

substantive therapeutic advantage. The proposal extended to the physicians and hospital was to use the drug on a given number of patients, at the patients' expense. Physician participants in the study were to be "reimbursed" 125 dollars for each patient enrolled. This sum was designated to cover "expenses" associated with the study.

A second example of an elaborate gratuity system has recently been utilized in our community. Selected physicians were invited by a pharmaceutical company's detail man to an expense-paid seminar in a popular vacation city. The meeting focused on a new antihypertensive drug (at the time, this drug company had the only formulation of this drug on the market). The educational component of the meeting was judged to be very good by the physician participants. This promotional package included airfare for the physician, lodging for the physician and spouse, meals, a cocktail party, and an evening of dining and dancing on a chartered river boat. In the year following this event, two other pharmaceutical companies have offered similar meeting packages to physicians in the community.

Such promotional efforts are clearly expensive. For instance, it has been estimated that each visit by a detail man to a physician costs the pharmaceutical company 75 dollars. Despite the expense, however, drug companies have found that the use of the detail man is the most effective means of promoting their products. These companies often prefer to characterize their detail man as "service representatives" purveying information, rather than as salespersons. One company not only requires the detail man to attend four tutorials a year, but also gives pharmacology tests to all its representatives quarterly. But such training does not negate the fact that, in practice, detail men function as aggressive, effective salespeople. Indeed, most of them are at least partially reimbursed on a commission basis. Their success as pharmaceutical representatives is clearly dependent upon their ability to sell drugs. Those drugs which representatives emphasize at any given time reflect corporate decisions based on such factors as competition, quotas and the patent status of the drugs.

Given the stated nature of the physician-patient covenant, the type of relationship that frequently exists between the physician and the detail man is ethically troublesome. More specifically, that relationship appears to violate all three of the basic ethical principles previously discussed. By virtue of the principles of autonomy and beneficence, the patient has a right to expect that he or she will be treated with dignity and respect. He or she expects to receive the best possible treatment the physician can generate. The patient has a right to assume that the physician's therapeutic decisions are based solely on scientific medical knowledge, unbiased by extraneous factors or inducements. Thus, the very nature of the physician-patient covenant, and the principles that underlie it, would seem specifically to preclude the physician from basing a drug-prescribing decision on factors other than what is objectively best for the individual patient. To the extent that the physician decides to try out a new drug or opt to prescribe regularly a medication simply because he likes a detail man or because he is consciously or unconsciously affected by his or her various inducements and salesmanship, the physician would seem to be violating the patient's trust. One wonders what a patient's reaction would be if he or she were explicitly aware that such interactions and inducements existed.

In addition, the principle of nonmaleficence can be violated by the physi-

cian-detail man relationship. Often the new drug formulations which are promoted offer no meaningful advantage over older drugs. Yet, in taking them, the patient risks the possibility of experiencing adverse effects as yet undiscovered or not well publicized (even when the drug has been approved by the Food and Drug Administration). The recent controversy surrounding the drug Oralflex constitutes such an example. This drug was vigorously promoted as a new, very effective agent for arthritic symptoms. Shortly after its release, this agent was removed from the market because it was associated with serious liver toxicity in some patients. Moreover, the patient usually pays considerable financial premium when a new drug formulation is used. Invariably, the newer drugs being marketed are significantly more expensive than older, and sometimes equally effective, drugs whose patents have expired (rendering them much less profitable to the pharmaceutical company). Again, the average patient has no insight into this fact. He or she certainly is not usually afforded the opportunity to decide autonomously whether the drawbacks and risks of a new drug formulation render it less advantageous than other, longer-established drugs. And indeed, even if the typical patient is given some knowledge of drug options, he or she lacks the expertise to participate seriously in the decision of which drug to employ. In fact, it is the physician alone who ordinarily must make the determination of which drug to employ. If this decision is based on sound, scientific data, the choice of a new and more costly drug may clearly be justified. However, to the extent that the physician does not rely on objective medical data (as published in medical journals or discussed at medical meetings), but rather derives his information from the drug companies' own representatives, a potential conflict of interest exists.

Pharmaceutical companies might respond to this assertion by observing that in our free enterprise system there is nothing wrong with vigorously marketing one's products. Indeed, in the open marketplace it is, of course, common to offer a variety of inducements, including rebates, coupons, gifts and other types of price reductions. However, this situation is not analogous to the relationship between the detail man and the physician. In the ordinary marketing arena, companies attempt to influence the purchaser and user of various products. This is categorically not the case in the relationship between the physician and the pharmaceutical companies. The patient is the passive, dependent recipient of the physician's practice decisions. By virtue of this fact, as well as the implicit covenant which exists between the physician and the patient, the physician has an obligation to strenuously avoid basing any prescription decisions on factors other than the strict medical indications for those drugs. To the extent that the physician is either unconsciously or manifestly induced to use the drugs of a given detail man or pharmaceutical company, in the absence of strict medical indication, a significant ethical problem exists.

The implications of this analysis are clearly troublesome. It would appear that the current standard of medical practice, in terms of the relationship between the physician and the pharmaceutical detail man, may readily promote outcomes not in the patient's best interest. Since the physician-patient covenant and the ethical principles which underlie it warrant that the patient's interests should be the prime focus of medicine, significant changes are warranted in the methods which pharmaceutical companies employ to market their drugs. Currently, pharmaceutical companies, medical

organizations and individual physicians are clearly party to, as well as beneficiaries of the present marketing techniques. Thus, there are powerful incentives to maintain this longstanding system. The pharmaceutical companies' profit makes it understandably difficult for them to endorse sweeping changes in their current, successful marketing practices. Many medical organizations and their scientific journals are largely dependent on the advertising which is purchased by the drug companies. And certainly the individual practitioner, too, clearly benefits from the current system of gifts and gratuities.

Changes in the present system of drug marketing will doubtless come slowly. Most likely, improvements will evolve only as individual physicians become better educated about these ethical concerns and committed enough to demand alterations in the present marketing practices. The individual physician's role in this process should not be viewed as an optional one. Rather, the physician is ethically mandated to work for change in this realm of drug marketing. This responsibility derives from the physician's clinical covenant with the patient and the moral principles which underlie it.●

#### MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Evans, one of his secretaries.

##### EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

#### MESSAGES FROM THE HOUSE

Under authority of the order of the Senate of January 6, 1999, the Secretary of the Senate on November 3, 2000, during the recess of the Senate, received a message from the House of Representatives announcing that the House has passed the following joint resolution, in which it requests the concurrence of the Senate:

H.J. Res. 124. Joint resolution making further continuing appropriations for the fiscal year 2001, and for other purposes.

##### ENROLLED BILL SIGNED

Under authority of the order of the Senate of January 6, 1999, the Secretary of the Senate on November 3, 2000, during the recess of the Senate, received a message from the House of Representatives announcing that the Speaker has signed the following enrolled bill and joint resolution:

S. 2413. An act to amend the Omnibus Crime Control and Safe Streets Act of 1968 to clarify the procedure and conditions for the award of matching grants for the purchase of armor vests.

H.J. Res. 123. Joint resolution making further continuing appropriations for the fiscal year 2001, and for other purposes.

Under authority of the order of the Senate of January 6, 1999, the enrolled bill was signed by the President pro tempore (Mr. THURMOND).