of this case would be the subject of an advertisement. The Panel noted that in Case AUTH/2939/2/17 Astellas had been reported by the Panel to the Code of Practice Appeal Board and by the Appeal Board to the ABPI Board. Additional sanctions had been imposed. These were ongoing. At the completion of this case the details would be available to both the Appeal Board and ABPI Board. The Panel decided, taking all the circumstances into account, not to report Astellas UK to the Appeal Board for it to consider in accordance with Paragraph 8.2 of the Constitution and Procedure.

Astellas Pharmaceuticals Limited (Astellas UK) voluntarily admitted that promotional materials which referred to both Betmiga (mirabegron) and solifenacin only contained prescribing information for Betmiga. Astellas still had exclusivity on the manufacture and marketing of solifenacin (as Vesicare) and considered that material which referred to solifenacin, even once, should also contain prescribing information for Vesicare. Betmiga and Vesicare were both indicated for the symptomatic treatment of overactive bladder syndrome.

Astellas UK also voluntarily admitted that promotional material which referred to both Advagraf (tacrolimus prolonged release capsules) and Prograf (tacrolimus capsules) did not contain prescribing information for the latter. Advagraf and Prograf were both indicated for the prevention of transplant rejection.

Whilst the voluntary admission was made under the self-regulatory system, given the potential impact on patient safety, the companies had copied the letter to the Medicines and Healthcare products Regulatory Agency (MHRA) which was informed that the PMCPA was dealing with the matter as a complaint under the Code.
As Paragraph 5.6 of the Constitution and Procedure required the Director to treat a voluntary admission as a complaint, the matter was taken up with Astellas UK.

VOLUNTARY ADMISSION

Astellas UK explained that during its investigation of the issues with prescribing information in Case AUTH/2939/2/17, its urology marketing team uncovered four promotional items for Betmiga, on 15 February 2017, which also referred to solifenacin but only contained prescribing information for Betmiga; all four items were withdrawn on the same day. An email to the UK healthcare compliance team on 17 February outlined what had been discovered and actions taken to date which included a deviation being raised for this omission. A further item was subsequently discovered by the urology marketing team and withdrawn on 17 February.

Given that the voluntary admission for Case AUTH/2939/2/17 was submitted on 21 February 2017, Astellas UK considered that this additional issue should have been included in that admission. However, aside from the email, the urology marketing team did not further raise the issue with the healthcare compliance team or those involved in drafting the voluntary admission for Case AUTH/2939/2/17 and the healthcare compliance team did not action the email from urology until 8 May. Whilst there was no excuse for this, Astellas UK explained that the healthcare compliance team was extremely busy in February and March 2017 preparing for the April PMCPA audit, in particular, revising policies and procedures.

Astellas UK submitted that as far as the functionality on Zinc allowed, it had identified a further 46 Betmiga items which also referred to solifenacin, but only contained the prescribing information for Betmiga (a list of items was provided). These dated back to 2013 and were all withdrawn before the issue of lack of Vesicare prescribing information was identified, mostly because updated versions of the items were to be introduced. With the latter in mind, Astellas UK noted that many of these items were certified and recertified without this issue being identified.

In addition, during this investigation, a further 25 promotional items for Vesomni (tamsulosin/solifenacin) were identified that referred to Vesicare (solifenacin), outside of it being a component of Vesomni, without inclusion of the Vesicare prescribing information. All of this material had already been withdrawn from use.

Astellas UK also submitted that a review of material produced by other brand teams had identified that detail aids for Advagraf (tacrolimus prolonged release capsules) which referred to Prograf (tacrolimus capsules) did not contain the prescribing information for the latter; the withdrawal of both items was initiated immediately on discovery.

Astellas UK considered that this issue constituted multiple breaches of Clause 4.1, given that promotional material that referred to prescription only medicines failed to contain prescribing

information for such medicines. Astellas UK also considered that this amounted to a failure to maintain high standards, contrary to the requirements of Clause 9.1. In addition, given the potential to impact patient safety, Astellas UK considered that this matter reduced confidence in the industry and brought the industry into disrepute, in breach of Clause 2.

Astellas UK stated that it had treated this issue with the utmost seriousness; it recognized the gravity of the situation that had been uncovered and had addressed it as a priority. The company was appalled to, yet again, find itself making a voluntary admission about prescribing information. Astellas UK noted that investigation into the circumstances surrounding this case might result in disciplinary action for certain individuals.

RESPONSE

Astellas UK provided further documentation requested by the case preparation manager but otherwise made no further comment.

PANEL RULING

The Panel noted that during Astellas UK's investigation of the issues with prescribing information in a separate case, Case AUTH/2939/2/17, its urology marketing team uncovered four promotional items for Betmiga which referred to solifenacin (Vesicare) but only contained prescribing information for Betmiga. All four items were withdrawn on the day the errors were discovered (15 February 2017) and UK healthcare compliance was notified by email two days later on 17 February. A fifth item was subsequently discovered and withdrawn on 17 February. The Panel agreed with Astellas UK's submission that this matter should have been included in its voluntary admission, Case AUTH/2939/2/17, submitted on 21 February 2017. The Panel considered that given the importance of patient safety, this should have been an absolute priority. The amount of time that had elapsed between Astellas UK first discovering the problem on 15 February 2017 and the healthcare compliance team taking action on 8 May 2017 was totally unacceptable. The Panel did not consider that the explanation that the healthcare team was extremely busy in February and March 2017 preparing for the April PMCPA audit justified the delay.

The Panel was very concerned to note that in addition to those five items noted above a further 46 Betmiga items which referred to solifenacin but did not contain its prescribing information were identified which dated back to 2013. All of these items had already been withdrawn before this matter was identified.

In addition, the Panel noted that a further 25 promotional items for Vesomni (tamsulosin/solifenacin) were identified that referred to Vesicare (solifenacin) alone and failed to provide its prescribing information. All of these items had already been withdrawn before this matter was identified.

The Panel further noted that two detail aids for Advagraf (tacrolimus prolonged release capsules) which referred to Prograf (tacrolimus capsules) did not contain its prescribing information. These items had not already been withdrawn. Their withdrawal was initiated immediately upon their discovery.

The Panel ruled breaches of Clause 4.1 in relation to each item subject to the voluntary admission which did not include the requisite prescribing information.

Failing to provide the requisite prescribing information was a serious matter. The Panel was very concerned that the company's systems including certification and, in relation to some materials, recertification had not picked up these errors sooner. Overall, the Panel considered that high standards had not been maintained. A breach of Clause 9.1 was ruled.

The Panel noted its comments above and the failure of the company to treat this matter as a priority and include these matters in its voluntary admission in Case AUTH/2939/2/17. The Panel considered that these failures brought discredit upon and reduced confidence in the pharmaceutical industry. In particular, the Panel was concerned about the volume of materials involved and that this error had occurred across business units. It was very difficult to understand how, and of concern that, these matters had not been picked up previously. It was crucial that health professionals and others could rely completely upon the industry for up-to-date and accurate information about their medicines. A breach of Clause 2 was ruled.

The Panel noted that had the investigation been appropriately followed up, the matters in this case would have been included in the voluntary admission in Case AUTH/2939/2/17. The Panel noted its comments above and its ruling of a breach of Clause 2 which would mean that brief details of this case would be the subject of an advertisement. The Panel noted that in Case AUTH/2939/2/17 Astellas had been reported by the Panel to the Code of Practice Appeal Board and by the Appeal Board to the ABPI Board. Additional sanctions had been imposed. These were ongoing. The Panel noted that at the completion of this case its case report would be published in the normal way and details of this case would be available to both the Appeal Board and ABPI Board. The Panel decided, taking all the circumstances into account, not to report Astellas UK to the Appeal Board for it to consider in accordance with Paragraph 8.2 of the Constitution and Procedure.

Complaint received **23 May 2017**

Case completed **19 July 2017**

CASE AUTH/2958/5/17

VOLUNTARY ADMISSION BY ASTELLAS EUROPE

Use of withdrawn advertisement

Astellas Pharma Europe (Astellas Europe) voluntarily admitted that an electronic advertisement for Xtandi (enzalutamide) referred to the medicine as 'new' more than 12 months after it was introduced. Xtandi was for use in certain men with metastatic castration-resistant prostate cancer.

As Paragraph 5.6 of the Constitution and Procedure required the Director to treat a voluntary admission as a complaint, the matter was taken up with Astellas Europe.

Astellas Europe explained that Xtandi was approved on 21 June 2013, and the 'new' indication and data referred to in the advertisement at issue related to an extension of indication approved in November 2014.

The detailed response from Astellas Europe is given below.

The Panel noted Astellas Europe's submission that the extended indication referred to in the claim 'new indication' had been available for over 12 months. Thus the Panel ruled a breach of the Code as acknowledged by Astellas Europe.

Similarly, the TERRAIN study (Shore *et al* 2016), described as a new publication, was published in January 2016, more than 12 months before the advertisement which was the subject of the voluntary admission. The Panel considered that the description of the publication as new was misleading and high standards had therefore not been maintained. A breach of the Code was ruled.

As the advertisement, subject to the voluntary admission, had not been certified a further breach of the Code was ruled.

The Panel noted the sequence of events that led to the publication of the advertisement at issue and that fundamental errors had occurred. In certain respects Astellas had been let down by third parties for which it was, nonetheless, responsible under the Code. Nonetheless, Astellas Europe's governance of its agency and control of materials had been poor. High standards had not been maintained. A breach of the Code was ruled. The Panel found it difficult to understand how such errors could occur at a time when compliance at Astellas was under the spotlight with particular reference to Cases AUTH/2780/7/15, AUTH/2883/10/16, AUTH/2939/2/17 and AUTH 2940/2/17. In this environment the Panel considered that the company's failure in 2017 to send any instruction to its agency in relation to the withdrawal of the advertisement certified in June 2016 (ref XTD/15/0027/EU) and to follow the withdrawal/ recall process was incomprehensible. In addition, the advertisement subject to the voluntary admission had not been certified. The Panel considered that the circumstances had brought the industry into disrepute. A breach of Clause 2 was ruled.

Astellas Pharma Europe Limited (Astellas Europe) voluntarily admitted that an electronic advertisement for Xtandi (enzalutamide) referred to the medicine as 'new' more than 12 months after it was introduced. Xtandi was for use in certain men with metastatic castration-resistant prostate cancer.

As Paragraph 5.6 of the Constitution and Procedure required the Director to treat a voluntary admission as a complaint, the matter was taken up with Astellas Europe.

VOLUNTARY ADMISSION

Astellas Europe explained that Xtandi was marketed in a number of its European affiliates including the UK. It was initially approved on 21 June 2013, and the 'new' indication and data referred to in the advertisement at issue related to an extension of indication:

> 'for the treatment of adult men with metastatic castration-resistant prostate cancer who are asymptomatic or mildly symptomatic after failure of androgen deprivation therapy in whom chemotherapy is not yet clinically indicated.'

The European Commission (EC) decision to approve the extended indication was taken on 28 November 2014, and the new indication was introduced in December 2014, with advertising materials which included the claim 'new indication'.

The TERRAIN study (efficacy and safety of enzalutamide vs bicalutamide for patients with metastatic prostate cancer (TERRAIN): a randomised, double-blind, phase 2 study) was published in January 2016 (Shore *et al* 2016) and subsequent Xtandi advertisements used the claim 'new publication' to refer to this study.

An Astellas Europe employee saw an advertisement on Medscape for Xtandi in the first weekend in May 2017, and noted that it included the terms 'new indication' and 'new publication'. On the next working day (8 May 2017), the employee informed the HealthCare Compliance team, and an investigation was commenced.

Investigation

A digital advertisement (ref ENZ/14/0077/EUd(1)) was certified in July 2015 which comprised of the following:

- a scrolling leaderboard consisting of four rotating screens to be displayed as a header/footer banner,

- an expanded leaderboard displayed when the user hovered over the scrolling leaderboard, and
- a click through page of advertising plus prescribing information displayed when clicking on the 'click to find out more' or 'Prescribing Information' buttons.

Astellas Europe provided a summary which explained the experience for viewing the advertisement.

The advertisement included a 'new indication' claim to reflect the new indication which was launched in December 2014. These materials were available on two internet-based services which provided scientific literature and medical news to health professionals.

Astellas Europe submitted that, via its third party advertising agency, it provided instructions to cease using the advertisement before the 12-month anniversary of the new indication launch date, and the two internet based services confirmed that it was discontinued in September 2015 although the job bag was not withdrawn in Zinc until 7 September 2016.

A revised advertisement (ref XTD/15/0027/EU) without the 'new indication' claim was certified on 2 June 2016 and was only available on one other site offering the latest medical news and information from 14 June 2016. Again, this comprised of the scrolling header/footer banners, expanded leaderboard and click through page of advertising plus prescribing information. This advertisement referred to the TERRAIN study as a 'new publication'.

In August 2016, when the advertising agency implemented the digital links for the advertisement for mobile devices, it inadvertently provided a link for a different file for the click through page of advertising plus prescribing information (ref XTD/16/0013/APELb). The content and prescribing information were identical, including the claim 'new publication', but the job code and date of preparation were different, and this item was certified for use as a print journal advertisement. Astellas did not know at the time that the incorrect file was used. This was discovered as a result of its investigations in May 2017.

In November 2016, there were technical issues with the display of the scrolling leaderboard. The relevant company sourced what it believed were the same file links via an advertisement server hosted by a third party provider to Astellas' advertising agency. It appeared that old/withdrawn files were still available on the advertisement server and so the company inadvertently linked to one of the withdrawn, out-dated scrolling leaderboard files which included the 'new indication' claim (ref ENZ/14/0077/EUd(1)). Astellas Europe was not told about the technical issue or the actions taken to address this.

Astellas Europe also discovered during the investigation that the advertisement certified for use from June 2016 was automatically withdrawn on its expiry date in Zinc, 1 March 2017. The Astellas recall/withdrawal procedure was not followed, and therefore its advertising agency was not instructed to withdraw this advertisement.

Astellas Europe had thus concluded that the advertisement consisted of files from three different job bags:

1 A scrolling leaderboard file from an old/withdrawn job bag which included the claim 'new indication'. This was visible from November 2016 to May 2017 (ref ENZ/14/0077/EUd(1)).
2 Click through page of advertising plus prescribing information, which although with the same content as the item at issue, was certified for a different use. This included the claim 'new publication', referring to data published in January 2016. This was visible from August 2016 to May 2017 (ref XTD/16/0013/APELb).
3 A scrolling leaderboard file from the intended advertisement. This job bag was automatically withdrawn in Zinc on its expiry date, 1 March 2017, however the complete Astellas withdrawals procedure was not followed, and hence Astellas Europe's advertising agency was not instructed to remove this advertising at that time. This was visible from June 2016 to May 2017 (ref XTD/15/0027/EU).

Astellas Europe confirmed that all Xtandi advertisements and prescribing information were removed on 8 May 2017. All items were now withdrawn in Zinc, and the complete Astellas recall/withdrawals process was in progress. At no time was incorrect or out-of-date prescribing information available to health professionals.

Agency Oversight

Astellas Europe submitted that as part of the investigation in to these issues, it had reviewed:

- The terms of engagement between it and its advertising agency and the third party used by the advertising agency and compliance to these terms
- Astellas internal supplier vetting procedures.

The advertising agency contract

Astellas Europe stated that it had signed a master services agreement (MSA) with the advertising agency which was effective 13 April 2012 and subsequently extended. This investigation revealed that the MSA had, however, expired in September 2016.

The MSA included clauses intended to ensure that agency personnel were appropriately trained, that Astellas' permission was required to change any project material and that prior written agreement was required from Astellas Europe before the advertising agency could subcontract any activities. The advertising agency had provided evidence of training on the Code delivered in September 2014 and repeated in February 2017. Sections of the contract which dealt with project material, personnel and assignment and sub-contracting were reproduced.

Astellas Europe noted that there was no contractual arrangement between Astellas and the third party used by the advertising agency, and the advertising agency had not requested Astellas' written consent to assign the role of managing the advertisement server for Astellas advertisements to the advertising agency's third party. Until this incident occurred and the resulting investigation was conducted, Astellas Europe did not know about the advertising agency's third party's involvement.

Agency vetting and monitoring

Astellas Europe stated that it now had a process (effective 18 August 2016) whereby third party suppliers were vetted in accordance with its standard operating procedure (SOP), Working with suppliers SOP-1479. This SOP required that a summary of key Astellas Europe SOPs, Rules of Engagement, was sent to all suppliers providing services that fell within the scope of the Code, and certain suppliers were also required to complete a supplier questionnaire designed to elicit information about Astellas Europe key compliance requirements. If this questionnaire was not satisfactorily completed, then further action was taken such as, *inter alia*, training, audits of the supplier or removal from the list of approved suppliers to Astellas.

The advertising agency was provided with the Rules of Engagement and completed the supplier questionnaire; it confirmed that it would comply with the Rules of Engagement in August 2016.

Use of the word 'new' and the withdrawal of materials

Astellas Europe stated that the relevant Astellas SOPs and checklists were reviewed to assess the clarity of instruction provided around managing materials including 'new' claims. The existing recall/withdrawals procedure was also reviewed. The current recall/withdrawals SOP was considered to be robust and clear and no changes would be made. The SOP and checklists concerning the review of materials would be revised to provide more explicit instruction on managing materials including the word 'new'.

In addition, face-to-face training on the 'EHQ [European Headquarters] Review and Approval of Material and Activities' and the 'Material Recall and Withdrawal' SOPs was scheduled through June 2017 for all relevant staff. This training would emphasise the importance of appropriately managing items including the word 'new' and the importance of conducting robust recall/withdrawal of expiring materials.

Relevant clauses

Given the above, Astellas Europe fully accepted that it had breached the following clauses:

Clause 7.11 use of the claim 'new' for a therapeutic indication promoted for more than 12 months, and for a publication greater than 12 months after the publication date

Clause 14.1 use of un-certified material (ie material used following withdrawal) and use of material certified for a different purpose.

Conclusion

Astellas Europe submitted that it had taken immediate steps to ensure removal of incorrect material as soon as it was discovered.

Astellas Europe did not consider there was any attempt or intention on its part to use material that was out-of-date, withdrawn, or certified for another purpose, it fully recognised that under the Code it was responsible for its actions whether intentional or not, and for any acts or omissions of its third party suppliers.

Astellas Europe considered that the actions begun following its earlier voluntary admissions to reinforce its process for third party management (Cases AUTH/2912/12/16 and AUTH/2883/10/16) would also help to prevent these mistakes in the future.

Astellas Europe was asked to provide the Authority with any further comments in relation to the requirements of Clauses 2 and 9.1 in addition to Clauses 7.11 and 14.1 as cited by the company.

RESPONSE

Astellas Europe stated that when it made its voluntary admission, the three job bags in question had been withdrawn in Zinc, and the complete recall/withdrawals process was in progress. During the recall of one of the three job bags, further relevant information was discovered.

Astellas Europe explained that the print advertisement that appeared in error (XTD/16/0013/APELb) was part of a family of four identical print advertisement job bags which differed only with respect to the intended journal. All four were recalled together at the end of May 2017. During that process, it was discovered that one of those print advertisements, which included the claim 'new publication' based on a publication from January 2016, appeared in the Journal of Clinical Oncology in January and February 2017 (XTD/16/0013/APELc). The Journal of Clinical Oncology had formally acknowledged that it was instructed verbally and in writing on 4 November 2016 to cancel the advertisement but, in error, it did not do so. Thus, this was regrettably a further example of an advertisement containing a 'new publication' claim to appear more than 12 months after the date of the new publication.

Astellas Europe stated that it had no further comment in relation to Clauses 7.11 and 14.1.

With regard to Clauses 9.1 and 2, Astellas Europe stated that it acted immediately to ensure the removal of incorrect material as soon as it was discovered. Astellas Europe did not consider there

was any attempt or intention on its part to use material that was out-of-date, withdrawn, or certified for another purpose. The company recognised that under the Code it was responsible for its actions intentional or not. In addition, whilst Astellas Europe considered that it was let down by the agency, it had recognised that it remained fully responsible for any acts or omissions of its third party suppliers.

With regard to the print advertisement the completion of the formal recall/withdrawals process revealed that this advertisement ran in error in the journal of Clinical Oncology in January and February 2017. The journal had provided written acknowledgement that it was instructed in November 2016 to cancel the advertisement, but in error it did not do so. However, again Astellas Europe recognised that it remained fully responsible for the acts or omissions of its suppliers.

On reflection, and following discovery of another error during the formal recall/withdrawals procedure, Astellas Europe acknowledged that it had not maintained high standards in relation to control of materials or third party management and had therefore breached Clause 9.1 of the Code.

Given the comments above, Astellas Europe understood that the Panel might wish to consider the requirements of Clause 2 in relation to the lack of control of materials and third party management.

PANEL RULING

The Panel noted Astellas Europe's admission that an advertisement for Xtandi on Medscape which was noticed by an employee on a website offering medical news and information for health professionals during the first weekend in May 2017 included the terms 'new indication' and 'new publication'.

The Panel noted Astellas' submission that a new extended indication for Xtandi was approved in November 2014 and promoted using the claim 'new indication' from December 2014. A digital advertisement (ref ENZ/14/0077/EUd(1)) which included a 'new indication' claim was discontinued in September 2015. (This was not withdrawn in Zinc until 7 September 2016). The Terrain study was published in January 2016. A revised digital advertisement (ref XTD/15/0027/EU) published on the website without the 'new indication' claim referred to the TERRAIN study as a 'new publication' and was certified on 2 June 2016. The Panel noted that there were three distinct parts to the digital advertisement: a scrolling leaderboard comprising four rotating screens, an expanded leaderboard and a click through page of advertising which included prescribing information.

The Panel noted Astellas Europe's submission that the advertisement at issue consisted of files from three different job bags.

In relation to the scrolling leaderboard, the Panel noted Astellas Europe's explanation that in November 2016, due to technical issues with the display and without reference to Astellas, the publisher had, on its own initiative, linked to a withdrawn and out-of-date scrolling leaderboard file (ref ENZ/14/0077/EUd(1)) which it had discovered on a server hosted by a third party provider to Astellas Europe's advertising agency. This withdrawn file included the 'new indication' claim. This out-of-date scrolling leaderboard was visible as part of the advertisement at issue from November 2016 to May 2017.

In relation to the click-through page of advertising and prescribing information, in August 2016 when Astellas Europe's agency implemented the digital links for the advertisement for mobile devices, it inadvertently provided a file that was certified for use as a print journal advertisement (ref XTD/16/0013/APELb). It contained identical content and prescribing information to the intended version, only the job code and date of preparation were different. It included the claim 'new publication'. This was visible as part of the advertisement at issue from August 2016 to May 2017.

The balance of the advertisement, the expanded leaderboard, was from the original advertisement (ref XTD/15/0027/EU) referred to above. It was certified on 2 June 2016 and referred to the 'new publication'. This job bag was automatically withdrawn on its expiry date in Zinc (1 March 2017) but the Astellas recall/withdrawal procedure was not followed and therefore its agency was not instructed to withdraw the advertisement from Medscape. It was visible as part of the advertisement at issue from June 2016 to May 2017.

The Panel noted that Clause 7.11 required that the word 'new' must not be used to describe any product or presentation which had been generally available, or any therapeutic indication which had been generally promoted, for more than twelve months in the UK. The Panel further noted Astellas Europe's submission that the extended indication referred to in the claim 'new indication' had been available for over 12 months. Thus the Panel ruled a breach of Clause 7.11 as acknowledged by Astellas Europe.

Similarly, the TERRAIN study (Shore *et al*), described as a new publication, was published in January 2016, more than 12 months before the advertisement which was the subject of the voluntary admission. The Panel noted that Clause 7.11 applied to products, presentations and therapeutic indications. It did not refer to publications. Nonetheless, the Panel considered that the principle was of broader application and the description of the publication as new was misleading and high standards had therefore not been maintained. A breach of Clause 9.1 was ruled.

Overall, the Panel considered that the advertisement subject to the voluntary admission had not been certified and a breach of Clause 14.1 was ruled.

The Panel noted the sequence of events that led to the publication of the advertisement at issue. Fundamental errors had occurred. In certain respects Astellas had been let down by third parties

for which it was, nonetheless, responsible under the Code. For example, its agency had not advised the company about problems with the published scrolling leaderboard and the publisher's access to, and use of, a withdrawn file retrieved from a server hosted by a third party. Nonetheless, Astellas Europe's governance of its agency and control of materials had been poor. High standards had not been maintained. A breach of Clause 9.1 was ruled. The Panel found it difficult to understand how such errors could occur at a time when compliance at Astellas was under the spotlight with particular reference to Cases AUTH/2780/7/15, AUTH/2883/10/16, AUTH/2939/2/17 and AUTH 2940/2/17. In this environment the Panel considered that the company's failure in 2017 to send any instruction to its agency in relation to the withdrawal of the advertisement certified in June 2016 (ref XTD/15/0027/EU) and to follow the withdrawal/recall process was incomprehensible. In addition, the advertisement subject to the voluntary admission had not been certified. The Panel considered that the circumstances had brought the industry into disrepute. A breach of Clause 2 was ruled.

The Panel noted Astellas Europe's submission that a print advertisement that included the 'new publication' claim appeared in the Journal of Clinical Oncology in January and February 2017. The Journal of Clinical Oncology formally acknowledged that it was instructed verbally and in writing on 4 November 2016 to cancel the advertisement but did not do so. Whilst Astellas Europe had been let down by the publisher, it was an established principle under the Code that pharmaceutical companies were responsible for third parties even if that third party acted outside the instructions from the pharmaceutical company. The Panel noted that this submission was not the subject of the company's voluntary admission and thus the Panel made no rulings on this matter.

During its consideration of this case the Panel was concerned to note that the advertisement intended for use on the site containing medical news and information for health professionals from June 2016 (ref XTD/15/0027/EU), which included the claim 'new publication', was automatically withdrawn on its expiry date in Zinc (1 March 2017), despite the company acknowledging that it instructed the Journal of Clinical Oncology to cancel the print version of the advertisement in November 2016. It appeared that this advertisement and the three job bags which comprised the advertisement subject to the voluntary admission were only recalled at the end of May 2017. The Panel requested that Astellas Europe be advised of its concerns.

Voluntary admission received **23 May 2017**

Case completed **17 July 2017**

HEAD OF MEDICINES MANAGEMENT AT A HEALTH BOARD v BAYER

Recruitment of patients for market research

The head of medicines management at a health board complained about an email sent by a market research recruitment agency inviting a hospital consultant to recruit patients for a market research project. The email stated that the agency was working on behalf of a pharmaceutical company looking particularly at stroke prevention in patients with non valvular atrial fibrillation treated with any one of four anticoagulants. Contact with patients would be via a 15 minute interview and an honourarium would be paid to patients and physicians would receive a 'finder's fee' per qualifying patient.

The complainant stated that companies should not offer inducements to health professionals for any action that was not appropriate (in this case passing on patients' details and breaking confidentiality).

The complainant explained that whilst the health board accepted that it might be possible for consultants to avoid breaking patient confidentiality, the email did not make that clear. The health board was concerned that inexperienced health professionals might break patient confidentiality and misuse NHS time and resources.

The market research agency stated that it was working on behalf of Bayer.

The detailed response from Bayer is given below.

The Panel noted that the required that market research activities must not be disguised promotion. Supplementary information to the Code referred to the guidelines from the British Healthcare Business Intelligence Association (BHBIA). The Panel considered that market research had to be conducted for a *bona fide* purpose. If market research was ruled to be disguised promotion any payment was likely to be in breach of the Code. In addition, the company should be mindful of the impression created by the invitation to participate in the survey and description therein of any payment.

The complainant was concerned that the finder's fee was an inducement to break patient confidentiality. There was no mention in the materials regarding patient confidentiality. The Panel considered that health professionals would be well aware of their obligations with regard to patient confidentiality. The complainant also referred to possible misuse of NHS time and resources. The Panel considered that health professionals responding to the request would be responsible for ensuring that they followed relevant NHS policies and procedures. There was no evidence that NHS time and resources had been misused.

The email in question asked health professionals to contact the agency if interested in helping recruit patients. Such health professionals would be provided with letters to give to patients who would then contact the agency direct. The patients had to have been taking one of four treatments for at least three months; one was Bayer's medicine and the other three were competitors'. The Panel thus considered that there was no incentive to change a patient's medication to Bayer's product or to increase prescribing of it for new patients. The health professional would not pass on patient details to the agency. The finder's fee would only be paid in relation to patients who completed the survey.

Although there was no allegation that the market research was disguised promotion, in order to consider the allegations, the Panel had to address this point first. On the information before it, the Panel did not consider that the survey was disguised promotion of Xarelto and, as a consequence, it was not unreasonable to pay health professionals. The Panel noted the allegations about the payment offered and its comments above and ruled no breach of the Code in this regard.

The Panel noted that the email did not mention patient confidentiality and did not consider that the method of identifying and enrolling patients was inappropriate. The position was clearer on receipt of the further information about the arrangements, which would be sent to interested health professionals, than from the email in question. Given all the circumstances, the Panel ruled no breach of the Code including no breach of Clause 2.

The head of medicines management at a health board, complained on behalf of the health board about an email received by one of his/her consultant/ cardiologist from a market research agency inviting him/her to recruit patients for a market research project.

The email subject referred to 'Finders Fee for recruitment of patients with AF [atrial fibrillation]'. The email went on to describe the agency as an international market research company that was working on behalf of an international pharmaceutical company which wanted to speak to patients diagnosed with non valvular atrial fibrillation being treated for stroke prevention to understand more about their treatment and dosing regimen.

Potential respondents were to be over 19 and receiving one of four named treatments for at least 3 months. Xarelto (rivaroxaban) Bayer's product was one of the treatments listed with its dose as was Lixiana (edoxaban), Eliqius (apixaban) and Pradaxa

(dabigatran). Xarelto's indications included the prevention of stroke and systemic embolism in adult patients with non valvular atrial fibrillation with one or more risk factors.

The email included details of the study including that the telephone interview would take 15 minutes and that an honorarium of £30 for patients and a physician fee of £50 per qualifying patient was offered. Interested health professionals were to contact the agency for further details.

COMPLAINT

The complainant noted that although the agency was a market research company, the Code stated that pharmaceutical companies were responsible for the activities and materials that market research companies carried out on their behalf. The complainant stated that companies should not offer inducements to health professionals for any action that was not appropriate (in this case passing on patients' details and breaking confidentiality).

The complainant explained that whilst the health board accepted that it might be possible for consultants to avoid breaking patient confidentiality by first contacting their patients to gain their consent before passing on their details to the agency, the email did not make that clear. The health board was concerned that inexperienced health professionals might break patient confidentiality and misuse NHS time and resources.

In response to a request from the case preparation manager, the agency identified the relevant pharmaceutical company as Bayer.

When writing to Bayer, the Authority asked it to bear in mind the requirements of Clauses 2, 7.2, 9.1 and 18.1 of the Code.

RESPONSE

Bayer acknowledged that it was an established principle that market research must be carried out in such a way as to not contravene the Code and in accordance with the requirements of Clause 12.2, market research material must be examined. The British Healthcare Business Intelligence Association (BHBIA) code and the Legal and Ethical Guidelines for Healthcare Market Research were also relevant.

Bayer submitted that the payment offered to health professionals participating in the market research was £50 per patient who met the selection criteria and successfully completed an interview. The fee was calculated on the assumption that each physician would contact an average of six patients, in order to find one who was willing to take part in the study; each referral typically took around 5-10 minutes, therefore physicians would spend approximately 30 minutes on each patient who was recruited to take part in the study. This value was consistent with Bayer's fair market value table for the amount of work undertaken by health professionals and as such was not considered to be an inducement or an inappropriate payment. It was also important to note that the market research material referred to all of the available direct oral anticoagulants (DOACs) with their respective licensed doses for stroke prevention in non valvular atrial fibrillation. There was no reference to Bayer and no emphasis placed on its products. Therefore it was not an inducement to prescribe any specific product and as such the activity was not in breach of Clause 18.1.

Bayer submitted that the email in question outlined the patient group of relevance to the market research, and requested that health professionals interested in recruiting patients contact the agency project manager. The email did not request patient information of any kind to be passed on. The instruction was very clear and therefore not in breach of Clause 7.2.

Bayer recognised that market research material must be examined. The email in question was sent by the agency without approval by Bayer. Bayer enclosed a copy of the communication which was intended for health professionals with evidence of examination by Bayer.

The emails between Bayer and the market research agency 22 November 2016 and the subsequent email of the same date between the market research agency and the recruitment agency, enclosing the health professional and patient letter stating they were approved by the UK and that recruitment could commence was provided.

Bayer confirmed that to date 42 health professionals had responded to the email and five had been paid the qualifying fee.

Bayer provided copies of the communication intended for health professionals and the letter that was provided to participating health professionals to pass on to patients. The letter contained details of how those patients could contact the market research recruitment agency. Bayer also provided the patient screening questionnaire that was used by the recruitment agency.

Bayer was disappointed that the email that was sent out to the health professional was not the version that it had examined. The emails from 22 November 2016 were very clear in this regard. Bayer was investigating the matter and in the interim further recruitment of health professionals had been put on hold. However, Bayer submitted that the email that was sent to the health professionals from the recruitment agency would have been approvable had it been put forward for examination and as such had not compromised patient safety. Therefore, Bayer submitted that high standards had nevertheless been maintained and refuted a breach of Clause 9.1.

Bayer submitted that the matter did not bring the industry into disrepute and therefore a breach of Clause 2 was not warranted.

PANEL RULING

The Panel noted that the email in question was from a market research recruitment agency whereas Bayer was working with another agency in relation to the survey. It appeared that market

research agency contracted the recruitment agency to help with recruitment. It was not clear why the recruitment agency had not used the agreed email. The differences between the two included listing the products strength and doses. In any event Bayer was responsible under the Code for its third party arrangements.

The only requirement in the Code that specifically mentioned market research was Clause 12.2 which provided that market research activities, clinical assessments, post-marketing surveillance and experience programmes, post-authorization studies (including those that were retrospective in nature) and the like must not be disguised promotion. They must be conducted with a primarily scientific or educational purpose. The supplementary information to Clause 12.2 referred to the BHBIA Guidelines. The Panel considered that market research had to be conducted for a *bona fide* purpose. If market research was ruled to be disguised promotion contrary to Clause 12.2, any payment was likely to be in breach of Clause 18.1. In addition, the company should be mindful of the impression created by the invitation to participate in the survey and description therein of any payment.

The complainant was concerned that the finder's fee was an inducement to break patient confidentiality. There was no mention in the materials regarding patient confidentiality. The Panel considered that health professionals were responsible for patient confidentiality and would be well aware of their obligations in this regard. The complainant also referred to possible misuse of NHS time and resources. The Panel considered that health professionals responding to the request would be responsible for ensuring that they followed relevant NHS policies and procedures. There was no evidence that NHS time and resources had been misused.

The email in question asked health professionals to contact the third party agency if interested in helping recruit patients. Such health professionals would be provided with letters to give to patients who would then contact the market research agency directly. The patients had to have been taking one of four treatments for at least three months; one was Bayer's medicine and the other three were competitors'. Given these conditions, the Panel considered there was no incentive to change patient's medication to Bayer's product or to increase prescribing of it for new patients. The health professional would not pass on patient details to the third party agency. The finder's fee would only be paid in relation to patients who completed the survey.

The Panel noted that there was no allegation that the market research was disguised promotion and thus the company had not addressed the point. However, in order to consider the allegations, the Panel had to address this point first. On the information before it, the Panel did not consider that the survey was disguised promotion of Xarelto and, as a consequence, it was not unreasonable to pay health professionals. The Panel noted the allegations about the payment offered and its comments above and ruled no breach of Clause 18.1 of the Code in this regard.

The Panel noted that the email did not mention patient confidentiality and did not consider that the method of identifying and enrolling patients was inappropriate. The position was clearer on receipt of the further information about the arrangements, which would be sent to interested health professionals, than from the email in question. Given all the circumstances, the Panel ruled no breach of Clauses 7.2, 9.1 and 2.

Complaint received **25 May 2017**

Case completed **31 July 2017**

CASE AUTH/2960/6/17

HOSPITAL DOCTOR v A MENARINI

Certification of company website

When the complainant in Case AUTH/2949/3/17 (a complaint about A Menarini's corporate website) was advised of the outcome in that case he submitted a number of comments related to the certification and approval of that website. The complainant noted the company's submission in the previous case that the web page at issue had been created and approved in 2011. The complainant stated that surely the website had been updated since then and even if not, the Code required materials to be recertified every two years. The complainant noted that the original screenshot he had saved referred to a campaign launched in 2014; the website had thus been updated since 2011 and so should have a more recent approval date.

The complainant stated that the company's submission in Case AUTH/2949/3/17 implied a very relaxed approach to patient safety and process. In particular, the complainant noted that despite knowing that a link to the Medicines and Healthcare products Regulatory Agency (MHRA) Yellow Card Scheme was missing from its website, the company did nothing until it received a complaint about it two months later.

The detailed response from A Menarini is given below.

The Panel noted A Menarini's submission that the webpage at issue was examined and approved against the 2011 Code. The website provided information about the company's products and access to it was not limited to health professionals and other relevant decision makers; it was a source of information for the public including patients taking the company's medicines. The Panel noted that A Menarini added a link to educational material for the public in January 2014 and its submission that it failed to review its website and certify the content at that time.

The Panel noted that the Code required that, *inter alia*, promotional material must not be issued unless its final form, to which no subsequent amendments will be made, has been certified.

The Panel noted A Menarini's submission that neither the content of the website, nor the link to the educational material for the public added in 2014 were promotional. The Panel considered that the complainant had not established that the website was promotional and no breach of the Code was ruled.

The Panel further noted, however, that the Code required, *inter alia*, educational material for the public or patients issued by companies which related to diseases or medicines but was not intended as promotion for those medicines to be certified.

The Panel noted that A Menarini had failed to certify the website when it was first created in July 2011 as required by the 2011 Code and a breach of that Code was ruled.

The Panel noted A Menarini's submission that the website had not been reviewed since July 2011. The Panel noted that the current Code required, *inter alia*, that material which was still in use be recertified at intervals of no more than two years to ensure that it continued to conform with the relevant regulations relating to advertising and the Code. The Panel noted that A Menarini had not reviewed the website since July 2011 and as such it had not been re-certified in line with the Code and a breach was ruled.

The Code required companies to preserve certificates for material for not less than three years after the final use of the material. The Panel noted that as the website had never been certified, there was no certificate. A further breach of the Code was ruled.

The Panel noted its rulings above and considered that the failure to certify and re-certify its website meant that A Menarini had failed to maintain high standards. A robust certification procedure underpinned self-regulation. The Panel considered that A Menarini's lack of such a process and its failure to review and certify material aimed at the public or patients meant that it had brought the industry into disrepute. Breaches of the Code were ruled including of Clause 2.

The Panel noted its concern in Case AUTH/2949/3/17 in that despite discovering that the hyperlink to the MHRA Yellow Card Scheme had disappeared on 31 January 2017 and promptly notifying its parent company responsible for website maintenance, no action was apparently taken until A Menarini was notified of that complaint on 27 March 2017. This showed a disregard for patient safety issues. The Panel had ruled a breach of the Code in that case in relation to failing to maintain high standards. Noting the complainant's allegations in Case AUTH/2949/3/17 the Panel considered that patient safety was of the utmost importance and A Menarini's failures in this regard brought discredit upon and reduced confidence in the pharmaceutical industry. A further breach of Clause 2 was ruled.

A hospital doctor complained about the adverse event function on A Menarini's website which was taken up as Case AUTH/2949/3/17. When advised of the outcome of that case, whilst the complainant did not appeal the Panel's rulings of no breach of the Code, he submitted a number of comments which generally raised matters related to certification and approval of the website. In addition the complainant also referred to a patient safety matter dealt with in

Case AUTH/2949/3/17 but which had not been subject to an alleged breach of Clause 2. The new matter raised by the complainant and the alleged breach of Clause 2 were thus taken up as a new complaint under the Code.

COMPLAINT

The complainant noted A Menarini's submission in Case AUTH/2949/3/17 that the webpage at issue (www.menarini.co.uk/products/welcome) was created in 2011 and thus an older version of the Code applied. Initially he only registered this as an insight into the workings of an industry he did not know that well but thinking it over he was puzzled by the company's statement that this website was approved on 20 July 2011.

The complainant queried whether A Menarini really created this website in 2011 and never updated it in the past six years and considered that that could not be right; surely it must have been updated since then with new information. Even in the unlikely event that the company did not update the website, the complainant considered that it had a responsibility to keep its materials up-to-date. In that regard the complainant noted that Clause 14.5 required materials to be certified in their final form and recertified at intervals of two years. In that regard the web page must have been recertified nearly 3 times since it was originally approved in 2011. If changes had been made since 2011, there must have been a more recent approval or certification than 2011.

The complainant stated that he had noted from the original screenshot that he had saved, two links in the top right corner which A Menarini had since removed – 'Stamp out Gout' and 'Firing too quickly'. A google search showed 'Firing too quickly' was a premature ejaculation campaign launched in 2014. The complainant thus concluded that the website had been updated since 2011 to add that banner, contrary to A Menarini's submission. The complainant queried why the company referred to 2011 and not a more recent approval.

The complainant raised the following questions:

- Did A Menarini really not update its website since 2011 when it claimed it went live and was approved? Evidence suggested otherwise. If A Menarini's submission was true, it was in breach of Clause 14.5. It should review and approve all materials every two years and based on its submission in Case AUTH/2949/3/17, it admitted it did not. Where was the most [recent?] certificate which was issued for this website within the past 2 years?

- Had A Menarini updated its website after the launch and approval in 2011 without proper review process? At least one banner was added after 2011 – 'Firing too Quickly'; a campaign which was launched in January 2014. Also A Menarini admitted the adverse event statement disappeared since 2011. This kind of thing did not happen by itself. Someone gave instructions for changes to be made and did not check the outcome. In the complainant's view it appeared that A Menarini had very poor control over who put what on its website. In that regard the complainant referred to Clauses 14.5 and 14.3.

- Why did A Menarini not act immediately when it found out its website had a problem? In Case AUTH/2949/3/17 the company submitted that it knew at the end of January 2017 that its website did not have all the required information, yet it only acted when it received a complaint two months later. This was poor form.

The complainant stated that the company's submission implied a very relaxed approach to patient safety and process. The company claimed the webpage was created and approved in 2011 and implied that it had been untouched since then. Clearly this was not the truth. The complainant suspected that the company had lied and that it had a very poor grip on its materials and processes. Clearly the website had been changed since 2011 without due process and review. In that regard the complainant cited Clauses 14.1, 14.5 and 14.6.

The complainant added that, even worse, the company was warned that it was non-compliant in January and for two months it did nothing until it received a complaint. The complainant alleged that this was very poor and irresponsible. The complainant expected higher standards from a pharmaceutical company when it came to patient safety and in that regard alleged breaches of Clauses 2 and 9.1.

When writing to A Menarini, the Authority asked it to respond in relation to the requirements of Clauses 2, 9.1, 14.1, 14.3, 14.5 and 14.6. In relation to the allegation that the matter at issue in Case AUTH/2949/3/17 was not dealt with promptly, the company was asked to respond in relation to the requirements of Clause 2 only (the alleged breach of Clause 9.1 had already been addressed).

RESPONSE

A Menarini explained that, under the 2011 Code its website www.menarini.co.uk was considered a corporate advertising website and as such did not contain information that required certification. However, when the link to the 'Firing too quickly' website, which contained educational material for the public, was added in January 2014 the company failed to review the website and certify the content appropriately.

A Menarini submitted that since it joined the ABPI it used a paper based approval system for materials which was ineffective and challenging to administer. From January 2016, the company implemented an electronic approval system which had helped in improving the approval process and the management of materials life cycle.

Clauses 14.1 and 14.3

A Menarini noted that it was a requirement of Clause 14.1 of the 2014 Code that:

> 'Promotional material must not be issued unless its final form, to which no subsequent amendments will be made, has been certified by two persons on behalf of the company in the manner provided for by this clause. One of the two persons must be a registered medical practitioner or a pharmacist registered in the UK or, in the case of a product for dental use only, a registered medical practitioner or a pharmacist registered in the UK or a UK registered dentist. The second person certifying on behalf of the company must be an appropriately qualified person or senior official of the company or an appropriately qualified person whose services are retained for that purpose.'

It was a requirement of Clause 14.3 of the 2014 Code that:

> 'The following must be certified in advance in a manner similar to that provided for by Clause 14.1: educational material for the public or patients issued by companies which relates to diseases or medicines but is not intended as promotion for those medicines …'

The menarini.co.uk website was considered a corporate advertising website under the 2011 Code and as such did not contain information that required certification. However, in January 2014 when the link to the 'Firing too quickly' website which contained educational material for the public was created, the company failed to review its website and certify the content appropriately. However, neither the content of the website nor the link to the educational material for the public website, were deemed to be promotional. A Menarini thus considered that it was in breach of Clause 14.3 but not in breach of Clause 14.1.

Clause 14.5

A Menarini noted that it was a requirement of Clause 14.5 of the 2016 Code that:

> 'The certificate for promotional material must certify that the signatory has examined the final form of the material to ensure that in his/her belief it is in accordance with the requirements of the relevant regulations relating to advertising and this Code, is not inconsistent with the marketing authorization and the summary of product characteristics and is a fair and truthful presentation of the facts about the medicine. The certificate for material covered by Clause 14.3 above must certify that the signatory has looked at the final form of the material to ensure that in his/her belief it complies with the Code. Material which is still in use must be recertified at intervals of no more than two years to ensure that it continues to conform with the relevant regulations relating to advertising and the Code.'

A Menarini submitted that it failed to review the website and certify the content appropriately in January 2014. Subsequently, the website should have been recertified no later than January 2016 as it was still in use. As the company had failed to recertify the website appropriately, it accepted a breach of Clause 14.5.

Clause 14.6

A Menarini noted that it was a requirement of Clause 14.6 of the 2016 Code that:

> 'Companies shall preserve all certificates. In relation to certificates for promotional material, the material in the form certified and information indicating the persons to whom it was addressed, the method of dissemination and the date of first dissemination must also be preserved. In relation to certificates for meetings involving travel outside the UK, details of the programme, the venue, the reasons for using the venue, the audience, the anticipated and actual costs and the nature of the hospitality and the like must also be preserved. Companies shall preserve certificates and the relevant accompanying information for not less than three years after the final use of the promotional material or the date of the meeting and produce them on request from the Medicines and Healthcare products Regulatory Agency or the Prescription Medicines Code of Practice Authority. The certificates for material covered by Clause 14.3 above shall be preserved for not less than three years after the final use of the material and companies shall produce them on request from the Medicines and Healthcare products Regulatory Agency or the Prescription Medicines Code of Practice Authority.'

A Menarini noted that it failed to review and certify the website appropriately in January 2014 or recertified no later than January 2016 as it was still in use. No certificates had been preserved in relation to the website and in that regard A Menarini accepted a breach of Clause 14.6.

Clauses 2 and 9.1

In relation to the certification clauses above, A Menarini accepted that it had not maintained high standards at all times, in breach of Clause 9.1. The company also accepted a breach of Clause 2 in that its 'Activities or materials associated with promotion must never be such as to bring discredit upon, or reduce confidence in, the pharmaceutical industry.'

In relation to Case AUTH/2949/3/17 under the allegation that the matter was not dealt with promptly, A Menarini denied a breach of Clause 2.

PANEL RULING

The Panel noted A Menarini's submission that the webpage at issue was examined and approved, against the 2011 Code, on 20 July 2011 before going live on the same day. The Panel noted that in Case AUTH/2949/3/17 it had disagreed with A Menarini's submission that under the 2011 Code its website www.menarini.co.uk was considered a corporate advertising website and as such did not contain information that required certification.
The Panel noted that the website provided information about the company's products. The

Panel noted that access to the website was not limited to health professionals and other relevant decision makers, and it was therefore also a source of information for the public including patients taking its medicines.

The Panel noted that A Menarini added a link to the 'Firing too quickly' website, which it acknowledged contained educational material for the public in January 2014. The Panel noted A Menarini's submission that it failed to review its website and certify the content at that time.

Turning to Case AUTH/2960/6/17, the Panel noted that Clause 14.1 of the 2011 Code required that, *inter alia*, promotional material must not be issued unless its final form, to which no subsequent amendments will be made, has been certified by two persons on behalf of the company in the manner provided for by this clause.

The Panel noted A Menarini's submission that neither the content of the website, nor the link to the educational material for the public added in January 2014 were promotional. The Panel considered that the complainant had not established that the website was promotional and the Panel therefore ruled no breach of Clause 14.1.

The Panel noted that Clause 14.3 of the 2011 Code required that, *inter alia*, educational material for the public or patients issued by companies which related to diseases or medicines but was not intended as promotion for those medicines must be certified in advance in a manner similar to that provided for by Clause 14.1.

The Panel noted that A Menarini had failed to certify the website when it was first created in July 2011 as required by the 2011 Code and a breach of Clause 14.3 was ruled as acknowledged by the company.

The Panel noted A Menarini's submission that the website had not been reviewed since July 2011. The Panel noted that Clause 14.5 of the current Code required, *inter alia*, that material which was still in use be recertified at intervals of no more than two years to ensure that it continued to conform with the relevant regulations relating to advertising and the Code. The Panel noted that A Menarini had not reviewed the website since July 2011 and as such it had not been re-certified in line with Clause 14.5 and a breach of the current Code was ruled as acknowledged by the company.

Clause 14.6 of the current Code stated, *inter alia*, that companies shall preserve all certificates and that the certificates for material covered by Clause 14.3 shall be preserved for not less than three years after the final use of the material and companies shall produce them on request from the Medicines and Healthcare products Regulatory Agency or the Prescription Medicines Code of Practice Authority. The Panel noted that as the website had never been certified, there was no certificate. The Panel therefore ruled a breach of Clause 14.6 as acknowledged by the company.

The Panel noted its rulings above and considered that the failure to certify and re-certify its website meant that A Menarini had failed to maintain high standards. A breach of Clause 9.1 of the current Code was ruled. The Panel noted that a robust certification procedure underpinned self-regulation. The Panel considered that A Menarini's lack of such a process and its failure to review and certify material aimed at the public or patients meant that it had brought the industry into disrepute. A breach of Clause 2 was ruled. These breaches were acknowledged by the company.

The Panel noted its ruling in Case AUTH/2949/3/17 in that it was very concerned that despite discovering that the hyperlink to the MHRA Yellow Card Scheme had disappeared on 31 January 2017 and promptly notifying its parent company responsible for website maintenance no action was apparently taken until A Menarini was notified of that complaint on 27 March 2017. This showed a disregard for patient safety issues. The Panel had ruled a breach of Clause 9.1 in that case. Noting the complainant's allegations in Case AUTH/2949/3/17 the Panel considered that patient safety was of the utmost importance and A Menarini's failures in this regard brought discredit upon and reduced confidence in the pharmaceutical industry. A breach of Clause 2 was ruled.

Complaint received **6 June 2017**

Case completed **9 August 2017**

ANONYMOUS, NON-CONTACTABLE v BAYER

Conduct of representative

An anonymous, non-contactable complainant alleged that a named Bayer representative had not declared a conflict of interest in that her husband was a doctor in a named trust and gave her access.

Bayer's detailed response is given below.

The Panel noted that there would be occasions when representatives had links with health professionals and other relevant decision makers which would be of potential concern. In such cases it might be prudent for companies to consider changing a representative's territory so they did not call upon such people. The external perception of the arrangements was important.

The Panel noted that the representative's husband was a junior doctor in a named trust within her territory working as a cardiothoracic surgeon. This was disclosed by the representative to her manager when she was given the additional responsibility of promoting Xarelto in secondary care including the named trust at which her husband worked.

The Panel noted Bayer's submission about the actively promoted indications for Xarelto for Xarelto promotional activity and that, in its view, there was, therefore, no conflict of interest to declare as neither her husband nor the department within which he worked were targets for Xarelto promotional activity. The Panel further noted Bayer's submission that its representative call reporting system had revealed no call history corresponding to either the representative's husband, or the team within which he worked.

The Panel considered that there was no evidence to support the allegation that the representative had failed to maintain high standards and no breach of the Code was ruled.

An anonymous, non contactable complainant that signed them compaint off with a named health trust complained about the conduct of a named Bayer plc representative.

COMPLAINT

The complainant alleged that the representative was in breach of the Code as she had not declared a conflict of interest in that her husband was a doctor in the named trust and gave her access.

When writing to Bayer, the Authority asked it to consider the requirements of Clause 15.2.

RESPONSE

Bayer submitted that the representative in question was an employee of a third party agency and had been contracted to Bayer for approximately 12 months. When first contracted to Bayer, she was employed as a Territory Manager (TM), with responsibility to promote Xarelto (rivaroxaban) in primary care. Since May this year she had also been given in addition two small hospital accounts.

The representative's husband, was a junior doctor, a fellow in cardiothoracic surgery (ST6 level) at one of the named trusts.

Bayer noted that Xarelto was licensed for:

- Co-administration with acetylsalicylic acid (ASA) alone or with ASA plus clopidogrel or ticlopidine, for the prevention of atherothrombotic events in adult patients after an acute coronary syndrome (ACS) with elevated cardiac biomarkers.
- Prevention of venous thromboembolism (VTE) in adult patients undergoing elective hip or knee replacement surgery.
- Prevention of stroke and systemic embolism in adult patients with non-valvular atrial fibrillation with one or more risk factors, such as congestive heart failure, hypertension, age ≥ 75 years, diabetes mellitus, prior stroke or transient ischaemic attack.
- Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE), and prevention of recurrent DVT and PE in adults.

Xarelto was actively promoted only in the latter two indications listed above. Therefore, in the secondary care setting, Xarelto was promoted to cardiologists, stroke physicians, care of the elderly physicians, respiratory physicians and haematologists. Cardiothoracic surgeons were not within the target scope of promotion for Xarelto.

As stated above, when the representative was initially contracted to Bayer, she only worked in the primary care setting. As her husband worked as a surgeon in secondary care, there was no conflict of interest to declare.

When the representative was given the responsibility of working additionally in secondary care, she told her manager that her husband was a junior doctor within the named trust, working as a cardiothoracic surgeon. Cardiothoracic surgeons do not routinely manage patients with non-valvular atrial fibrillation, nor patients within scope of any of the other licensed indications for Xarelto. Therefore, Cardiothoracic surgeons, have never been within promotional scope for Xarelto representatives and, as such, there was no conflict of interest to declare as her husband and the department within which he worked was not within the target scope of promotion for Xarelto.

Bayer submitted that its representative call reporting system had revealed no call history corresponding to the representative's husband, nor corresponding

to the team within which he worked. Indeed, her husband was not listed within Bayer's customer database. Bayer noted that the representative's husband was a junior doctor within his department, and was not considered to be an opinion leader or influential decision maker within the NHS or the trust.

The representative's activity level at the NHS trust in question had been appropriate compared with the other areas she worked in; it represented 2.62% of her overall call volume.

Bayer submitted that it had uncovered no evidence to support an undeclared conflict of interest, nor had it uncovered any evidence to support allegations of inappropriate or unusual access to the NHS trust in question. In that regard Bayer noted that, the anonymous complainant had incorrectly cited the name of the trust despite claiming to work there.

Bayer considered that the representative in question had at all times maintained a high standard of ethical conduct in the discharge of her duties. Bayer therefore denied a breach of Clause 15.2.

PANEL RULING

The Panel noted that the complainant was anonymous and non-contactable. The Constitution and Procedure stated that anonymous complaints would be accepted, but that like all other complaints, the complainant had the burden of proving his/her complaint on the balance of probabilities. All complaints were judged on the evidence provided by the parties. The complainant could not be contacted for more information.

The Panel noted that there would be occasions when representatives had links with health professionals and other relevant decision makers which would be of potential concern. In such cases it might be prudent for companies to consider changing a representative's territory so they did not call upon such people. The external perception of the arrangements was important.

The Panel noted that the representative's husband was a junior doctor in a named trust within her territory working as a cardiothoracic surgeon. This was disclosed by the representative to her manager when she was given the additional responsibility of promoting Xarelto in secondary care including the named trust at which her husband worked.

The Panel noted Bayer's submission about the actively promoted indications for Xarelto and that, in its view, there was, therefore, no conflict of interest to declare as neither her husband nor the department within which he worked were targets for Xarelto promotional activity. The Panel further noted Bayer's submission that its representative call reporting system had revealed no call history corresponding to either the representative's husband, or to the team within which he worked.

The Panel considered that there was no evidence to support the allegation that the representative had failed to maintain high standards and no breach of Clause 15.2 was ruled.

Complaint received **31 August 2017**

Case completed **28 September 2017**

CODE OF PRACTICE REVIEW – November 2017

Cases in which a breach of the Code was ruled are indexed in **bold type.**

AUTH/2783/7/15	**The Daily Telegraph/Director v Stirling Anglian**	**Arrangements for a meeting**	**Breaches Clauses 2, 9.1, 18.1, 21, 22.1, 22.1** **Required by the Appeal Board to issue a corrective statement** **Audit and two further re-audits required by Appeal Board**	**No appeal** **Report from Panel to Appeal Board**	**Page 3**
AUTH/2825/3/16 and AUTH/2826/3/16	**Janssen v Boehringer Ingelheim and Lilly**	**Promotion of Jardiance**	**Breaches Clauses 2, 3.2, 9.1 and 12.1** **Required by the Appeal Board to issue a corrective statement** **Recovery of item required by Appeal Board** **Audit and re-audit required by Appeal Board**	**No appeal** **Report from Panel to Appeal Board**	**Page 22**
AUTH/2923/12/16	**Hospital pharmacist v Merck Sharp & Dohme**	**Remicade advertisement**	**Breach Clause 7.2** **Two breaches Clause 7.10**	**Appeal by complainant**	**Page 38**
AUTH/2943/3/17	**Ex-employee of a service provider v Bayer**	**Conduct of an employee**	**Breaches Clauses 2, 9.1 and 15.9**	**No appeal**	**Page 45**
AUTH/2947/3/17	**Anonymous v Sanofi**	**Representatives' call rates**	**Breaches Clauses 9.1 and 15.9**	**No appeal**	**Page 53**
AUTH/2948/3/17	**General practitioner v Novo Nordisk**	**Promotion of Tresiba**	**Breaches Clauses 7.2 and 7.3**	**No appeal**	**Page 57**
AUTH/2949/3/17	**Hospital doctor v A Menarini**	**Yellow Card Scheme details missing from company website**	**Breaches Clauses 9.1 and 26.3**	**No appeal**	**Page 62**
AUTH/2953/4/17	**Tillotts v Dr Falk**	**Promotion of Salofalk Granules**	**Breaches Clauses 7.2, 7.3, 7.4 and 7.10**	**No appeal**	**Page 65**
AUTH/2954/4/17	**Health professional v AstraZeneca**	**Conduct of a representative**	**Breaches Clauses 7.2, 7.4, 9.1, 15.2, 15.4 and 15.9**	**No appeal**	**Page 73**
AUTH/2955/4/17	Anonymous non-contactable employee v Boehringer Ingelheim	Call rates	No breach	No appeal	Page 78

AUTH/2956/5/17	Ex-employee v Napp	Flutiform promotional practices	No Breach	No appeal	Page 85
AUTH/2957/5/17	**Voluntary admission by Astellas UK**	**Omission of prescribing information**	**Breach Clause 2** **Multiple breaches Clause 4.1** **Breach Clause 9.1**	**No appeal**	**Page 99**
AUTH/2958/5/17	**Voluntary admission by Astellas Europe**	**Use of withdrawn advertisement**	**Breaches Clauses 2, 7.11, 9.1 and 14.1**	**No appeal**	**Page 102**
AUTH/2959/5/17	Head of medicines management v Bayer	Recruitment of patients for market research	No Breach	No appeal	Page 107
AUTH/2960/6/17	**Hospital doctor v A Menarini**	**Certification of company website**	**Two Breaches Clause 2** **Breaches Clauses 14.3, 14.5 and 14.6**	**No appeal**	**Page 110**
AUTH/2973/8/17	Anonymous, non-contactable v Bayer	Conduct of representative	No Breach	No appeal	Page 114

PMCPA | Prescription Medicines Code of Practice Authority

The Prescription Medicines Code of Practice Authority was established by the Association of the British Pharmaceutical Industry (ABPI) in 1993 to operate the Code of Practice for the Pharmaceutical Industry at arm's length from the ABPI itself. Compliance with the Code is obligatory for ABPI member companies and, in addition, over sixty non member companies have voluntarily agreed to comply with the Code and to accept the jurisdiction of the Authority.

The Code covers the advertising of medicines to health professionals and other relevant decision makers and also covers information about prescription only medicines made available to the public.

It covers:

- journal and direct mail advertising
- the activities of representatives, including any printed or electronic material used by them
- the supply of samples
- the provision of inducements in connection with the promotion of medicines and inducements to prescribe, supply, administer, recommend, buy or sell medicines by the gift, offer or promise of any benefit or bonus, whether in money or in kind
- the provision of hospitality
- the organisation of promotional meetings
- the sponsorship of scientific and other meetings, including payment of travelling and accommodation expenses
- the sponsorship of attendance at meetings organised by third parties
- all other sales promotion in whatever form, such as participation in exhibitions, the use of audio or video-recordings in any format, broadcast media, non-print media, the Internet, interactive data systems, social media and the like.

It also covers:

- the provision of information on prescription only medicines to the public either directly or indirectly, including by means of the Internet
- relationships with patient organisations
- disclosure of tranfers of value to health professionals and organisations
- joint working between the NHS and pharmaceutical companies
- the use of consultants
- non-interventional studies of marketed medicines
- the provision of items for patients
- the provision of medical and educational goods and services
- grants, donations and benefits in kind to institutions.

Complaints submitted under the Code are considered by the Code of Practice Panel which consists of three of the four members of the Code of Practice Authority acting with the assistance of independent expert advisers where appropriate. One member of the Panel acts as case preparation manager for a particular case and that member does not participate and is not present when the Panel considers it.

Both complainants and respondents may appeal to the Code of Practice Appeal Board against rulings made by the Panel. The Code of Practice Appeal Board is chaired by an independent legally qualified Chairman, Mr William Harbage QC, and includes independent members from outside the industry. Independent members, including the Chairman, must be in a majority when matters are considered by the Appeal Board.

In each case where a breach of the Code is ruled, the company concerned must give an undertaking that the practice in question has ceased forthwith and that all possible steps have been taken to avoid a similar breach in the future. An undertaking must be accompanied by details of the action taken to implement the ruling. Additional sanctions are imposed in serious cases.

Further information about the Authority and the Code can be found at www.pmcpa.org.uk

Complaints under the Code should be sent to the Director of the Prescription Medicines Code of Practice Authority, 7th Floor, Southside, 105 Victoria St, London SW1E 6QT

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