NO BREACH OF THE CODE

CASE AUTH/3425/11/20 and AUTH/3426/11/20

ROYAL COLLEGE COMMITTEE v PFIZER AND BRISTOL-MYERS SQUIBB

Eliquis email campaign

The Royal College of General Practitioners (RCGP) Overdiagnosis Group complained about an Eliquis (apixaban) promotional email (ref PP-ELI-GBR-6974) sent jointly from Pfizer Limited and Bristol-Myers Squibb (the Alliance) via Pulse. The email promoted a pulse check for atrial fibrillation (AF) in over 65 years olds during influenza vaccination clinics.

Eliquis was indicated, *inter alia*, for the prevention of stroke and systemic embolism in adult patients with non-valvular atrial fibrillation (NVAF), with one or more risk factors.

The complainants stated that the email promoted screening for atrial fibrillation and failed to meet the Code requirements in that it was not balanced, was not up-to-date, and was not sufficiently complete in that the latest guidance from the National Screening Committee (August 2019), which had rigorously appraised the evidence regarding atrial fibrillation, did not recommend screening. This critical information was omitted from the email. Further, the guidance from the National Institute for health and Care Excellence (NICE) which was referenced in the email, specifically indicated when the pulse should be taken to detect atrial fibrillation, and this did not include for screening. This information was also omitted from the email. These two critical omissions of the latest information meant that the evidence presented was partial, biased and done in the interests of increasing the prescribing of the Alliance's products.

The complainants added that suggesting pulse checks increased touching in a pandemic and increased public transmission risk too.

The detailed response from Pfizer and Bristol-Myers Squibb is given below.

The Panel noted the subject heading for the email in questions was 'Pulse check for atrial fibrillation at your next flu vaccination programme – on behalf of the BMS Pfizer Alliance'. The email began with information about Eliquis and the next main heading referred to the results of an opportunistic screening programme in Dorset in over 65 year olds where AF was newly diagnosed in 8 out of a 1000 people who received a manual pulse check whilst attending flu vaccination clinics. The email also referred to other opportunities to check for AF and to maximise any face to face interactions. In relation to the question why perform pulse checks the email stated, *inter alia*, 'Leading guidance recommends pulse checks for > 65-year-olds to assess the presence of an irregular pulse that may indicate AF' and this was referenced to NHS RightCare, accessed October 2020, and Hindricks *et al* 2020. The only reference to NICE Guideline CG180 was in

relation to patients where AF was confirmed and initiation of treatment in high-risk patients where anticoagulation was appropriate.
In the Panel's view, it was clear that the email in question was referring to opportunistic screening and not systematic population screening.

There was no reference in the email in question, either directly or indirectly, to a systematic population screening programme nor was there any information within the email that the NSC (2019) did not recommend such screening.

The Panel noted the Alliance's submission that the objective of the email in question was to provide information on an opportunistic screening pathway that could be implemented in patients over 65 years of age within a primary care setting as part of a routine flu vaccination clinic, as indicated in the subject title of the email, 'Pulse check for atrial fibrillation at your next flu vaccination programme'.

The Panel considered that it was a matter for health professionals to decide whether to carry out a pulse check bearing in mind all the relevant factors including the advice for examining patients during the pandemic.

The Panel noted the Alliance's submission that in order to improve detection of asymptomatic atrial fibrillation, opportunistic screening in all patients ≥65 years by taking the pulse was recommended by RCPE consensus statement since 2012, and opportunistic screening by pulse taking or ECG strip received a Class I, Level B evidence based recommendation in the most recent ESC guidelines.

The Panel further noted that the NHS RightCare High value intervention in atrial fibrillation stated: 'Add pulse checking to existing GP and pharmacy enhanced services for people over 65'; and the CVD prevention during the COVID-19 pandemic Guidance for primary care teams stated: 'Patients attending for blood tests, ECGs, dressings, etc, could have their pulse and BP checked by a healthcare assistant or phlebotomist (with appropriate training)' beneath the heading face-to-face encounters.

The Panel noted the complainant's concern that the guidance from NICE which was referenced in the email, specifically indicated when the pulse should be taken to detect atrial fibrillation, and this did not include for screening which was also omitted from the email.

The Panel noted the Alliance's submission that within the recommendations, NICE referred to symptomatic or asymptomatic paroxysmal, persistent, or permanent atrial fibrillation. It was well established that atrial fibrillation could present as symptomatic but often asymptomatic. As highlighted by NICE CG180, treatment of atrial fibrillation must include measures to prevent stroke which was not determined by the presence of symptoms. Initiation of stroke prevention therapy in the form of anticoagulation was based on a person's stroke risk, it was not based on a symptomatic or asymptomatic presentation of atrial fibrillation. The Panel noted the Alliance's submission that the email did not contradict the NHS guidance and was aligned with key UK and NHS recommendations.

In the Panel's view, there appeared to be a difference between opportunistic screening as referred to within the email in question and systematic population screening which was not recommended by the UK NSC.

The Panel did not consider that there was evidence to show that the email, by failing to include reference to the fact that systematic population screening was not recommended by the UK NSC, was misleading. No breaches of the Code were ruled including Clause 2.

The Royal College of General Practitioners (RCGP) Overdiagnosis Group complained about an Eliquis (apixaban) promotional email (ref PP-ELI-GBR-6974) sent jointly from Pfizer Limited and Bristol-Myers Squibb (the Alliance) via Pulse. The email promoted a pulse check for atrial fibrillation (AF) in over 65 years olds during influenza vaccination clinics.

Eliquis was indicated, *inter alia*, for the prevention of stroke and systemic embolism in adult patients with non-valvular atrial fibrillation (NVAF), with one or more risk factors.

COMPLAINT

The complainants alleged a breach of Clause 7.2 which required:

> '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. They must not mislead either directly or by implication, by distortion, exaggeration or undue emphasis.
>
> Material must be sufficiently complete to enable the recipient to form their own opinion of the therapeutic value of the medicine.'

The complainants stated that the email promoted screening for atrial fibrillation and failed to meet the Code requirements in that it was not balanced, was not up-to-date, and was not sufficiently complete in that the latest guidance from the National Screening Committee (August 2019), which had rigorously appraised the evidence regarding atrial fibrillation, did not recommend screening. This critical information was omitted from the email. Further, the guidance from the National Institute for health and Care Excellence (NICE) which was referenced in the email, specifically indicated when the pulse should be taken to detect atrial fibrillation, and this did not include for screening. This information was also omitted from the email. These two critical omissions of the latest information meant that the evidence presented was partial, biased and done in the interests of increasing the prescribing of the Alliance's products.

The complainants stated that they looked forward to a correction being sent to health professionals, giving prominence to the National Screening Committee advice, and an apology from the Alliance.

The complainants added that suggesting pulse checks increased touching in a pandemic and increased public transmission risk too.

When writing to Pfizer and Bristol-Myers Squibb, the Authority asked the companies to consider the requirements of Clauses 2, 7.2 and 9.1 of the Code.

RESPONSE

Pfizer responded on behalf of both companies and explained that the email in question was certified on 21 October 2020 in accordance with the requirements of Clause 14.1 (certificate provided).

The Alliance stated that the Pulsetoday.co.uk website, owned and administered by a healthcare marketing agnecy, was intended for a primary care audience in the UK, including general practitioners. Registration was also open to other primary care health professionals, including nurses and pharmacists. Pulse held a list of health professionals who had consented and opted-in to receive third party communications, including promotional content from pharmaceutical companies (copy provided). The email in question was sent through that mechanism by Pulse to general practitioners on behalf of the Alliance. This one-off distribution was sent to 17,100 general practitioners on 6 November 2020.

The Alliance stated that one of its key objectives was to provide accurate, balanced and up-to-date, evidence-based information to health professionals, to support the NHS in reducing the burden of atrial fibrillation and to improve patient outcomes. In order to achieve that objective, the Alliance took its responsibility to operate within the remit of the Code very seriously and ensured that its communications and activities were of the highest standard.

The Alliance strongly refuted the suggestion that the email or any aspect of it did not meet the requirements set out in the Code.

By way of background, the Alliance explained that atrial fibrillation, the most common heart rhythm disturbance, affected 1.2 million people in the UK and accounted for up to one in five strokes in the UK. Atrial fibrillation increased the risk of stroke by five times. While some patients with atrial fibrillation were symptomatic, leading to an appropriate diagnosis and treatment, in people who were asymptomatic, atrial fibrillation was often only diagnosed opportunistically during a general medical check-up or after a stroke or transient ischaemic attack. Detection and diagnosis of atrial fibrillation in those individuals could lead to initiation of appropriate therapy and therefore reduced their risk of stroke and the complications associated with atrial fibrillation progression.

The Alliance stated that the NHS Long Term Plan was committed to preventing up to 150,000 heart attacks, strokes and dementia cases over the next 10 years by improving early detection and treatment of cardiovascular disease (CVD) risk factors. This followed recognition that a significant number of individuals were living with undetected, high-risk conditions such as atrial fibrillation.

The Alliance submitted that in line with this ambition, NHS RightCare introduced its High-Value Intervention, recommending the addition of pulse checking to existing GP and pharmacy enhanced services for people over 65 years of age.

The Alliance submitted that the email was consistent with the current body of evidence, including NHS Organisations and European guidelines, recommending opportunistic screening in patients ≥65 years of age for the detection of atrial fibrillation. In that regard the Alliance noted that opportunistic screening occurred when health professionals took the opportunity to check a patient's pulse for atrial fibrillation during a routine consultation (a patient visit to a health professional for a different reason other than the purpose of screening). Usually patients

would need to be above a certain age, eg ≥65 years. Systematic population screening was where all people above a certain age were invited to attend their general practice or another location for screening as part of a whole population screening programme.

The Alliance noted that the UK National Screening Committee had recommended against systematic population screening programmes for atrial fibrillation. The complainants referred to that recommendation and suggested that the email in question was incomplete due to its omission.

The Alliance submitted that the objective of the email in question was to provide information on an opportunistic screening pathway that could be implemented in patients over 65 years of age within a primary care setting as part of a routine flu vaccination clinic, as indicated in the subject title of the email, 'Pulse check for atrial fibrillation at your next flu vaccination programme'.

There was no reference, in any aspect of the email, either directly or indirectly, to a systematic population screening programme, as recommended against by the NSC in 2019. A national screening programme would have a significant impact on capacity across the entire referral pathway in order to ensure appropriate patient management.

Opportunistic screening was when a health professional took a patient's pulse (or ECG rhythm strip) to check for atrial fibrillation during a routine consultation. As per the objective of the email, using a routine flu vaccination clinic to take the pulse in patients over 65 years of age, was an appropriate method to detect atrial fibrillation in the UK, a position endorsed by key NHS organisations as outlined in Table 1 below. The role of the UK National Screening Committee was to advise UK ministers and the NHS about all aspects pertaining to population screening and to support their implementation. The NHS itself, through relevant organisations as listed below, had recommended opportunistic screening for atrial fibrillation in patients ≥65 years of age as part of routine clinical practice.

These recommendations made by NHS bodies were consistent with the most recent European Society of Cardiology 2020 Guidelines for the Management of Atrial Fibrillation, which recommended opportunistic screening in patients over 65 years of age.

The Alliance stated that the objective of the email, to provide information on opportunistic screening within a flu vaccination setting in patients ≥65 years of age, was therefore wholly aligned with the latest European guidelines and recommendations from authoritative NHS organisations.

Table 1: Key authoritative national and international guidelines and recommendations

National guidelines and recommendations	
1. NHS RightCare, within the CVD prevention pathway	Recommends adding pulse checking to existing GP and pharmacy enhanced services for people over 65 years of age**.**

2. NHS improvement programme, Getting It Right First Time (GIRFT)	A recently published practical guide '**CVD prevention during the COVID-19 pandemic: a guide for primary care'** recommends during face-to-face encounters, patients attending for other medical reasons could have their pulse checked by appropriately trained healthcare staff. • 'Maximise all encounters, especially face to face', was a key point highlighted in the guide • The guide was co-authored by the **Primary Care Cardiovascular Society (PCCS)** and supported by the **Oxford Academic Health Science Network**
3. Academic Health Science Network (AHSN), established by NHS England to spread innovation and improve health	Promoted the adoption of the 'Detect' strategy, which focused on raising public awareness of atrial fibrillation and the importance of pulse checking as part of routine clinical practice to identify those with undiagnosed atrial fibrillation. • Within the atrial fibrillation Toolkit, recommendations and case studies were provided on how to incorporate atrial fibrillation detection into routine clinical practice • The Toolkit specifically stated, 'A manual pulse check was the simplest, most cost-effective method of identifying undetected atrial fibrillation and should be undertaken in all routine clinical practice, especially for those at increased risk of atrial fibrillation'.
4. British Journal of General Practice	Editorial by John Robson and Richard Schilling, published in 2019, discussed the current available evidence and suggested that opportunistic case finding for atrial fibrillation was simple and feasible in general practice for whole populations at older ages.
5. Public Health England (PHE)	The PHE ambition, as part of the NHS Long Term Plan, was to detect 85% of expected individuals with atrial fibrillation by 2029. PHE modelling suggested there were around 300,000 people in England with undiagnosed atrial fibrillation.
6. Royal College of Physicians of Edinburgh (RCPE)	The 2012 consensus statement recommended opportunistic screening by pulse palpation of people aged 65 years or older in primary care.
International guidelines and recommendations	
7. 2020 European Society of Cardiology (ESC) Guidelines for the management of AF	Recommend opportunistic screening for atrial fibrillation by pulse taking or ECG rhythm strip in patients ≥65 years of age, a Class I, Level B1 evidence-based recommendation. The definition of Class I was evidence and/or general agreement that a given treatment or procedure was beneficial, useful, effective. Wording to use: Is recommended/indicated; Level of evidence B: Data derived from a single randomised clinical trial or large non-randomised studies.

8. European Heart Rhythm Association, AF-SCREEN International Collaboration	The European Society Cardiology Guidelines were mirrored by international recommendations from the **European Heart Rhythm Association** and the **AF-SCREEN International Collaboration**.
9. European Primary Care Cardiovascular Society (EPCCS)	Recommends that opportunistic case finding should be carried out for timely detection of atrial fibrillation in all patients over 65 years of age, and in anyone who received routine cardiovascular follow- up: • The EPCCS recommend that pulse palpation, at least once a year could be incorporated into already existing medical visits, for instance during an annual cardiac disease review, and/or at flu vaccinations or pharmacy visits.

The Alliance submitted that before the COVID-19 pandemic, it was estimated by Public Health England that there were over 300,000 people across England who were unaware they had atrial fibrillation. With reports suggesting a decrease in people seeking routine or emergency healthcare during the pandemic, including for cardiovascular conditions such as heart attack and stroke, this might point to even more cases of undetected atrial fibrillation. Data available for Denmark showed that, following a national lockdown, there was a 47% drop in registered new-onset atrial fibrillation cases. UK data from Salford, showed that, between 1 March and 31 May 2020, diagnoses of circulatory system diseases, including atrial fibrillation, fell by 43.3%.

The guide referred to in line 2 in the table above, 'CVD [cardiovascular disease] prevention during the COVID-19 pandemic: a guide for primary care' was produced to help primary care continue to deliver cardiovascular disease preventative interventions during the Covid-19 pandemic, including pulse checking during routine medical consultations. It highlighted the importance of maximising all face-to-face encounters during the pandemic to treat preventable cardiovascular events such as stroke.

Developed with expertise from NHS primary care, including the Primary Care Cardiovascular Society (PCCS), that guidance fully supported the objective of the email in question, in which an opportunistic screening pathway for atrial fibrillation could be considered within a flu vaccination setting to maximise GP face-to-face appointments for at-risk patients.

The Alliance submitted that the email was aligned with the 2014 NICE CG180 guidance for the management of atrial fibrillation and consistent with the most up-to-date scientific evidence. The relevant recommendations from the NICE guidance were referred to within the email, where appropriate.

The Alliance submitted that the NICE CG180 guidance had not provided any recommendations with regards to opportunistic screening for the detection of atrial fibrillation**,** the subject of the email in question. The guidance did, however, provide the recommendations shown in Table 2 below regarding diagnosis and assessment.

Table 2: 2014 NICE CG180 clinical guideline on atrial fibrillation management

1.1 Diagnosis and Assessment
1.1.1 Perform manual pulse palpation to assess for the presence of an irregular pulse that might indicate underlying atrial fibrillation in people presenting with any of: breathlessness/dyspnoea, palpitations, syncope/dizziness, chest discomfort, stroke/TIA
1.1.2 Perform an electrocardiogram (ECG) in all people, whether symptomatic or not, in whom atrial fibrillation was suspected because an irregular pulse had been detected
1.4 Assessment of stroke and bleeding risks
1 Use the CHA_2DS_2-VASc stroke risk score to assess stroke risk in people with any of the following: • Symptomatic or asymptomatic paroxysmal, persistent or permanent atrial fibrillation, atrial flutter, a continuing risk of arrhythmia recurrence after cardioversion back to sinus rhythm 2 Use the HAS-BLED score to assess the risk of bleeding in people who were starting or had started anticoagulation.

The Alliance stated that within those recommendations, NICE referred to symptomatic or asymptomatic paroxysmal, persistent or permanent atrial fibrillation. It was well established that atrial fibrillation could present as symptomatic but often asymptomatic. As highlighted by NICE CG180, treatment of atrial fibrillation must include measures to prevent stroke which was not determined by the presence of symptoms. Initiation of stroke prevention therapy in the form of anticoagulation was based on a person's stroke risk, as outlined in Table 2. It was not based on a symptomatic or asymptomatic presentation of atrial fibrillation.

The Alliance submitted that the email did not contradict the guidance as shown in Table 2 and was aligned with key UK and NHS recommendations (Table 1), including the European Society Cardiology 2020 Guidelines for the management of atrial fibrillation.

The Alliance submitted that the relevant sections of NICE guidance on the management of atrial fibrillation were presented within the email to ensure balanced information was provided to the reader. The email made prominent references to the NICE CG180 guidance on two separate occasions. The importance of staying 'up-to-date with the most recent atrial fibrillation management guidance (NICE, European Society Cardiology)' was emphasised within the email itself and the specific recommendations from NICE regarding treatment initiation were also highlighted further down the email: 'If AF is confirmed, stroke risk could be reduced in high-risk patients where anticoagulation was appropriate. In line with NICE guidance, when initiating a treatment, discuss with the patient the risks and benefits of the interventions, and consider individual needs, values and preferences.'

With regard to Clause 7.2, the Alliance submitted that the email provided an accurate, balanced, fair overview of the latest scientific evidence and guideline recommendations relating to opportunistic pulse checking for the detection of atrial fibrillation, thus allowing the recipient to make an objective assessment.

The email was consistent with all requirements of Clause 7.2 and therefore the Alliance did not consider any aspect of the email was in breach of that clause.

The Alliance stated that it had acted in the interest of patients and health professionals; it had raised awareness of atrial fibrillation detection and stroke prevention, which was a national priority as outlined by the NHS, particularly during the pandemic where a reduced number of patient visits to clinicians had decreased the opportunity for pulse palpation and detection of atrial fibrillation. As highlighted by the NHS improvement programme, GIRFT, making the most of all contacts with patients, particularly face-to-face, was critical to delivering cardiovascular disease preventative interventions.

The body of evidence, reflected in a large number of national and international authoritative guidelines, showed that opportunistic screening could be used to detect atrial fibrillation and implement appropriate stroke prevention measures. Without effective detection and prevention, many patients, including those without any symptoms, were at increased risk of stroke and death.

The Alliance submitted that the information provided within the email was an accurate representation of the most up-to- date scientific evidence and as such it considered that the email demonstrated the Alliance's commitment to maintaining high standards and did not bring discredit upon the industry. The Alliance therefore denied a breach of Clauses 9.1 and 2.

PANEL RULING

The Panel noted that extreme dissatisfaction was usually required on the part of an individual before he or she was moved to complain. All complaints were judged on the evidence provided by the parties.

The Panel noted the subject heading for the email in questions was 'Pulse check for atrial fibrillation at your next flu vaccination programme – on behalf of the BMS Pfizer Alliance'. The email began with information about Eliquis and the next main heading referred to the results of an opportunistic screening programme in Dorset in over 65 year olds where AF was newly diagnosed in 8 out of a 1000 people who received a manual pulse check whilst attending flu vaccination clinics. The email also referred to other opportunities to check for AF and to maximise any face to face interactions. In relation to the question why perform pulse checks the email stated, *inter alia*, 'Leading guidance recommends pulse checks for > 65-year-olds to assess the presence of an irregular pulse that may indicate AF' and this was referenced to NHS RightCare accessed October 2020 and Hindricks *et al* 2020. The only reference to NICE Guideline CG180 was in relation to patients where AF was confirmed and initiation of treatment in high-risk patients where anticoagulation was appropriate.

In the Panel's view, it was clear that the email in question was referring to opportunistic screening and not systematic population screening.

The Panel noted that the UK National Screening Committee's last review in August 2019 did not recommend a national screening programme (systematic population screening) for atrial fibrillation in adults because: there were different types of atrial fibrillation and it was not clear if these all had the same risk for stroke; it was not known how effective treatment for atrial fibrillation was in people found through screening; and it was not known if screening was more beneficial for people with atrial fibrillation than the current approach.

The Panel noted the Alliance's submission that systematic population screening was where all people above a certain age were invited to attend their general practice or another location for

screening as part of a whole population screening programme. There was no reference in the email in question, either directly or indirectly, to a systematic population screening programme nor was there any information within the email that the NSC (2019) did not recommend such screening.

The Panel noted the Alliance's submission that the objective of the email in question was to provide information on an opportunistic screening pathway that could be implemented in patients over 65 years of age within a primary care setting as part of a routine flu vaccination clinic, as indicated in the subject title of the email, 'Pulse check for atrial fibrillation at your next flu vaccination programme'.

The Panel noted the Alliance's submission that opportunistic screening was when a health professional took a patient's pulse (or ECG rhythm strip) to check for atrial fibrillation during a routine consultation.

The Panel considered that it was a matter for health professionals to decide whether to carry out a pulse check bearing in mind all the relevant factors including the advice for examining patients during the pandemic.

The Panel noted the Alliance's submission that in order to improve detection of asymptomatic atrial fibrillation, opportunistic screening in all patients ≥65 years by taking the pulse was recommended by RCPE consensus statement since 2012, and opportunistic screening by pulse taking or ECG strip received a Class I, Level B evidence based recommendation in the most recent ESC guidelines.

The Panel further noted that the NHS RightCare High value intervention in atrial fibrillation stated: 'Add pulse checking to existing GP and pharmacy enhanced services for people over 65'; and the CVD prevention during the COVID-19 pandemic Guidance for primary care teams stated: 'Patients attending for blood tests, ECGs, dressings, etc, could have their pulse and BP checked by a healthcare assistant or phlebotomist (with appropriate training)' beneath the heading face-to-face encounters.

The Panel noted the complainant's concern that the guidance from NICE which was referenced in the email, specifically indicated when the pulse should be taken to detect atrial fibrillation, and this did not include for screening which was also omitted from the email.

The Panel noted that the NICE guideline [CG180], published 2014 and provided by Pfizer in response to the complaint [an update was published on 27 April 2021] stated in relation to diagnosis and assessment to perform manual pulse palpation to assess for the presence of an irregular pulse that may indicate underlying atrial fibrillation in people presenting with any of the following:

- Breathlessness/dyspnoea
- palpitations
- syncope or dizziness
- chest discomfort
- stroke or transient ischaemic attack. [2006].

The Panel noted the Alliance's submission that within the recommendations, NICE referred to symptomatic or asymptomatic paroxysmal, persistent, or permanent atrial fibrillation. It was well

established that atrial fibrillation could present as symptomatic but often asymptomatic. As highlighted by NICE CG180, treatment of atrial fibrillation must include measures to prevent stroke which was not determined by the presence of symptoms. Initiation of stroke prevention therapy in the form of anticoagulation was based on a person's stroke risk, it was not based on a symptomatic or asymptomatic presentation of atrial fibrillation. The Panel noted the Alliance's submission the email did not contradict the NHS guidance and was aligned with key UK and NHS recommendations.

In the Panel's view, there appeared to be a difference between opportunistic screening as referred to within the email in question and systematic population screening which was not recommended by the UK NSC.

The Panel did not consider that there was evidence to show that the email, by failing to include reference to the fact that systematic population screening was not recommended by the UK NSC, was misleading and no breach of Clause 7.2 was ruled.

The Panel consequently ruled no breaches of Clauses 9.1 and 2.

Complaint received **15 November 2020**

Case completed **11 June 2021**