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Beyond rhetoric in debates about the ethics of marketing prescription medicines to consumers: The importance of vulnerability in people, situations and relationships

Authors: Stacy M. Carter^{1,2}, Gabrielle N. Samuel¹, Ian Kerridge^{1,3}, Richard Day⁴, Rachel A. Ankeny^{1,5}, Christopher F.C. Jordens¹ Paul Komesaroff⁶ (2010)

¹ Centre for Values, Ethics and the Law in Medicine, Medical Foundation Building (K25), The University of Sydney NSW 2006 Australia

² School of Public Health, The University of Sydney NSW 2006 Australia

³ Haematology Department, Westmead Hospital, Sydney, NSW 2145, Australia

⁴ Clinical Pharmacology, St Vincent's Hospital Clinical School, Faculty of Medicine, University of New South Wales, NSW, Australia.

⁵ School of History and Politics, The University of Adelaide, Napier Building, Adelaide SA, 5005 Australia

⁶ Centre for Ethics in Medicine and Society, Monash University, Alfred Hospital, Commercial Road, Prahran, Victoria 3181, Australia

Corresponding author: Stacy M. Carter. Centre for Values, Ethics and the Law in Medicine, The University of Sydney NSW 2006 Australia. Phone: + 61 2 9036 3405. Email: stacy.carter@sydney.edu.au

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Abstract

Background This article examines community responses to the marketing of prescription medicines. Historically, debates about such marketing have focused on alleged unscrupulousness of pharmaceutical companies and on the quality of information provided.

Methods Six focus groups were conducted in Sydney, Australia, three with older and three with younger community members. Analysis examined interactions between group members, the positions participants took up, conflicting arguments, and explanations for variation.

Results Participants argued specifically rather than generally about consumer marketing of medicines. Neither the moral purpose of corporations nor the quality of information in advertisements was particularly important. Instead, pharmaceutical marketing was assessed in relation to vulnerabilities that existed in individual consumers, in doctors, in the contexts of illness and as a result of medications being potentially dangerous.

Conclusions The critical ethical issue in prescription medicine marketing may be the existence of vulnerabilities and the responsibilities they may generate. We outline three possible policy responses suggested by these participants.

Key words: DTCA, direct-to-consumer advertising, marketing, vulnerability, doctor-patient relationship, drug industry

Introduction

This article reports on an Australian qualitative study examining lay people's responses to the practice of marketing prescription medicines to consumers (henceforth referred to as consumer marketing of medicines). In most markets, medicines are promoted via media including television, radio, magazines, the Internet, billboards and other outdoor advertising, and consumer group sponsorship. However jurisdictions vary according to whether consumer marketing of prescription medicines may legally include brand names or detailed claims about the therapeutic benefits of a drug. The inclusion of brand names and health claims is legal only in the United States of America (USA) and in New Zealand (NZ). In other jurisdictions, including the United Kingdom (UK), Canada, the European Community and Australia, where this study was conducted, the inclusion of brand names in consumer marketing of prescription medicines is illegal. However even in these markets, pharmaceutical companies commonly engage in unbranded marketing which encourages consumers to 'ask their doctor' about a specific health condition treated by the company's drug. These practices often test the limits of regulatory regimes, are largely self-regulated by industry, and have been widely criticized, leading to debates about impacts on consumers, and about the proper regulation of pharmaceutical industry communications (Australian Consumers Association; Australian Medical Association). In Australia, for example, a review recommended that Australia continue to prohibit branded advertisements for prescription medicines to consumers (Galbally 2001), and concluded that industry self-regulation or co-regulation using a code of practice would be unlikely to achieve the necessary controls. Nonetheless, arguments continue to be made internationally that such prohibitions are an inappropriate restriction on liberty in an area where there is no demonstrable harm.

In both the USA and NZ, where branded consumer marketing of medicines is legal, spending on such marketing has increased rapidly during the last decade: in the USA, it rose from an estimated \$375 million in 1995 to \$4.2 billion in 2005 (U.S. General Accounting Office 2006). This increase has sparked vigorous debate, but, as is common on issues of corporate ethics and social responsibility, the discourse has been polarized with opposed groups staking claims and counter claims. Advocates of consumer marketing of medicines claim that it informs and empowers patients, leads to better exchange of information in patient-doctor encounters and to the detection of untreated disease, fosters compliance, strengthens the doctor-patient relationship, increases patient awareness of health issues and ultimately increases health overall (Bonaccorso and Sturchio 2002; Holmer 2002). Opponents counter that it reinforces the link between disease and drug treatment, exaggerates the need for and benefits of treatment while de-emphasizing the risks, and exploits the

fears and concerns of consumers by misleading and misinforming, thereby motivating clinical action. It is also argued that consumer marketing of medicines creates tension between patients, doctors and insurers, diverts doctors' attention away from more pressing health concerns, and inevitably increases inappropriate demand for new and expensive drugs, health care costs and net ill-health (Mintzes 2002; Moynihan et al. 2002; Vogel et al. 2003; Woloshin et al. 2001).

If sound policy decisions are to be made about consumer marketing of medicines the debate needs to move beyond formulaic rhetoric. One way to make this move is to engage with consumers, the targets of this marketing. Research about consumer marketing of medicines has focused on branded advertising of drugs, has been largely quantitative and survey-based, and has emanated primarily from the USA, and to a lesser extent NZ, Canada, and Australia (Alliance for Access to Medical Information (AAMI) 2002; Hoek et al. 2004; Miller and Waller 2004). These studies have focused on consumer awareness of marketing, consumer preferences regarding the content of marketing, and consumer attitudes towards marketing. The results suggest several important patterns. As the prevalence of branded consumer marketing of medicines has increased, consumer awareness of this marketing has also increased (Prevention magazine 2008; Prevention Magazine 2005; 2006; Prevention magazine 2007), particularly among consumers taking medications or positively disposed towards marketing (Bell et al. 1999a). Consumers have consistently expressed a desire for information on indications and drug side effects (Foley and Gross 2000; Tucker and Smith 1987; Woloshin et al. 2004; Young et al. 2005). In opinion and attitude research, consumers have generally been found to have 'neutral' or 'positive' attitudes to consumer marketing of medicines as a source of information (Alliance for Access to Medical Information (AAMI) 2002; Bell et al. 1999a; Beltramini 2006; Gonul et al. 2000; Herzenstein et al. 2004; Hoek et al. 2004; Huh et al. 2004a; Huh et al. 2004b; Miller and Waller 2004; Murray et al. 2004; National Consumers League 2003; Perri and Nelson Jr. 1987; Robinson et al. 2004; Vatjanapukka 2004). However exposure to consumer marketing of medicines does not appear to improve the accuracy of consumers' knowledge about drugs (Brodie 2001; Hoek 2007; Kaphingst et al. 2005), and consumers generally express skepticism about the quality and credibility of information provided by such marketing and conflicting, diverse or inconsistent attitudes on the benefits and risks posed by it (Alperstein and Peyrot 1993; Foley and Gross 2000; Herzenstein et al. 2004; Marinac et al. 2004; Miller and Waller 2004; Robinson et al. 2004; Young et al. 2005b).

The inconsistencies in the findings of existing survey-based studies are difficult to explain. This is a common epistemic problem for quantitative inquiry. Quantitative techniques permit consistent measurement of fixed variables in large random samples of the population, producing population 'average' statistics about, for example, 'agreement' or 'opinions', which can then be readily compared. However the converse of this strength is a weakness: quantitative studies need to reduce complex issues to a small set of predetermined variables and draw conclusions about an 'average' person. Qualitative inquiry, conversely, cannot produce representative 'average' measurements. However it can approach problems naturalistically, investigate the experience of specific, contextualized individuals, and discover new variables and relationships of importance during investigation by allowing participants to respond on their own terms and provide explanations. Thus qualitative techniques, whilst sacrificing statistical representativeness, can provide deeper and more original understanding of a complex issue.

The complexities implicit in marketing prescription medicines to consumers are clearly highlighted in both the quantitative empirical research, and the ongoing ethical and policy debates. It is surprising, then, that very few qualitative studies have been conducted regarding this form of marketing. Young and his colleagues investigated perceived information needs and the degree to which consumer marketing of medicines met those needs in focus groups with people who had chronic illnesses (Young et al. 2005b). However the knowledge generated did not extend beyond what had already been derived from quantitative studies. With this background in mind, we undertook to

better use qualitative inquiry to investigate lay people's responses to the practice of marketing prescription medicines directly to consumers. Specifically, we aimed to evaluate:

1. how lay people construct this practice in group interactions;
2. the context in which lay people make sense of this practice; and
3. the arguments lay people use regarding this practice.

To achieve these aims, we conducted focus groups in which we showed respondents hypothetical examples of consumer marketing of medicines. We created these as stimuli for group discussion. These illustrations of marketing activities were for fictional brands but were based on real marketing practices from Australia, USA and NZ. Some of the conversations we report on thus concern illegal marketing practices that do not exist in Australia and would not have been experienced by participants in their 'real life'. This was deliberate, because we thought it conceivable that interested parties may attempt to legalize these practices in Australia in future, and thus we were interested in participants' reactions to them. The exemplars used were concrete and well-illustrated, and were explained clearly to the participants.

Based on our findings we will argue that these participants rarely drew on traditional anti-corporate rhetoric in their conversations and that the poor quality of information in consumer marketing of medicines was not a basis for automatic rejection of such marketing. Instead arguments relied on invoking doctors' and patients' vulnerabilities in different situations, and the responsibilities that these vulnerabilities may or may not entail for policy makers and practitioners.

Methodology and methods

This study employed focus group methods. Six groups were conducted in Sydney, Australia, three with people under the age of 50 and three with people 50 and over. This division was intended to create a generationally more homogeneous and thus interpersonally safer environment (Barbour and Kitzinger 1999; Morgan and Scannell 1998). As most people use prescription medications at some time in their life and this was not considered to be a particularly sensitive issue, we did not divide groups according to medication use, although we expected that the older participants were more likely to be regular prescription medication users. Participants were recruited via advertisements in local free press distributed directly to households and offices in Sydney. We targeted a 15km radius around the focus group location, which included the busy Central Business District and residential areas from high to low socioeconomic status (SES). The advertisement read: Would you like to participate in a research project? Researchers from The University of Sydney want to hear your ideas about drug companies advertising their drugs to people in the community. A group discussion will be held in June at Sydney University, Camperdown, for approximately 2 hours. You will be reimbursed for your time. In all 40 participants attended; each group contained between 5 and 8 participants. Groups were of mixed gender and a wide range of SES, each group had approximately equal numbers of men and women. Participants were offered \$AUD50 compensation for their attendance.

Each group lasted 90 minutes and followed the same basic format, although participants had considerable freedom to direct the conversation. After a neutral 'warm-up' question, and a general discussion about advertising, including advertising medicines, the moderator introduced two separate activities. In the first written task, participants were asked to rate the following statements on a 5-point Likert scale from "Very important" to "Not at all important": Ads make people think they are sick, Drug companies have a right to communicate, Ads provide misleading biased information, Ads promote expensive brand-name drugs, An ad might tell you about a drug you need, Ads create demands that use up doctors' time, Ads promote drugs that aren't proven safe, Doctors prescribe whatever patients ask for, Drug ads raise general health awareness. The rationales for

their ratings were then freely discussed and compared. Written ratings were not recorded, as this was not the purpose of the exercise. It was designed to expose participants to common rhetoric, allow time for them to consider, and encourage expression of contrasting evaluations of the various arguments, thus moving beyond simple reproduction of well-rehearsed positions.

In a second exercise, participants were given a set of cards illustrating different pharmaceutical marketing activities. They were asked to imagine that they were law-makers, and to sort the activities into three piles: ban, approve and send to a committee (the latter meaning 'undecided'). This was done individually. When sorting was complete, an open discussion of the process of decision-making was facilitated. Again the purpose was not to enumerate responses, but to provide concrete examples of marketing for discussion, allow time for private reflection, and encourage clarification of the means by which individuals had evaluated marketing practices. In the final 10 minutes, the moderator told the participants about a meeting with decision-makers planned for the end of the project, and asked what messages they would most like us to take to those decision makers.

As analysts, we understood that these focus groups were, above all, interactions between groups of strangers. This is reflected in our presentation of data below which, consistent with contemporary standards in focus group reporting, presents interactions rather than decontextualized statements from individuals. In these data excerpts, 'I' represents the interviewer, 'F' represents a female participant and 'M' a male participant. We did not approach analysis assuming that we could access the true opinions, beliefs or attitudes of participants – in fact we did not presume that such things existed in a static form. Rather, we were interested in the positions that people took up in this forum. This reflects both the broadly constructivist theoretical perspective that we bring to qualitative inquiry (Charon 2007) and a rejection of the naïve methodological reasoning which treats focus group data like any other data (Barbour and Kitzinger 1999).

Each group was transcribed in detail by a professional transcriber. Initial detailed coding (at a line-by-line level), consistent with our interactionist perspective, focused on process and action, encoding what participants were doing with their talk and how they were constructing and modifying meaning together. This coding, and comparison between and within groups, was used to develop models of the sense-making processes participants enacted, with particular attention to the positions that they took up, conflicting arguments, and explanations for variation. We did not use computer-aided data analysis software: we annotated directly onto transcripts in Microsoft Word and used mind-mapping software (Inspiration 2007) to relate and develop concepts. Analysis was conducted cooperatively by two of the authors (GS and SMC) and discussed with the research team as it evolved. In the interests of confidentiality, all names in the focus group transcripts were changed to pseudonyms.

The study protocol was approved by the University of Sydney Human Research Ethics Committee.

Findings

Participants argued specifically rather than generally about consumer marketing of medicines.

To begin, it should be noted that people argued about the acceptability of consumer marketing of medicines in the context of the specific drug, consumer, illness, and prescriber in question, and different contexts changed the positions people took up. Rather than outright rejection or acceptance of marketing, participants often argued that 'it depends'. Three key issues within and across participants' accounts explained rejection or acceptance of marketing practices: these were the dimensions along which it 'depended'. Participants distinguished between active consumers and vulnerable consumers. They argued that whilst they wanted access to good information about

medicines, marketing campaigns could not provide such information: they could only alert to the existence of a drug. The appropriateness of such an alert depended on whether one was an active or a vulnerable consumer. Finally, participants talked about 'good' and 'bad' doctors, and the significance of their relationships with active or vulnerable consumers. We will discuss each of these issues in turn.

The active consumer versus the vulnerable consumer

F ... I think you know, if you've got the Internet, I'm on 14 prescription drugs. Every time I'm given a new one, okay I get it, but first I go home, look it up on the Internet, look at all the information, probably spend an hour, two hours on it before I take it. Now once I've done that, ads quite frankly don't count.

I Interesting.

F But I would say a lot of elderly people.

F That's right.

F That's, that's true, but every chemist now, when you get your prescription, you can ask for a printout, and I think people really must read that, because your doctor often doesn't really think through that you're on the 11 ... other 11 drugs.

[...]

M Can I just say something... I was going to say like that's a ... all this is sort of on the presumption that people sort of generally worry about their drugs, I don't think they do actually.

F No, I agree. I think ...

M They just throw them down and that's it.

F I disagree with that.

F The elderly people now that I'm looking after and I've found that quite honestly, the doctor said 'Take this tablet.' They will take it and they really don't care what the side effects are, they don't care, except they want to get better or the doctor has said that that's gospel truth.

I Hm. Interesting.

F And I think that that's ... this is all an age-related thing now, if you're talking about someone who's young or even up to middle-aged, I think yes, they will look into it. Anyone elderly. Forget it, they just take it blindly.

F I'd disagree with that (F: Do you?), if you've had a bad experience, you'll never take anything else again with that experience.

[Group 2, age 50 and over]

As illustrated above, participants' talk implied two possible subject positions that a consumer could take up in relation to pharmaceuticals and health in general. These subject positions were pervasive in participants' reasoning about consumer marketing of medicines, as will be shown in subsequent sections. The first position was the active, independent, critical, responsible consumer, seen above in the participant who spends two hours on the Internet researching each new drug she is given, or the assertion that people 'really must read' the information sheets from pharmacists. Most participants adopted this position for themselves. Active consumers valued health information and awareness, and adopted a highly critical, even untrusting stance towards health professionals, particularly doctors, which necessitated seeking health information from a variety of sources.

The contrasting subject position was the vulnerable consumer. Vulnerable consumers sometimes sought health information, but consumed it uncritically. In our analysis of participants' talk, we saw vulnerable consumers of three 'types'. Consumers of the first type, who are discussed above, were easily controlled, insufficiently self-protective, weak, or unable to stand up for themselves. We will refer to this type as 'compliant consumers'. This could include older consumers made frail by age and/or accustomed to highly paternalistic medicine who would 'blindly' do as the doctor said, persons intellectually ill-equipped to navigate the health system, or persons who were simply inattentive to their health. The second type of vulnerable consumer we will refer to as 'suggestible questing consumers'. These consumers were those always looking for a new 'cure' and could be led by advertising to act against their own best interests (that is, demand medicine they didn't need). We will see talk below about such consumers, who see an advertisement and think 'well that's the answer to my problems and I'm going to find a doctor who can give that to me.' 'Suggestible questing consumers' were often mocked, a joke that was readily shared. They were talked about as irresponsible, irrational, even somewhat pathetic. The third type of vulnerable consumer we will refer to as 'seriously ill consumers'. These very sick (especially fatally ill) consumers were driven by the severity of their illness to completely trust their doctors or accept any treatment, and thus became vulnerable.

The 'vulnerable consumer' was a dangerous subject position for participants to take up. Only a rare, brave participant was prepared to risk 'outing' herself or himself as vulnerable, so there was little opportunity to observe the 'vulnerable' position being enacted. Instead, people frequently speculated on ways in which these vulnerable 'others' would be more susceptible to marketing.

Appropriate access to health and drug information

F Well I'm reading up about the new cervical vaccination the Gardasil um, and it has been direct advertising to the consumer and I was very dismayed to find out that actually the latest news is that it's cost a lot of bad side effects (F: that's right) and all that and I thought you know they should be advertising it all, in total all the details and everything to the GPs [general practitioners/family physicians] before they you know targeting it at the consumer because the consumer is not very – is not able to really understand these things from a more, (indistinct) maximal value, er, viewpoint.

I Right so you can't get an informed decision?

F Yeah because the GPs are responsible for a lot of things. You know?

F Yeah that's a – it's a good point but you see on the other hand that if you don't advertise it to the consumer they're not going to go to the doctor and ask, just in general, what can I do to improve my health? Most people aren't going to do that so I mean that one you're talking about is it Gardasil (F: yeah Gardasil) the new one, I think that it's probably a good one to advertise because if your doctor didn't tell you about that you'd miss that 9 month period where the government's doing it for free for all women under a certain age, or just if you didn't happen to go to the doctor in that period. You kind of miss out on that. I sort of think you need to know something like that (indistinct) is so beneficial.

[...]

F [...] I would only pay attention to anything that was relevant to me and it's sometimes good to see choices. Um, so I actually think it would be a good thing.

[...]

F ...This Gardasil, they found in the States that this actually caused cancer. There was another bit of information that was left out in the, direct, it was been advertised directly to the consumer. So I think that's terrible you know.

- I So the idea of drug safety is a bigger issue for you?
- F Yes. Yes.
- I Yeah they shouldn't advertise any drugs that aren't safe.
- M How much information can you put in 30 seconds?
- F It's kind of a hard call too because I think advertising drugs, you've got to be careful because if you're mixing it with something else you, you've got to be really careful you can't just take what's advertised as gospel.
- I Right
- F Yeah because there's so many variations of the individual person.
- F Yeah I think to add to that and you have the issue of drug interaction you know. I mean if you're on 10 or more different drugs a day my goodness, you could be a very bad, fatal cocktail like the case of I think Heath Ledger you know
- [...]
- F ...Certain drugs that you know should be very seldom prescribed, at the time I mean look at Prozac, it was considered to be a cure-all for everything and it's got a horrendous, but if someone's very depressed and they see these happy-looking Prozac ads then they could really convince themselves, 'Well that's the answer to my problems and I'm going to find a doctor who can give that to me.'
- F Yeah.
- M Maybe the drugs need to be categorized like my reaction would be different to different categories. I don't know what the categories are (I: Right yeah) but you know this drug on TV, fine, this one not fine (I: Yes) this one maybe perhaps you know.

[Group 7, age 50 and under]

The provision of information was a key issue in participants' discussions. Consistent with other research, participants in this study said they wanted to receive extensive accurate information about health, and that 'people' should be made more aware of their health. This was sometimes constructed as a right and sometimes a means by which one could help others. This desire for information was a common backdrop to discussions about marketing of medicines, exemplified above in the implicit framing of Gardasil as something 'I can do to improve my health', and the concern about missing such opportunities if one's awareness was not raised through marketing.

Also consistent with existing research, participants were very concerned about drug safety: there was an almost universal desire expressed for comprehensive, comparative information about drugs and side effects. This is seen above in the 'dismay' about the alleged serious side effects of Gardasil, about 'very bad, fatal cocktail(s)' of drugs, and the statement, commonly made, that 'they shouldn't advertise any drugs that aren't safe'. Many participants traced their desire for drug information back to an experience of drug side effects, and worried out loud that they were ill-informed about side effects and contraindications. Implicit in these discussions was a clear differentiation made between types of or particular drugs, as reflected above: drugs had different profiles of potential harm or benefit, and could be inherently unpredictable.

These participants were unified by a desire to receive health information and drug safety information. However they generally agreed that consumer marketing of medicines was a poor source of health information and was never sufficient to inform consumers about side effects. Drug marketing was always spoken of as misleading, biased and coercive. It was not possible to inform in

the time and space allotted to advertisements or in the inherently persuasive marketing genre. For this reason, advertisements could not inform, they could only alert. This was a general truism, such that it would be considered misguided and ridiculous to argue for advertisements as a source of information. Advertisements could act only as an alert, to make people aware, indicating that a product or service existed. Information – real information – came from sources including pharmacists, doctors, one’s own research on the Internet or professional medical publications, and stories from friends and family. Branded drug marketing was particularly problematic in these conversations: the addition of a brand trivialized medicines, made the communication inevitably commercial, and decreased its acceptability.

Arguments did not hinge on whether marketing informed: it clearly did not. The critical issue was whether or not an alert was a useful or acceptable thing. The degree to which an alert was acceptable depended on the profile of the drug, the subject position of the consumer, and the responsibilities taken towards different types of consumers.

As noted above, most participants framed themselves as active consumers. However active consumers took a variety of positions on the acceptability of alerting, demonstrated in the sample interaction above. Active consumers sometimes expressed concern about drug safety, but said this concern was not sufficient to prevent marketing. Despite its shortcomings, marketing alerted people, stimulating health awareness, personal research and visits to the doctor. Even if a drug had significant safety issues, active consumers should be informed and judge for themselves, evaluating marketing as they would any other source of information.

This position was resisted by other participants in several ways. One was to argue that alerts were not useful, even for active consumers. Another was to propose conditions for prohibiting marketing. The first condition for prohibition was when drugs had not been proven to be safe, or when their side effects were not known (this creates difficulties for regulators which we will come to in our discussion). In this case, drug safety concerns overrode the desire to be generally informed. The second prohibitive condition was when the drug treated extreme or life threatening illness. We have already seen the concern expressed for ‘seriously ill consumers’, made vulnerable by the situation of their illness. Because of this concern, consumer marketing of medicines for life-threatening illnesses was generally talked about as flippant, trivializing, and unacceptable. Seriously ill consumers needed a trustworthy doctor, not marketing of medicines.

Finally, some active consumers argued that marketing would always be problematic, because of ‘suggestible questing consumers’ and ‘compliant consumers’. These vulnerable people would consume marketing campaigns uncritically or irresponsibly, and it was more important to protect them than it was to provide an alert to active consumers.

Health professionals and ‘doctor shopping’

M Um, I think it’s worth that we are going to, it’s really going to conjure up the idea that virtually it’s a supermarket now at the doctor’s surgery [consulting rooms] and you can go in and ask for what you want and if the doctor doesn’t give it to you then you’re going to find a doctor who does. So they are all going to start having to do it.

I How do other people feel about that idea about the doctor’s surgery?

M I agree a lot with what Bill’s saying.

I So you’re nodding your head Jane.

F Yeah, I know that I’ve probably got two or three doctors depending on whether I’ve got the time to sit around in the waiting room mainly, or not and one time I went to the 24 hour medical centre and I said look - it was the honest truth my regular doctor wouldn’t give me this, this or this and she just gave me all three scripts. (Hm) I was in and out in less than five minutes. So I mean if I’d

shopped around doctors to find one that would eventually give me something that I wanted, I would have been incredibly happy [laughter]. I was pleased that I did get what I needed and I didn't have to wait around until the you know next business hours to hopefully get an appointment to see my usually doctor. But I mean she didn't even flinch. She just went okay fine. I knew the name and I knew the usual dosage and that was it.

M So you're very sort of comfortable with whatever drugs you were taking?

F Yeah.

M So it's not as if you were going in for an ailment that you needed to-

F Yeah and I did give her the name of the other doctor you know I said he's closed on the weekend, obviously I can't get in and I've run out of whatever.

I How do you feel about that idea that doctors can just give people drugs?

F Well it was a bit worrying because she didn't question me at all and she didn't give me a smaller script, say enough tablets to then go and wait for my regular doctor. She just gave me a full two months prescription [laughter].

M God love them.

F Yeah, and I just thought hm do you get paid by the clock or by however many people you see or how many scripts you write or -

I So the question is I suppose does that bother you so much that it would affect your opinion as to whether you should advertise prescription drugs?

F It just worried me that it was it was that easy. I mean maybe I've got an honest face or maybe she had something else on her mind or...

[Group 5, age 50 and under]

Central to the evaluation of consumer marketing of medicines was concern about whether one could trust one's doctor, and how one navigated the trustworthiness of doctors. The above is just one excerpt from the extensive narrative evidence that was presented, by participants of all ages and sexes, about the untrustworthiness of some doctors. There were good and bad doctors, and good doctors sometimes acted badly due to time pressures or exhaustion. Bad doctors failed to prioritize the patient's interests, spent insufficient time with the patient, and did not provide health information, especially about drug side effects. These doctors were vulnerable themselves, to the influence of both patients' requests and the pharmaceutical industry's communications. They were poor gatekeepers with regard to prescribing; thus they facilitated the biomedicalization of society, a trend which would be worsened by consumer marketing of medicines. This professional vulnerability was just as important as the vulnerability of consumers in evaluating marketing of medicines.

An important relationship was observed between the trustworthiness of doctors, doctor shopping and consumer subject position. Active consumers doctor-shopped to locate a professional who could be trusted not to over-prescribe (and participants appeared to have faith in their ability to identify trustworthy doctors). In this context, consumer marketing of medicines was more acceptable as both the consumer and the doctor would act responsibly towards appropriate medicine use. In contrast, the 'suggestible questing consumer', influenced by marketing, would doctor-shop to find an untrustworthy practitioner who would prescribe freely. So although a trustworthy doctor-patient dyad could use consumer marketing of medicines as a resource, because of extensive narrative evidence that untrustworthy doctors and 'suggestible questing consumers' would always exist, marketing remained a potentially pernicious influence.

Additional issues

We note that we did not see important differences between the responses of older and younger groups in our analysis. As expected, older people often had a much more extensive experience of medication use on which to draw, including experiences of caring for their very elderly relatives: perhaps for this reason, they seemed to have greater altruistic concern for the health of vulnerable others, and seemed more likely to see prescription drugs as a very serious matter that should not be trivialized. Otherwise, the older and younger groups were similar in their responses.

Discussion

The findings of this study provide an interpretive context for the apparently conflicting or uncertain results that have been obtained by previous quantitative research. Some research questions, particularly regarding the proportion of consumers who are aware of and can recall prescription drug consumer marketing, are best-answered using quantitative techniques. However the form of investigation most commonly used in this field – that is, asking consumers to rate on a scale their agreement with statements such as ‘advertising of prescription medicines would help consumers make better choices’ or ‘advertising prescription medicines is a good idea’ – has effectively prevented research participants from saying ‘it depends’, setting out reasons for agreement, disagreement, or varying agreement with prescription drug marketing to consumers, and relating issues to one another as they did in these focus groups. Qualitative techniques are particularly useful for developing complex understandings that go beyond simple agreement or disagreement.

These participants saw the marketing of prescription medicine to consumers as a poor-quality and low-credibility information source. This was so obvious that the quality of information provided was largely irrelevant to the acceptance or rejection of such marketing. Marketing could only ever alert consumers to the existence of a product or service. Attempts to ameliorate the negative effects of marketing by improving the ‘balance’ of information presented thus appear to miss the point. No matter how hard we try, marketing may never be a good source of information. Acceptance of consumer marketing of medicines in this data ‘depended’ on other key dimensions, which we argue should take priority in policy debates about consumer marketing of medicines.

As noted, the traditional pro- and anti-drug marketing debate is, on the whole, a pro- and anti-corporate debate, much like the debate on food advertising to children (Senate of the Parliament of Australia 2008) and tobacco marketing (Carter 2003). The pharmaceutical industry, and experts paid by them, produce commentary in favor of marketing; anti-corporate activists and academics produce commentary against it. This contest focuses on critical and structural questions: the task, essentially, becomes that of ‘proving’ that industries are fundamentally good or bad, socially responsible contributors or ruthless profiteers. Participants in these focus groups instead invoked vulnerabilities inherent in patients, inherent in doctors, and arising from situations. Few participants positioned themselves as vulnerable, but most participants had at least some concern for vulnerable consumers, and about doctors who were vulnerable to influence. This suggests that a closer examination of the concept of vulnerability and its conditions and implications can make useful and critical contributions to the development of policies about consumer marketing of medicines.

Although most people have an intuitive sense of what ‘vulnerability’ means, many disparate definitions are employed in both everyday and technical usage. Recent discussions on this subject have focused on two key questions. The first is a question of generality. Some authors have argued, for example, that for ‘vulnerability’ to be a useful concept it is necessary to define it restrictively, so as to apply only to subgroups of people (for example, those whose autonomy is compromised and/or are unable to protect their own interests from exploitation), thus providing those people with a claim to special protection (Hurst 2008; Jecker 2004; Silvers 2004). Opponents to this view

argue that vulnerability should be defined as a universal, existential human characteristic, ontologically prior to autonomy, the 'bridging factor between moral strangers', creating an ethical imperative to prevent the wounding that we are all capable of giving and receiving (Finder 2004; Jecker 2004; Rendtorff 2002) and thus perhaps providing a justification for the application of a general precautionary principle (Grinnell 2004). This debate hinges in part on whether defining subgroups as vulnerable is more likely to ensure just treatment of members of that group, or to lead to their unjust stigmatization or exclusion (Hurst 2008; Kipnis 2004; Silvers 2004). The second key question considers the degree to which vulnerability should be conceptualized as arising from situations, contexts or relationships (Finder 2004; Henderson et al. 2004; Hurst 2008; Jecker 2004; Levine et al. 2004; O'Neill 1996; Shivas 2004) rather than as merely a characteristic of individuals: this question resonates with debates over the degree to which autonomy should be conceptualized relationally.

How do these issues play out in our data? Firstly, vulnerability was not spoken about as an existential universal inherent in human beings; the vulnerabilities in these conversations were specific aberrations in medicine use which increased the threat of harm to individual patients and society at large. We note that we must be cautious about taking these constructions at face value. As Shildrick has observed, the vulnerabilities that we see around us may reveal uncomfortable vulnerabilities in ourselves, and this discomfort may lead us to forcefully distance ourselves from the defective 'other' (Shildrick 2000). In fact we are rarely perfect active self-advocates and independent information-seekers. A belief in one's own invincibility to influence may in fact increase one's vulnerability. Participants' positioning of themselves as non-vulnerable cannot 'prove' a restricted rather than a universal form of vulnerability. However the talk of these participants does suggest types of vulnerability that might be especially relevant to consumer marketing of medicines. We have derived five types of vulnerability from this data. Two arose from constructed aberrant 'traits' of consumers: being suggestible and questing, or being compliant. One arose from a constructed aberrant 'state' or situation: being seriously ill. The fourth was perhaps the most general form of vulnerability, in that it arose from the questionable safety of medicines. Finally, some doctors were vulnerable, either consistently or due to circumstance.

The 'suggestible questing consumer' was readily influenced by persuasion, always looking for a new cure, and would 'shop around doctors to find one that would eventually give [them] something that [they] wanted'. Participants constructed the 'suggestible questing consumer' as lacking autonomy – they did not know what was good for them, and thus could not be considered self-actualizing (Benson 2000) – but as highly agentic in their search for new medicines. In contrast, 'compliant consumers' were vulnerable both because they took minimal action in relation to their health, and because their actions were not self-directed. Their passivity might arise from inattention or incompetence: they would 'take [medicines] and they really don't care what the side effects are... they just take it blindly.'

'Suggestible questing consumers' and 'compliant consumers' were vulnerable because of individual traits. In contrast, the third form of vulnerability arose from a (possibly temporary) state, the situation of serious illness. The threat of impending death – a threat to one's very existence – created vulnerability through desperation. The fourth form of vulnerability potentially applied to all consumers in that it arose from the unknown and perhaps unknowable dangerousness of a drug. As noted, the issue of drug safety was very real to participants due to their own experience of side effects. Even an active consumer who conducted their own research and had found a good doctor might take a dangerous drug if its toxicity was not yet properly understood, and being alerted to a drug by marketing may increase the likelihood of this occurring.

In these participants' accounts, vulnerabilities were relational, which leads us to the fifth type of vulnerability. A patient's vulnerability arose in the context of relationship with a prescribing doctor, who might also be more or less vulnerable to both patient and industry influence. An ideal doctor was impervious to influence and thus could act in a patient's best interests. Like the active

critical consumer, the ideal doctor seems unlikely to exist as an embodied reality. Indeed, as we have shown, participants presented extensive narrative evidence of the existence of bad doctors, who were vulnerable to the influence of patients and corporations. They used this evidence to argue three things. Firstly that it was necessary to be an active consumer to find an ideal doctor. Secondly that 'suggestible questing consumers' would work (and it would not be difficult) to find a bad doctor, generating a co-vulnerability that would lead to over prescribing and biomedicalization. Thirdly, that 'compliant consumers' and 'seriously ill consumers' might end up with a bad doctor because they were not capable of doing the work needed to find a good doctor.

To summarize, participants' accounts resonated across theories of vulnerability rather than conforming to a single theory. Participants constructed vulnerability as both individual and relational, inhering in situations and in personal traits, and as particular (in the case of 'questing suggestible' or 'compliant' consumers) but also universal in that anyone could fall foul of dangerous drugs or serious illness. We reiterate that these discussions occurred in Australia, where consumers are accustomed to being relatively protected from direct pharmaceutical marketing. If this study was replicated in another context – for example, the U.S. market where drug marketing is very familiar – consumers may be less likely to construct consumers and doctors as vulnerable.

A public policy response to consumer marketing of medicines that takes these insights into account would acknowledge the key importance of the concept of vulnerability. In fashioning such a policy the critical ethical question would therefore be: to what degree are we morally responsible or obligated in relation to these types of vulnerability? Several scholars have argued that vulnerabilities inevitably create responsibilities. O'Neill (1996), for example, argues that just as it is necessary for a society to reject inclusive principles of injuring (that is, if everyone in society injures everyone else with impunity, society will collapse), so is it impossible to universalize indifference to and neglect of others. Such an argument provides a basis from which indifference and neglect of vulnerable persons can be rejected in particular situations. Alternatively, Goodin (1985) argues from cases, often case law, that moral obligations do not arise solely from their voluntary self-assumption by an obliged person or persons, but that special responsibilities arise both from people's vulnerability and a responsible party's unique ability to mitigate that vulnerability. For example, as consumers became increasingly dependent upon companies for the provision of vital products and services, those companies incurred an increasing moral obligation to ensure the safety of their products and services, an obligation which was often eventually enshrined in law.

Space limits us from further discussion and defense of the idea that responsibility should be allowed as arising from vulnerability. Nonetheless, if the premise is granted, we can ask: what responsibilities might be generated by the particular vulnerabilities relevant to consumer marketing of medicines? Participants differed on this question, presenting varying conditions for universal rejection, universal acceptance or conditional acceptance of consumer marketing of prescription medicines.

The first position, universal rejection of such marketing, arose from two assumptions: that there would always be vulnerable consumers and doctors, who could not be offered effective protection from their susceptibility to marketing and to one another because they were extremely difficult to identify. Participants generally accepted that all doctors were susceptible to influence in certain situations (e.g. due to exhaustion and pressure). In addition, any consumers might suffer from serious illness, and all consumers were potentially vulnerable to dangerous drugs. From this point of view the only remedy was to ban consumer marketing of medicines altogether. The introduction of such a ban would no doubt be politically complex; and in jurisdictions where corporations can argue a right to freedom of speech, also legally complex. The second position was that marketing should be rejected only if drugs had significant safety issues or were intended to treat severe or life threatening illness. This position de-prioritized the problem of vulnerability inhering in specific individuals ('suggestible questing consumers' and 'compliant consumers') but acknowledged that anyone will become vulnerable in the situation of serious illness, and anyone can

be vulnerable to a dangerous drug. However this raises the question of how to define standards for seriousness or dangerousness. Sometimes these standards were evident: these participants, for example, largely ruled out consumer marketing of cancer medicines. However participants also recounted well-known stories in which a medicine's severe or life-threatening side effects were revealed only after mass marketing. These stories suggest that a fully informed judgment about the toxicity profile of a drug cannot always be made before it is marketed, so the desire of these participants for marketing only of 'safe' drugs may not be practically achievable.

The final position, taken by only a few participants, was that marketing should be universally accepted. This position proposed that active consumers had a right to be alerted, and made this proposed right the pre-eminent concern. Any responsibilities associated with vulnerabilities thus became implicitly less important than a right or moral imperative for individuals to act as autonomous agents in control of their own health care.

We believe that our analysis provides a basis for strong reservations about the acceptability of consumer marketing of prescription medicines. The basis for this rejection is not the nature of commercial corporations or the insufficient quality of the information provided in marketing, but the vulnerabilities that exist in all health care relationships and which may be elevated in certain consumers, practitioners and situations. It also depends upon acceptance of arguments that these vulnerabilities create responsibilities. These participants told us that their communities will always contain 'questing suggestible consumers', 'compliant consumers', 'bad' doctors, 'good' doctors under pressure, dangerous drugs and life-threatening illnesses, all in complex relationships with each another. Given this, rather than asking 'Are corporations bad?' or 'Is marketing a good source of information?', we believe that we should be asking: 'What does it mean for our society if we universalize indifference to and neglect of these vulnerabilities?' (after O'Neill 1996) or 'If these vulnerabilities exist, who might be particularly able to, and thus morally obliged to, mitigate them?' (after Goodin 1985).

Future research on consumers' views of marketing of prescription medicines should pay close attention when participants say 'It depends'. As we have shown here, qualitative inquiry can take us beyond common rhetoric and pre-conceptions, enabling a re-definition of important questions in applied ethics. We suggest that the new insights discussed here could be explored in further qualitative and quantitative research. In particular, the categories generated in this small-scale qualitative study – active and vulnerable consumers, informing versus alerting, and 'shopping' for 'good' or 'bad' doctors – could be used to design a more extensive qualitative study to explore the nuances and relationships between them in more depth and in different situations. In conclusion, as a result of our qualitative investigation, we suggest that discussions regarding consumer marketing of medicines should be attentive to the vulnerabilities that inhere in individuals, relationships and situations in healthcare, and consider closely the responsibilities that these vulnerabilities might create.

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