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The invisible hand of the marketing department

The cost of bringing a new drug to market is estimated at about US$600 million.[1] Return to shareholders on such an investment can be achieved only by convincing physicians to prescribe the new drug. No one seriously doubts that pharma's profit motive is in conflict with its higher human purposes. Rather, the question is the *extent* to which financial interest exerts itself.

It makes business sense for the drug industry to favour common conditions over rarer ones in the search for therapeutic compounds. It makes sense to target pharmaceutically accessible risk factors — cholesterol, for example — and promise risk reduction for a large population rather than reduced morbidity and mortality for a few. And to carve out market share by building marginally better variants of existing treatments.

It also makes sense not to shoot a new product in the foot with discouraging data. There is accumulating evidence that companies design clinical trials to obtain results favourable to their product.[2] It makes sense to exploit a bias toward the recruitment of healthy (and younger) study subjects, whose risks of adverse events are lower.[3] And, after the drug is on the market, it's in the manufacturer's interest to conduct so-called phase IV trials — not to evaluate serious health effects but to expand market share by broadening target age ranges, extending off-label uses or simply making doctors and patients more familiar with a product.[4]

And then there's that chameleon, marketing. As direct-to-consumer advertising becomes emboldened, messages to clinicians grow more subtle. We have learned to beware the free lunch and trivial giveaway. But what about our acceptance of information that industry has paid for? Few clinicians have the time or expertise to critically evaluate the original literature, and the widening gap between evidence and practice is one that the pharmaceutical industry is keen to help us leap over. But how do we detect the influence of industry sponsorship on clinical practice guidelines, consensus conferences, narrative and systematic reviews and continuing professional development? In a recent study, over 59% of experts writing CPGs reported financial ties (honoraria, consulting contracts, equity, etc.) with the manufacturers of the products they recommended.[5] Although few (7%) of the experts admitted that money influenced their recommendations, 19% thought that their colleagues were so influenced.

In another example, 6 of 9 experts selected by the American Heart Association to write guidelines on the management of acute stroke — guidelines that recommended alteplase as the initial treatment of choice — received money from Genentech, the drug's manufacturer.[6] In a 10-year period, Genentech "donated" over US$11 million to the AHA. One might call such donations a purchase — and the item purchased, influence.

We are not so naive as to imagine that financial conflicts of interest can be eliminated entirely. But they should be disclosed: by physicians who receive money to enrol patients in phase IV trials; by participants in consensus conferences; by the writers of CPGs and reviews. Prescriber beware: marketing departments are experts in disguise, and one of those disguises is science. — *CMAJ*

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