Pharma's Bad Karma

Resistance Is Not Futile

The pharmaceutical industry (pharma) spends over \$15 billion annually promoting its products in the U.S. market.¹ Two studies in this issue of *JGIM* add to the extensive peer-reviewed literature suggesting that relying on such promotional sources for information may be detrimental to the health of our patients.²

Cooper et al.³ used explicit criteria to evaluate graphs found in pharmaceutical advertisements and found 20% violated Tufte's rules⁴ that there exist only as many dimensions in the graphic as exist in the data. Tufte's "lie factor"⁴ compares the size of the graphic to the size of the data and considers a ratio of <0.95 or >1.05 as significant distortion. Although not clear if these were the exact criteria used, Cooper et al. found that over one third of ads exhibited numeric distortion. Furthermore, 60% lacked sufficient information to interpret the results.

Shi et al. found half of all users of phenazopyridine (a urinary tract analgesic) did not intend to seek medical advice for symptoms of an infection.⁵ Carefully describing this type of rigorous survey methodology and its feasibility among purchasers in community pharmacies is also an important contribution. Lacking in the study was a discussion of the most likely causative mechanism. Yet, a quick visit to a local pharmacy confirmed our suspicions. The front of the package containing phenazopyridine prominently listed the symptoms the product would provide rapid relief for and noted the product was #1 doctor recommended. The much smaller black and white print on the back of the box only advised users to consult a physician if they had persistent symptoms or the symptoms suggestive of pyelonephritis. Not mentioned was that all users must consult a physician for diagnosis and treatment of the infection (as noted in the product website).⁶

Given extensive evidence of such misdeeds, who will step up to protect the public? While both articles discuss the potential role of the Food and Drug Administration (FDA), we see little hope, given the current climate at the FDA.⁷ The other suggested interventions were making journal readers and the public aware of such deceptions. To this end, the New York City Department of Consumer Affairs has recently begun a campaign to educate the public on pharma direct-to-consumer advertisements (J. Seaman, written communication, February 2003). However, caveat lector and caveat "educated" emptor are lackluster solutions absolving all other complicit parties.

Chief among these is the medical profession. Demonstrating excellent business acumen, pharma generously shares their bounty with academia, professional organizations, medical journals, and individual providers. The dividends from these investments are astronomical. Despite smoking-gun level of evidence such as in these 2

articles, for the most part medicine at best turns a blind eye or at worst knowingly serves as an active collaborator with pharma's advertising deceptions.

Have we all really been bought out? Not entirely!!!!

Cooper notes that while many journal editors feel some responsibility toward ensuring the truthfulness of advertisements, they continue to publish misleading and deceptive ads. Responsibility is absolved by providing readers with the ability to distinguish advertisements from actual journal content.⁸ The typical justification is that without pharmaceutical revenues, such journals would not exist or subscription prices would be too high. Yet, *JGIM* is an example of a publication providing high-quality articles to a large physician audience without having to publish pharmaceutical ads.

Similarly, at the annual meeting of almost any medical organization will be evidence of the active partnership of organized medicine with pharma's advertising high jinks. Yet the annual meetings of the Society of General Internal Medicine (SGIM) remain free of drug company influence; no pharma samples, paraphernalia, or representatives seeking to misinform the audience. This is partly because many of our SGIM leaders have been key figures in highlighting the perils of ties between the pharmaceutical industry and the medical profession. As a result, SGIM has wisely maintained financial independence from pharma. The recent adoption of the rules on external funding⁹ have operationalized this healthy skepticism. These guidelines need to be widely disseminated and can serve as blueprints for leaders at other organizations who wish to end their pharma dependence.

SGIM is not alone. Other medical organizations that have been extremely vocal about ties between pharma and the medical profession include the American Medical Student Organization, Physicians for a National Health Program (PNHP), and our own No Free Lunch. As an example, the New York chapter of PNHP recently sponsored a "Big Pharma Equals Bad Karma" grass roots-type protest in front of the headquarters of a pharma leader to raise public awareness of these issues.

Finally, the inroads pharma has made into the research, educational, and clinical missions of academic health centers have been well publicized.¹⁰ Yet notable pockets of resistance exist. An increasing number of departments and divisions will not allow students, residents, and, in some instances, faculty to have contact with pharma representatives. At our institution, we have developed an exportable curriculum for medical students and residents that highlights the dangers of ties between physicians and industry.¹¹ Included are specific examples of the dangers of reading pharma advertisements.

We must note that numerous organizations, researchers, and even journals¹² have been sorely bruised when they have incurred pharma's wrath. Yet, viable examples of those who have just said no to deceptive advertising exist. However, to make a real dent, a much larger number of leaders in academia, organized medicine, and medical journals, and among concerned providers will need to emerge. Lacking FDA intervention, only a strong and forceful stand by the medical profession will rein in unethical pharma behavior. With a critical mass, such resistance will not be futile.—**OLVEEN CARRASQUILLO, MD, MPH, ROBERT L. GOODMAN, MD**, *Columbia University College of Physicians and Surgeons, New York.*

REFERENCES

1. Prescription Drugs and Mass Media Advertising. 2000. Washington DC: National Institute for Health Care Management Research and Educational Foundation; 2001.
2. For an exhaustive bibliography of pharmaceutical promotion see URL <http://www.healthyskepticism.org>. Accessed February 5, 2003.
3. Cooper RJ, Schrager DL, Wallace RC, Mikulich VJ, Wilkes MS. The quantity and quality of scientific graphs in pharmaceutical advertisements. *J Gen Intern Med*. 2003;18:294–7.
4. Tufte ER. *Visual Display of Quantitative Information*. Cheshire, Conn: Graphic Press; 1983.
5. Shi C-W, Asch SM, Fielder E, et al. Usage patterns of over-the-counter phenazopyridine (pyridium). *J Gen Intern Med*. 2003;18:281–7.
6. Uristat can help. Available at: URL <http://www.uristat.com/shorted.htm>. Accessed February 4, 2003.
7. Wolfe SM. Remedies needed to address the pathology in reporting adverse reactions and Food and Drug Administration use of reports. *J Gen Intern Med*. 2003;18:72–3.
8. International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. Available at URL <http://www.icmje.org/index.html#advertising>. Accessed February 3, 2003.
9. Society of General Internal Medicine. Policy on acceptance and disclosure of external funds. Available at: URL: <http://www.sgin.org/policies.cfm>. Accessed February 3, 2003.
10. Angell M. Is academic medicine for sale? *N Engl J Med*. 2000;342:1516–8.
11. Goodman RL, Landefeld S, Steinman M. A curriculum on physician-pharmaceutical interactions. Available at: <http://www.nofreelunch.org/nofreelunchweb4/index.htm>. Accessed February 3, 2003.
12. Fletcher RH. Adverts in medical journals: caveat lector. *Lancet*. 2003;361:10–1.