"Writing the truth as I see it; trying not to offend those who will disagree."

The truth as I see it™

Idaho Common Sense™

The power of advertising medicines

Craig L. Bosley, MD

July 28, 2008

Traditionally, pharmaceutical advertising has focused on advertisements in medical journals and sending representatives to meet with individual physicians. During the last ten years, their advertising has increased over four-fold and they have also added direct to consumer advertising (DTCA). According to Emergency Medical Abstracts, only the United States and New Zealand allow DTCA. Is there a reason most nations do not allow pharmaceutical advertising? Are expensive commercials the right way to select a medication? Have you ever seen a television advertisement for an inexpensive medication?

The goal of DTCA is to convince the patient to ask their physician for the advertised medication if they are diagnosed with the illness it treats. Moreover, the advertising often does just that, resulting in patients requesting and being prescribed the advertised drug. More important, once a patient starts a medication that works well, the physician and patient tend to continue it rather than considering less expensive alternatives.

Further proof that DTCA works is the substantial amount of money the pharmaceutical companies spend on it. The New England Journal of Medicine (NEJM) reported that pharmaceutical companies' 1996 advertising costs were $985 million, growing to over $4.2 billion in 2005, reaping a return of $2.20 for every $1.00 spent. Could this marketing partly explain why spending on prescription medications has increased five-fold from 1990 to 2004?

In fairness, some new medications are clearly superior to existing medications, offering substantial benefits. But, many new medications are designed to compete with existing, less expensive medications, while offering little superiority to them. Moreover, new medications may be a slightly different version of a company's own existing medication that no longer has a patent. The "new", nearly identical medication has a new patent, allowing added years of non-competition.

The pharmaceutical companies' traditional form of advertising is sending representatives to visit physicians, explaining why their medications are superior to another company's medications. According to the NEJM, these representatives cost the pharmaceutical industry $3.7 billion in 1996, increasing to $6.7 billion in 2005. Assuming roughly 600,000 practicing physicians in the United States, the pharmaceutical industry spends $50,000 a year for each physician in practice. Also, the number of pharmaceutical representatives increased from 38,000 in 1995 to over 100,000 in 2005, translating to roughly one representative for every six physicians.

Moreover, while meeting with the physician, pharmaceutical representatives routinely leave samples of medications for the physician to give their patients. These samples are usually the company's newer, more costly medications. Further, if the physician gives the sample to a patient and it works well, the patient and physician are again reluctant to consider less costly alternatives. Not surprisingly; the pharmaceutical companies track individual physician prescribing practices to learn if their contact with the physician led to increased numbers of prescriptions. If not, they then decide how to modify their approach to that physician.

A paper in the Journal of the American Medical Association (JAMA) stated that contact between physicians and pharmaceutical representatives "is associated with higher levels of prescription costs." Interestingly, we (physicians) believe patient requests and visits by pharmaceutical representatives will influence other physicians but we personally cannot be influenced. But, if the visits by pharmaceutical representatives did not achieve the desired result of changing our prescribing practices, do you think they would continue to spend $6.7 billion a year to visit us?

Reviewing an article in JAMA, I was surprised to learn that tobacco companies influence pharmaceutical advertising. The article stated that Marion Merrell Dow, maker of Nicorette gum, is a subsidiary of Dow Chemical, a major supplier of various chemicals to tobacco growers. When tobacco manufacturer Philip Morris discussed suspending its orders with Dow Chemical because their subsidiary advertised Nicorette gum, the anti-smoking advertising campaign for Nicorette gum decreased substantially. And, Ciba-Geigy, the manufacturer of Habitrol nicotine patches used for smoking cessation, also has an agricultural division supplying pesticides to tobacco growers. Philip Morris met with the agricultural division of Ciba-Geigy and Habitrol suffered the same fate as Nicorette gum.

So, what is the solution? Should consumer advertising be banned, as in most other countries? Should sales representatives be regulated? Is there some advertising that is medically useful for the patients? Is there a conflict of interest if physicians meet with pharmaceutical company representatives, or is there enough educational value to override any potential conflict of interest? Would lawyers arguing a case before a judge be allowed to privately lobby that judge trying to sway his or her opinion?

As much as I dislike asking the government to add more bureaucracy, this may be an area needing attention. While awaiting answers to these questions, we need to understand the power of these types of advertising, influencing physicians and patients alike. Again, there are over 10 billion reasons proving how well this advertising works. Forewarned is forearmed.

Dr. Craig Bosley is an emergency physician practicing in Pocatello, Idaho. His column appears in the Idaho State Journal each Monday. If you would like to contact him directly, you can email him at craig@craigbosley.com or visit his Website, www.craigbosley.com where all of his columns are available.