Bad Medicine. The Prescription Drug Industry in the Third World. M. Silverman, M. Lydecker, Ph. R. Lee. Stanford, California: Stanford University Press, 1992, ISBN 0-8047-1669-2.

Imagine that you are travelling in a poor country in sub-Saharan Africa, or Southeast Asia, or Latin America. Imagine further that you become seriously ill. Imagine further still that you are very lucky—you find a well-trained physician who first can diagnose your illness and then knows how to treat it.

If he gives you a prescription, chances are that unless you yourself were a physician or a pharmacist you would not understand it. But you recognize the name or the logo of the manufacturer, and if you can tie the name or the symbol to a well-known, respected pharmaceutical manufacturer, almost certainly you will feel relieved. You will expect that the worst will soon be over and you will be on your way to recovery.

Would you fear that such a drug firm might have high ethical standards to govern its action at home but would conceal dangerous or lethal side effects of its products in a poor country? You probably would not be troubled by such worries. Your gut feeling would tell you to trust the decency and the moral common sense of a widely respected, honorable company.

Would you fear that such a drug firm would communicate openly and honestly with governmental drug authorities, the health profession, and patients in their own country—for example the United States, Germany, or Switzerland—but would allow serious inconsistencies or omissions to mark its communication in a developing country? You probably would not be troubled by such concerns. As a matter of fact, with widespread poverty, illiteracy, sickness, and hunger and with the pronounced scarcity of physicians, nursing persons, and pharmacists all influencing drug safety in many parts of the Third World, you would probably assume that a respected, honorable company would try even harder to maintain the safest possible use of its products.

Certainly, any other approach would be sheer lunacy. There is not one reason why an internationally honored corporation should put sick people at risk and jeopardize its own reputation. Worse, it would be indecent.

Yet, there is reason for worry. Silverman, Lydecker, and Lee reveal once again[1] that there still are companies that knowingly put corporate greed before human welfare, companies that obviously assign a lower value to lives in Africa, Asia, or Latin America than to lives in the USA, western Europe, and Japan. Their latest book gives not only a comprehensive review of historical errors in judgments and failures in the learning process that have occurred over the past 25 years, it also documents recent marketing decisions that are of questionable value or seem to be totally indefensible.

The report of these investigators, all of the University of California at San Francisco (UCSF), cannot be lightly dismissed. Since 1976, when they began the systematic examination of this international problem and first exposed it to public attention, they have maintained their credibility among both the attackers and the defenders of the pharmaceutical industry,[2] and information policies, promotional methods, and pricing policies of multinational phar-

maceutical corporations in Third World countries, and particularly the alleged or actual use of double standards—one set of rules for the rich nations, another set for the poor—have been the focus of critical attention.[3] It has long been evident that establishing appropriate health policies in a country with widespread poverty and sickness is difficult enough.[4] Where these difficulties have been compounded by additional problems created by careless, socially irresponsible pharmaceutical marketing, life for everyone—the patients, the health professions, the governments, and the entire pharmaceutical industry—becomes even more difficult.

It is only natural that there have been and still are differences of opinion on what the role of the pharmaceutical industry in a developing country should be. There can be no justification, however, for double standards on issues that may affect the health and especially the lives of patients. Any such differences are not merely unjustifiable, they are unethical, and they represent exceedingly bad business practices.

Although there is no need for a special "code of pharmaceutical ethics," there are important basic differences between the pharmaceutical industry and almost all other industrial groups. The ethical challenge for the pharmaceutical industry is inescapable: drugs are not commodities like other consumer products. They are used because the people who need them are sick or in pain, because they have disabling physical or mental disorders, or because they may be facing death. In the case of pharmaceutical products, "consumer sovereignty"—the freedom to choose or refuse a product—is limited.

In the pharmaceutical industry, drug safety and risk/benefit assessments made by company specialists or managers have a crucial impact. If these specialists or managers make mistakes, they err not just for themselves and their company but also for the sick people who are at their mercy. Even when the company seeks to defend its actions because the industry is governed by comprehensive laws and regulations, it must be ever conscious of the special responsibility it holds because of its intimate involvement in public health.

In some cases, Silverman and his colleagues have disclosed, pharmaceutical companies have sought to explain differences in standards by attributing them to what may be termed "local conditions"—the decision of a governmental agency in a Third World nation to permit inclusion of a particular claim or indication that is banned elsewhere or not to require disclosure of a particular hazard. In such cases, the companies have asserted that they were acting legally. Such an escape maneuver is unacceptable. Enlightened judgment would suggest that such an explanation as "But we're not breaking any laws" is insufficient under conditions in which there is no state-of-the-art regulation concerning drug safety. It is certainly insufficient in countries that are, as Gunnar Myrdal called them, "soft states," where laws exist but are not enforced.[5] These and other circumstances demand that corporations take a deeper look at their responsibilities and moral obligations. Even when the law appears to be adequate and its enforcement effective, there is room for ethical reflection. Knowledge within a pharmaceutical corporation often runs far ahead of regulatory procedures. Thus, acting legally is at best the ethical minimum and should not be taken as acting morally.

Perceived responsibility that stems from better information or better insight must lead to adequate and appropriate action, even though local law does not require it. Particularly in the area of drug safety, standards that embody state-of-the-art knowledge must be applied consistently, wherever in the world

they apply and regardless of whether or not they are required elsewhere.

The Silverman group has found that there has now been a striking improvement in the quality of the promotion of their products by multinational pharmaceutical companies. In comparison with 20 years ago, most of them—though certainly not all—have tempered their claims in developing countries to conform to scientific evidence, and they are more willing to disclose hazards. They are more likely to tell the same story in the Third World that they tell in industrialized countries. For a good number of internationally active pharmaceutical corporations, the effort to improve drug safety has become a joint responsibility. It involves consumers, public interest groups, and the media. In addition, this joint effort involves the traditional medicopharmaceutical groups in government, in teaching and research institutions, and within industry.[6]

A new problem increasingly endangering patients in Third World countries is posed by local companies manufacturing and marketing products that are spurious or counterfeit. This problem has been taken up for the first time in *Bad Medicine* (chapter 8) with adequate prominence.

The UCSF group represents a remarkable combination of skills: Silverman is a trained pharmacologist and also an internationally respected reporter, Lydecker (Mrs. Silverman) is fluent in many languages and has had many years of experience in editing material dealing with pharmaceuticals, and Lee is an experienced clinician, a onetime Assistant Secretary for Health in Washington, a former chancellor of UCSF, and now head of the university's Institute for Health Policy Studies. Through their wide network of fellow pharmacologists, fellow journalists, and fellow clinicians not only in the USA and Europe but also in Africa, Asia, and Latin America, they were able to obtain information never before released. In addition, they somehow managed to induce highly critical consumer advocates and overly defensive industry leaders—many on both sides had sworn they would never meet with the opposition—to sit down together and hold productive discussions. Their book presents, for the first time, a comprehensive, well-documented, and constantly fascinating account of their efforts.

The California team has contributed much to the successful outcome of discussions among industry, medical and social scientists, physicians, pharmacists, government leaders, representatives of the media, consumer activists, and public interest groups. Over the last 10 years, these discussions are successfully replacing "confrontations" with "conversations."

The discussions have likewise helped in finding shared understanding. The process of wrestling with problems that have no simple solutions, and the willingness to be challenged by people who have had different experiences and who base their judgments on different values, has dramatically heightened the quality of many kinds of results and not merely the quality of pharmaceutical marketing policies.

Although such discussions did not and, of course, never will lead automatically to comprehensive agreement on all matters in dispute, they are in any case broadening understanding as based on all available information. Even more significant, more and more of those involved are finding themselves able to dispense with claims to superiority, to reconsider their own positions, and if necessary to accept once unpalatable views. Such discussions illustrate the continuing value of the old Socratic distinction between "certainty," a subjective conviction that is no longer susceptible to doubt, and "truth," which is objectively identical with the real facts. We must recognize that however certain we

may be, none of us possesses the definite and complete truth.

It was sometimes painful in the past—and may be so in the future—to admit that it remains important to continue to search for new and more appropriate solutions, even when we are convinced that we have all the answers. Too often, individual or collective assumptions act as fences that keep some things inside and other things outside our awareness. Openness and pluralism are required. What is not needed is arbitrariness or cheap "tolerance" applied only to avoid arguments. True dialogue differs from manipulative persuasion by dealing critically with both the necessity of acting in an economically reasonable manner and the imperative requirement to consider wider public interests.

Are all the problems settled? They are not. On the one hand, the problem of drug safety has become an issue which increasingly involves domestic firms presenting claims that cannot be justified by scientific evidence and being reluctant to disclose hazards. On the other hand, there remains the hard truth "that corporate misconduct, like the lowly cockroach, is a plague that we can suppress but never exterminate."[7] This situation makes the continuous work of concerned and able people—people like Silverman, Lydecker, and Lee—necessary and valuable.

— Klaus M. Leisinger

Notes

1. See Silverman M. *The Drugging of the Americas. How Multinational Corporations Say One Thing About Their Products to Physicians in the United States, and Another Thing to Physicians in Latin America*. Berkeley: University of California Press, 1976; and Silverman M, Lee PR, Lydecker M. *Prescription for Death. The Drugging of the Third World*. Berkeley: University of California Press, 1982.
2. See Lexchin J. Pharmaceutical promotion in the Third World. In: *Journal of Drug Issues* 1992;22: 417–53.
3. See, e.g., Heller T. *Poor Health, Rich Profits, Multinational Drug Companies and the Third World*. Nottingham, England: Spokesman Books, 1977. Melrose D. *Bitter Pills. Medicine and the Third World Poor*. Oxford, England: Oxfam, 1982. Muller M. *The Health of Nations. A North–South Investigation*. London: Faber and Faber, 1982. Gereffi G. *The Pharmaceutical Industry and Dependency in the Third World*. Princeton, New Jersey: Princeton University Press, 1983. Medawar C. *Drug Disinformation*. London: Social Audit, 1980. Medawar C. *The Wrong Kind of Medicine?* London: Hodder and Stoughton, 1984. Chetley A. *Peddling Placebos: An Analysis of Cough and Cold Remedies*. Amsterdam: HAI, 1989. Chetley A. *World Health and the Pharmaceutical Industry*. London: Zed Books, 1990. Other books suggest that there is also reason to worry in countries like the USA. See Mintz M. *At Any Cost. Corporate Greed, Women, and the Dalkon Shield*. New York: Pantheon Books, 1985.
4. See Leisinger KM. *Health Policy for Least Developed Countries*. Basel: Ciba-Geigy Foundation for Cooperation with Developing Countries, 1985.
5. Myrdal G. *Asian Drama. An Inquiry into the Poverty of Nations*. Harmondworth, England: Penguin, 1968:66 (definition), 116 (ineffectual policies), 894 (failure to enforce legislation), 950–2 (prevalence of corruption).
6. See Horisberger B, Dinkel R, eds. *The Perception and Management of Drugs Safety Risks*. New York: Springer (Health Systems Research), 1989; Dinkel R, Horisberger B, Tolo KW, eds. *Improving Drug Safety—A Joint Responsibility*. New York: Springer (Health Systems Research), 1991.
7. Gellerman SW. Why good managers make bad ethical choices. *Harvard Business Review* 1986;Jul./Aug.:85.