
EDITORIAL POSTLUDE

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Information You Can't Use

Regardless of the consumer protection problem described in our term papers, the students in our 1975 graduate course mentioned "consumer information" as a major part of the solution. Deceptive car loan terms, misprescribed pharmaceuticals, or fraudulent car repairs would be less of a problem, we often said, if the businesses were required to provide consumers with more detailed and accurate information. Our instructor, Mary Gardiner Jones, had recently completed her service as a member of the Federal Trade Commission, and while she generally agreed with us, I will always remember her lament after one too many presentations on this theme: "I don't want to be required to be my own expert pharmacist, mechanic, accountant or doctor." She was a lawyer by education and that, she said, was difficult enough.

A few years ago, an Atlanta car dealer was advertising two special sale options on new cars, with different sets of purchase terms stated in combinations of downpayments, annual percentage rates, and other repayment alternatives. In a friend's office, three senior professors of finance spent an hour over their note pads and calculators, unable to discern which option would be more desirable. It is possible that consumer confusion was the advertiser's intent and that neither option was a real bargain. But an equally likely explanation is that the advertisement simply contained all of the legally-required terms that must be used to tell consumers the real costs for loans. The so-called explanations might have been very clear to the government lawyers who wrote the rules, but no one involved with writing the advertising considered composing a version in colloquial English (Rotfeld 2001). My expert colleagues had the complete information, but couldn't understand it.

And then there are prescription drugs.

Five decades ago, the U.S. government changed the relationships among doctors, patients, and pharmacists. Initially, prescriptions were a

doctor's recommendation of a potentially useful drug, but patients did not need the doctor's permission to make a purchase and pharmacists could also make recommendations. The 1951 Durham-Humphrey Amendment defined the kinds of drugs that can't be safely used without medical supervision and restricted their sale to prescription by a licensed practitioner. In theory, with all the new drugs just starting to come out at that time, patients would be forced to have the rational and informed expertise of a doctor involved in their drug-purchasing decisions.

With the medical doctors as the decision makers, for many years the pharmaceutical industry exclusively focused their brand-name promotional practices on physicians. Even with the advent of direct-to-consumer (DTC) advertising, the companies' sales representatives still have regular and expensive contacts with physicians, spending large sums of money per year promoting brand name drugs by giving doctors various gifts, travel subsidies, and free meals in addition to the arguably more educational (though potentially biased) sponsored teachings and symposia.

As with any other product, the physician's primary source of drug information is the manufacturer. Some critics of the pharmaceutical industry assert that the companies abuse this information power and intentionally desire to mislead medical people. Regardless of whether there is intentional malfeasance, one study found that a significant number of statements from the sale representatives contradicted information readily available to them, and that the physicians generally failed to recognize the inaccuracies (Ziegler, Lew, and Singer 1995). While our personal doctors might claim that they derive their information only from research articles, there exists persistent evidence that they may be misled about a brand's value apart from the scientific data on the matter (e.g., see: Avorn, Chen, and Hartley 1982). Even the medical practitioners don't always know or understand all the information they have available.

And since medical doctors are people, not decision-making machines, they are not always as rational in their prescribing decisions as we might like to presume. All these industry contacts do have an influence (Wazana 2000). Patients must at least wonder about the medical decision when their new prescription is pre-printed on the doctor's note pad, or when the brand name is emblazoned on pens or coffee mugs around the nurse's desk.

In recent years, consumers are once again expected to play a role in their drug decisions as they are increasingly bombarded with DTC advertising for various prescription drugs. The print versions are filled with the same page of print-heavy data on indications, contraindications and precautions found in medical journal advertisements, and the television

voiceovers and superimposed print disclaimers themselves provide enough warnings of side effects to make the audience members nauseous.

Yet you have to wonder about just what impact all this DTC advertising must have or what the companies hope to accomplish. The products are often brands under exclusive patent rights, so the company is trying to establish strong and broad demand while they still have an exclusive product. And since the ads often make emotional appeals based on general symptoms, people are encouraged to rush to doctors for what could be minor nonmedical concerns. Not every case of depression, sleep loss, or lowered sex drive should be treated by expensive drugs. Even highly educated medical students tend to spot each new disease studied in their own bodies, and freshman psychology students tend to suddenly find all sorts of neurotic difficulties in themselves or their friends, so these DTC ads can readily play on consumers' uncertainty about their own health.

Food and Drug Administrations officials repeatedly insist that the DTC advertising does not prompt unnecessary prescriptions, and at least in their view, the medical practitioners are still gatekeepers on the drug purchases.

Unfortunately, with the increasingly competitive environment of patient services and medical care, many doctors concentrate on patient satisfaction, satisfying the medical customer's short-term perceived needs even when the therapeutic solution is not so simple. A patient comes to the office wanting a cure or something that looks like a cure, and even without DTC advertising the physicians can make prescriptions that are, at best, useless, and possibly even harmful to the patient or to society as a whole.

For example, a common cause for a doctor visit is a sore throat, which is usually due to a viral upper respiratory tract infection. After testing with a throat culture, a small percentage of these infections—5% to 17% by most estimates—might be found to be caused by bacteria. Antibiotics can help treat bacteria-caused sore throats, not those caused by viruses, yet more than half of U.S. adults are treated with antibiotics for sore throats (Linder and Stafford 2001). Aside from the financial waste, the frequent use of these nonrecommended, more expensive, broad spectrum antibiotics has been blamed for the rise of various drug-resistant strains of highly infectious and potentially-deadly bacteria. The antibiotics are used so often when not needed, in the future they won't work when they are.

A sizable percentage of patients would probably respond negatively if their physician refused to prescribe the DTC drug the consumer thinks will solve the problem (Bell, Wilkes and Kravitz 1999). And many physicians must feel the pressure. It would be unrealistic to think that many

doctors would not give the requested drug, even when the advertised product is not a first choice, or even when the patient might be better off not taking any drug at all.

For many years, I would always visit my internist with my own drug compendia under my arm, usually one from a government group or Consumers' Union to offset the pharmaceutical industry materials I knew the physician must have read. Finally, though, while I would have try to have an informed discussion on the prescription, in the end I have to trust my physician's recommendations. After all, my advanced education is in social sciences, not biology. And I don't want to be my own doctor.

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