The art and science of marketing medications
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The paper by Ma and Parkin highlights, yet again, that we should assume the majority of claims in advertising materials, both to prescribers and to the public, will generally extend well beyond the published scientific evidence cited to justify them. Similar findings have been demonstrated in older and contemporary New Zealand contexts and in other jurisdictions.

We should not be surprised. Advertising is primarily designed for the purpose of selling products. Partial truth and hype is the advertiser’s stock-in-trade, misinformation is common and the exaggeration of benefits and minimisation of harm well defined.

The question here is “Why does misleading advertising matter?”

It matters because it has a negative influence on prescribing quality. Poor prescribing adversely influences both health outcomes that matter to patients and increases the costs to the health care system.

There is little regulatory control to counter these influences. The self-governing Advertising Standards Authority in New Zealand, and the self-monitoring codes of practice—designed and policed by industry—are both lax, and complaints and sanctions rarely applied. Penalties for breaches, even if identified, are absent or minimal. In the US, very large (multimillion dollar) fines are often levied for misleading advertising. Given the vast profits from the sale of blockbuster drugs, even fines of this magnitude and out-of-court settlements (with no culpability admitted) are simply seen and accepted as an affordable cost of doing business and often do not prevent repeat offending.

Given the widespread publicity around misleading marketing, it might be hoped readers of the magazines containing these advertisements would pay little or no attention to them. However, the industry’s market research suggests otherwise, as do studies of the negative influences of marketing on prescribers. Without a demonstrable positive return on investment, this type of advertising simply would not continue.

It would be impractical in a country the size of New Zealand to centrally vet all advertising claims against even the cited “evidence”, and without having access to the complete trial data, it is—and would remain—very difficult to ensure that claims are both evidence-informed and balanced.

Instead, the solution surely lies with prescribers voluntarily distancing themselves from biased industry sources of information, and for regulators, professional bodies, medical journals and academic funding institutions to support and incentivise this distancing. There is a growing chorus of consumer demand and pressure for the profession to disentangle itself from the harmful influence of industry.

These influences, of course, extend well beyond colourful advertisements in magazines. For those interested in reading more about the extent of the influence of the pharmaceutical industry, it is well summarised in the extensive UK parliamentary health select committee report. Education of medical graduates is largely lacking in any training of how to recognise and deal with the ‘hidden curriculum’ of acculturation to industry influence. To assist, the WHO has published a practical training manual for health professionals on the subject.

The public has little understanding of citations and references, and consumer advertisements are full of claims such as “clinically or scientifically proven”. Many
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