

## **The Pharms and Doctors: Corrupting Medicine**

By Wanda Hamilton

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*“It begins on the first day of medical school and lasts through to retirement, and it is the only reliable ‘cradle to grave’ benefit that doctors can truly count on any more.... It starts slowly and insidiously, like an addiction, and can end up influencing the very nature of medical decision-making and practice. It first appears harmless enough: a textbook here, a penlight there, and progresses to stethoscopes and black bags, until eventually come nights ‘on the town’ at academic conventions and all-expenses paid ‘educational symposia’ in lovely locales.”* *The Lancet* editorial is talking about pharmaceutical industry perks to physicians and influence on medical education in the U.S. (*The Lancet*, 356:781, Sept. 2, 2000).

*“The corporate world owns many of our political representatives in Washington DC. The medical situation is not very different: industry owns physicians and dictates the course of education, research, and ultimately the practice of medicine in degrees previously unimaginable.”* Augusto Sarmiento, MD, Letter to the Editor, *JAMA*, 286(3), July 18, 2001.

*The phrase, “First, do no harm” has been eliminated from the “modified” Hippocratic oath currently administered to graduating medical students in the U.S. The initial sentence in the Physicians’ Oath now reads: “I do solemnly swear by whatever I hold most sacred, that I will be loyal to the profession of Medicine and generous to its members.”*

The relationship between physicians and the pharmaceutical industry is unavoidably intimate because physicians depend on pharmaceutical products to treat patients. Nevertheless, there is substantial evidence that pharmaceutical company influence on physicians, medical education, and patient treatment is far more pervasive and insidious than even some physicians themselves realize, and it involves far greater ethical problems than physicians’ acceptance of gifts of penlights, free lunches, and all-expense-paid trips to symposia. For example, documents released by the U.S. House of Representatives Commerce Committee indicate that some doctors make money billing Medicare and Medicaid for more than they actually pay for drugs, a practice made possible by the manufacturers of the drugs.

*“Drug companies artificially inflate wholesale prices, investigators say, because Medicare and state Medicaid programs base their reimbursement on those numbers. Their goal is to have the highest wholesale price—and the lowest actual selling price.*

*“That way, they can market their drugs to doctors based on how much money the doctors can make by billing government programs for the higher amount.*

*“‘Profit maximization—it’s in the bag,’ reads a 1997 marketing memo from Glaxo Wellcome touting one of its drug’s wholesale price advantage over a competitor’s similar product.*

***“The Glaxo marketing document shows that a busy oncology practice using its 32 milligram bag of anti-nausea treatment could net \$13 million a year--\$2 million more than if the practice used its competitor’s product. All because the wholesale price, which no one except the government actually pays, is higher.”***

(Julie Appleby, “Drug makers accused of price scheme,” *USA Today*, Sept. 27, 2000, p. 1B)

Shocking as it might be, this wholesale price inflation by pharmaceutical companies to increase profits for themselves and physicians at the expense of the taxpayers is apparently quite legal.

It’s also quite legal for big pharmaceutical companies to track individual physician’s prescription patterns and then attempt to change those patterns, even if it means encouraging the physician to prescribe a more expensive drug when a less expensive drug is just as effective.

***“Over the past decade, with the advent of sophisticated new computer technology, pharmaceutical manufacturers have been quietly compiling resumes on the prescribing patterns of the nation’s health care professionals, many of whom have no idea that their decisions are open to commercial scrutiny.***

***“These ‘prescriber profiles’ are the centerpiece of an increasingly vigorous—and apparently successful—effort by drug makers to sway doctors’ prescribing habits. To create them, pharmaceutical marketers are buying information from pharmacies, the federal government and the American Medical Association, which generates \$20 million in annual income by selling biographies of every American doctor.”***

Sheryl Stolberg and Jeff Gerth, “High-Tech Stealth Being Used to Sway Doctor Prescriptions,” *The New York Times*, No v. 16, 2000. In addition to increased calls from drug sales reps, physicians may be offered such perks as “consultation fees” in an effort to influence their drug prescribing practices.

***And there are many other ways pharmaceutical companies influence physicians’ choices of prescription drugs—billions of dollars worth of free samples, advertising in medical publications, and direct-to-consumer advertising:***

- ***“The pharmaceutical industry gave \$7.2 billion worth of samples to US doctors in 1999”*** (Gavin Yamey, “Pen ‘amnesty’ for doctors who shun drug companies,” *News, BMJ*, 322:69, Jan 13, 2001).
- ***“Of the \$13.9 billion that the drug companies spent promoting their products last year, 87 percent, or about \$12 billion, was aimed at doctors and the small group of nurse practitioners and physicians’ assistants who can prescribe some medications, about one million prescribers all told.”*** Stolberg and Gerth, “High-Tech Stealth Being Used to Sway Doctor Prescriptions,” *The New York Times*, Nov 16, 2000. Many medical journals gain most of their revenue from pharmaceutical ads.
- ***“Doctors wrote 34.2% more prescriptions in 1999 than in 1998 for the 25 drugs promoted direct to consumers that contributed most to overall drug spending. Doctors wrote only 5.1% more prescriptions for all other prescription drugs.”*** Fred Charatan, “US prescription drugs sales boosted by advertising,” *News, BMJ*, Sept. 30, 2000.
- ***“We know that 66 per cent of patients that ask the doctor for a particular product get it.”*** Thomas Ebeling, head of pharmaceuticals at Novartis. Quoted in David

Pilling, “Direct promotion of brands gives power to the patients,” *Financial Times*, April 28, 2001.

These marketing practices in themselves do not necessarily compromise a physician’s prescription patterns. What is more problematic is that even highly ethical physicians depend on experts in their fields, professional journals, symposia, and reference books for their information on drugs, and these sources are largely funded by the pharmaceutical industry. For example, prominent physicians may be paid by pharmaceutical companies to promote the companies’ drugs to other physicians.

*“One pharmaceutical company employs several eminent British cardiologists to lecture to other doctors around the country to promote the company’s drugs. The cardiologists, known to company employees as The Road Show, are each paid 3,000 to 5,000 [U.K. pounds]...plus traveling expenses for a 1 hour evening talk in the UK.... Some members of The Road Show have spoken fortnightly for the company. As a result they receive more money each year from the company than their annual salary from their hospital or university.... Some have admitted to me that they have kept silent about adverse effects of drugs to avoid loss of lucrative research contracts with a manufacturing pharmaceutical company. Some opinion leaders involved in pharmaceutical research now command speaker fees that are so high that their engagements are negotiated by an agent.”* Wilmshurst P, “Academia and industry,” *The Lancet* 2000; 356:338-344, July 22, 2000.

Many of the top professional medical journals such as *The New England Journal of Medicine*, *JAMA*, and the *British Journal of Medicine* receive the bulk of their funding from pharmaceutical advertising. In addition, many of the journals’ editorial writers, peer reviewers and even many of the researchers whose studies appear in the journals have financial connections to the pharmaceutical industry. And many of the published drug studies themselves are funded by the very pharmaceutical companies manufacturing the drugs.

*The New England Journal of Medicine* published a study concluding that 30% of study subjects using bupropion (Glaxo Wellcome’s Zyban) as a smoking-cessation aid stayed off cigarettes for at least a year. Not only was the study funded by Glaxo Wellcome, but “eight of the 12 doctors involved in the study declared a link to the pharmaceuticals giant” (“Anti-depressants beat the craving,” *BBC News*, 3/4/99). Studies not funded by the manufacturer have found the drug’s success rate is half that claimed in the Glaxo Wellcome funded study. Further, the *NEJM* article did not highlight the considerable health risks posed by the drug.

Even worse is the common practice of pharmaceutical companies buying editorials and paying physicians and researchers to affix their names to journal articles they did not write.

*“The practice of buying editorials reflects the growing influence of the pharmaceutical industry on medical care. Thompson defines a conflict of interest as a ‘set of conditions in which professional judgment concerning a primary interest (such as a patient’s welfare or the validity of research) tends to be unduly influenced by a secondary interest (such as financial gain).’ The boundaries between these interests*

*are becoming more and more difficult to perceive, especially when information for physicians is carefully orchestrated by a public-relations firm. Indeed, the goal of public-relations firms that ghostwrite editorials and do other work for drug companies is to blur the distinction between primary and secondary interests.”*

*“In the past, publications were written by a study’s principal investigator. More recently, a practice that one might call the nonwriting author-nonauthor writer syndrome has developed.... The syndrome has two features: a professional medical writer (‘ghostwriter’) employed by a drug company, CRO [contract research organization], or medical communications company, who is paid to write an article but is not named as an author; and a clinical investigator (‘guest author’) who appears as an author but does not analyze the data or write the manuscript.”*

*“In one study, 19 percent of the articles surveyed had named authors who did not contribute sufficiently to the articles to meet the criteria for authorship....”*

The foregoing quotations are all from Brennan T, “Buying Editorials,” *The New England Journal of Medicine*, 331:10, Sept. 8, 1994.

In addition to professional journals, physicians also rely on symposia and professional meetings to update themselves on information about drugs, but many of these are also funded by pharmaceutical companies.

*“Most of the CME [Continuing Medical Education], the plenary sessions, and almost 75-80% of the general as well as specialty symposia are sponsored by one or the other pharmaceutical company.”* Kagalwala T, M.D., “The Conferences are a charade,” May 26, 2001, *BMJ* Electronic response Jackson T, “Are you being duped?” *BMJ* 2001; 322:1312, May 26, 2001. The Jackson article is a review of a 24-page guide published as a supplement in the May, 2001 edition of *Pharmaceutical Marketing*. Jackson writes: *“So what exactly does this guide say? It advises marketers, in identifying opinion leaders, not to ‘risk wasting money’ on doctors ‘who you eventually hear have no credibility with their peers.’ Instead, marketers should aim for those who are ‘on the editorial boards of key publications for ultimate target audiences,’ on scientific committees, members of key professional societies, representatives of national or international guideline committees, and key players on formulary committees. ‘The key aim,’ says the guide, ‘is to ensure that you are working with a mix of people who can ultimately be called upon to communicate on your behalf in different situations.’”*

Other sources of drug information for physicians are reference works, such as the *Physicians’ Desk Reference* [PDR] and national and international guidelines. But the PDR “was originally developed as a promotional device” and “there is no mechanism by which all clinically relevant dose-response data or important post release discoveries are regularly and rapidly incorporated into it” (Cohen J, “Dose Discrepancies Between the *Physicians’ Desk Reference* and the Medical Literature, and Their Possible Role in the High Incidence of Dose-Related Adverse Drug Events,” *Archives of Internal Medicine*, 161(7): 957-964, April 9, 2001). And the national and international guideline panels are loaded with researchers having strong financial ties to the pharmaceutical industry, as is the case with the U.S. Clinical Practice Guideline On Treating Tobacco Use and Dependence.

The lack of objective drug information available to physicians may account for at least some of the steep rise in fatal medication errors:

*“An examination of all US death certificates over the 10-year period [between 1983 and 1993], the most recent data available to the researcher, found that fatal medication errors had increased 2.6-fold. But among outpatients, the jump in such deaths was 8.5-fold.”* Richard Knox, “Researchers Report Surge in Deaths Due to Medication Errors,” *The Boston Globe*, Feb. 27, 1998, p. A1. In addition to medication errors, it is estimated that more than **100,000** Americans die each year from adverse effects of prescription drugs and that **1,000,000** more are injured so severely they must be hospitalized.

It also may account for many physicians’ misinformation on the health effects of smoking and environmental tobacco smoke.

### The AMA, the BMA and the Nicotine Wars

The American Medical Association (AMA) is a key player in the nicotine wars. The Association receives many millions of dollars every year from the pharmaceutical industry, and some of those millions are specifically for anti-tobacco work. The Robert Wood Johnson Foundation alone gives the AMA millions for “administering” (i.e. lending its name to) the RWJF’s SmokeLess States program.

The Journal of the American Medical Association (JAMA) also receives much of its budget from pharmaceutical advertising, as does the British Medical Association’s *BMJ*. Both journals have dedicated entire issues to “tobacco control” in addition to publishing numerous editorials supporting tobacco control and the pharmaceuticals’ “smoking-cessation” products. Both journals are also quick to print pharmaceutically funded studies on smoking-cessation drugs, done by researchers with stated financial ties to the pharmaceutical industry. It isn’t as though the journals’ editorial staffs aren’t aware of the bias in many industry-funded drug studies. Indeed, they have even published articles on the subject of researchers’ conflicts of interest.

*“By 1999, almost 7.6% of faculty investigators [researchers] reported personal financial ties with sponsors of their research. Throughout the study period, 34% of disclosed relationships involved paid speaking engagements (range, <\$1000-\$20,000 per year), 33% involved consulting agreements between researcher and sponsor (range, <\$1,000-\$120,000 per year), and 32% involved the investigator holding a position on a scientific advisory board or board of directors. Fourteen percent involved equity ownership, and 12% involved multiple relationships.”* Boyd E. Bero L, “Assessing Faculty Financial Relationships With Industry: A Case Study,” *JAMA*, 284(17), Nov. 1, 2000.

What they generally do not publicize are the medical associations’ own conflicts of interest and their own financial ties to the pharmaceutical industry, vested interests that in some instances appear to take precedence over objective publishing standards and patient well-being. Nowhere is this more apparent than in the nicotine wars.

Editors at the *BMJ* and *JAMA* and officers of the British Medical Association and the American Medical Association, among others, seem not to consider fully the possible harm of some of the anti-tobacco information they disseminate and the some of policies

they advocate. One example of this is their advocacy for lowering the nicotine content of cigarettes.

*Former Surgeon General C. Everett Koop said the nicotine content of cigarettes should not be lowered because smokers would just smoke more, thereby getting twice as much cancer-causing substances. “I don’t think the public health community would ever let FDA reduce nicotine remarkably in cigarettes,” said Koop. “Report: Tobacco, FDA Rift Settled,” AP, printed in *The Washington Post*, Aug. 24, 1997.*

But the very next year both the AMA and the BMA urged their respective governments to force tobacco companies to lower the nicotine content in cigarettes, a position they justified by promoting the pharmaceutical companies’ nicotine products.

*Reed Tuckson, senior vice president for professional standards of the AMA said smokers could use pharmaceutical products to supplement nicotine. “These problems can be avoided by providing alternative forms of nicotine delivery with less or little risk to health as a part of expanded access to treatment (using) products such as nicotine gum, patches, oral inhalers and nasal sprays.” “US, British doctors call for low-nicotine cigarette,” Reuters, Oct. 28, 1998.*

If that sounds like a ringing endorsement of the drug companies’ products, consider this from a BMJ editorial:

*“To meet the needs of the estimated 13 million current smokers in Britain, many of whom will never overcome their nicotine addiction, we also need legislation that explicitly encourages the development of alternative products that can deliver uncontaminated nicotine at a dose and rate comparable with cigarettes and in a way that is commercially and socially acceptable. If instead of nearly 13 million addicted smokers we have 13 million addicted to clean nicotine devices, so be it.” Britton J, McNeill A, Editorial, “Why Britain needs a nicotine regulation authority,” *BMJ* 2001; 322: 1077-1078, May 5, 2001. Both Britton and McNeill have been funded by the pharmaceutical companies which make and market smoking cessation products. In addition, McNeill participates in the pharmaceutically funded WHO partnership project on tobacco control .*

### Practicing Physicians

The majority of practicing physicians do not belong to the AMA, but there is no question that many if not most have accepted at least some of the misinformation they have been fed by the medical and public health establishment. Nevertheless, there are indications that at least some are uncomfortable with the constant barrage of anti-tobacco proselytizing.

A study published in *JAMA* in 1998 found that the journal readers polled ranked tobacco issues 55<sup>th</sup> in priority out of 73 total topics, while the editors ranked it 17<sup>th</sup>. This, of course, outraged some members of the tobacco control community, who were fearful that *JAMA* would change its publishing priorities to be more in line with what their readers wanted: “We wonder who is the *JAMA* readership, and if their readership is even representative of all practicing physicians. Their priorities certainly don’t match the best

interests of public health,” wrote Dennis Wahlgren and Melbourne Hovell in the BMJ journal *Tobacco Control* (Letter to the editor, Autumn, 1999).

It seems the practicing physicians were far more interested in articles that had to do with the actual practice of medicine than in reading about demon tobacco, and for that they are accused of not caring about public health.

There is also some evidence that at least some practicing physicians are uncomfortable with having to identify smokers among their patients, lecture them about smoking and offer them cessation medication, as the US Clinical Guidelines mandate. For example, pediatricians are expected to find out which of their patients’ *parents* smoke, tell the parents about the “hazards” of exposing their children to tobacco smoke, and prescribe nicotine replacement products for them. But a study published in the AMA’s *Archives of Pediatrics & Adolescent Medicine* found that pediatricians were far less likely than family practitioners to follow these guidelines (Perez-Stable EJ, Juarez-Reyes M, Kaplan CP, “Counseling smoking parents of young children,” 2001; 155:25-31). Further, there is little evidence to support that such intrusive intervention by pediatricians has any effect on getting the parents to quit smoking (France E, “Counseling Parents to Quit Smoking: Little Evidence of Long-term Success,” *Archives of Pediatrics & Adolescent Medicine*, 155(7), July 2001).

Again, the “experts” and the major medical associations seem to be unaware of or indifferent to the negative consequences of forcing physicians to harangue patients (or parents of juvenile patients) about smoking. Perhaps the most obvious of the negative consequences is that many smoking patients become angry with their doctors and may even avoid future medical appointments.

**“Conclusions: Doctor-patient relationships can be damaged if doctors routinely advise all smokers to quit.”** Butler C, Pill R, Stott N, “Qualitative study of patients’ perceptions of doctors’ advice to quit smoking: implications for opportunistic health promotion,” BMJ, 316:188878-1881, June 20, 1998. Among the “key messages” in the study: “Repeated ritualistic intervention on the part of doctors may deter patients from seeking medical help when they need it.”

**“Recent studies have shown that people who know they have health-endangering vices (like smoking or drinking) put off appointments because they do not want a healthy-living lecture.”** Randi Hutter Epstein, “Major Medical Mystery: Why People Avoid Doctors,” *The New York Times*, Oct. 31, 2000.

Thus in turning practicing physicians into scolds and smoking-cessation drug pushers, the major medical associations and the tobacco control community are not only destroying the physician-patient relationship but are actually discouraging some patients from getting needed medical care.

An even more dangerous result of the constant focus of the professional journals and professional associations on tobacco use and exaggerations about its risks is that some physicians and surgeons have become true believers and are refusing to treat smokers at

all. In some countries patients have died because physicians refused to perform life-saving operations on them unless they gave up smoking.

*“Some doctors have refused to perform transplants and other life-saving operations on smokers on ‘medical and moral’ grounds.”* “Smoker Dies After Doctors Refuse to Treat Him,” Sky News (Australia), Feb. 10, 2001.

And there are more subtle dangers such as misdiagnoses based on the smoking status of patients. Misdiagnosis is already an enormous problem in the medical profession.

*“There are distressingly high error rates reported in a wide range of medical practices with serious, sometimes fatal consequences,” a summary of the [Rand Corporation] study said. “For example, autopsy studies show high rates (35 to 40 percent) of missed diagnoses, often resulting in death.”* “Crisis in U.S. health system worse, group charges,” Reuters, Oct. 20, 1997.

*“Almost one death in five in a well-regarded medical intensive care unit was misdiagnosed, and in almost half the cases a correct diagnosis would have resulted in different treatment, a recent study has found.”* Mitka, M, “Autopsies Show Misdiagnoses,” JAMA, 285(12), Mar 28, 2001.

If physicians are focusing on a patient’s smoking status to assist in diagnoses, they are going to make errors. They may, for example, overlook symptoms of lung disease in non-smokers or assume a sick smoking patient has a “tobacco-related” disease when he or she does not. Given the sheer number of misdiagnoses, it is probable that patients’ smoking status plays a part in at least some of these.

A few courageous physicians are daring to speak out against the anti-tobacco stance advocated by the AMA and other pharmaceutically funded tobacco control “experts.” The Association of American Physicians and Surgeons, a lesser-known and far less wealthy alternative to the AMA, is one group of such physicians.

*“As physicians, we find reprehensible the use of excessive government intrusion and control to force changes in behavior affecting health and well-being. Many other voluntary activities are associated with adverse health effects, some more probable and more immediate than the hazards of tobacco use.”* “Doctors Criticize Clinton Tobacco Fines for Underage Smokers,” U.S. Newswire, Feb. 9, 2000. The AAPS states that it is “a national association of physicians in all specialties dedicated since 1943 to the sanctity of the patient-physician relationship, and the protection of their hundreds of thousands of patients against third-party intrusion into that relationship.”

*This group at least—along with some courageous individual physicians--is not among the medical partners of the pharmaceutical industry in its ruthless quest for profits in the nicotine war.*