Pharmaceutical Marketing, Capitalism, and Medicine: A Primer (Part I/III)

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By Kalman Applbaum

[This will be the first in a series of three posts intended to describe how pharmaceutical companies fit into (or diverge from) general trends in global capitalism, with particular attention paid to bioethical implications. This sequence will be followed by another of similar length devoted to the subject of specifically contemporary marketing adaptations.]

Part II — Part III

Pharmaceutical firms today increasingly resemble fast moving consumer goods (FMCG) companies, such as those selling cosmetics, beer, or detergents. This is an outcome of the rise of marketing as the driving force in the industry. There are many characteristics to this shift, some of which, such as the trend toward increased attention to branding, are still emergent.

Before addressing the latest trends, there are three traditional business activities that, if we recap them, will put us in the right frame for understanding recent developments. These are: 1) Seeking to lower costs through foreign sourcing of raw materials—in this case clinical trial subjects. 2) Seeking to expand the market for one's products by exporting to new markets and by deepening consumption in existing ones. 3) Muscling into local healthcare policy and administration to guarantee country environments healthy for pharma growth.

Sourcing:

Corporations have always sought to lower costs by searching abroad for low-cost labor and cheaper inputs for their manufacture. This was a driving motive behind colonialism.

In the pharmaceutical industry, drug development costs have grown for a variety of reasons, among them the expanding uses to which clinical trials are put. For instance, a drug might be tested for many possible indications at once; if successful, this greatly expands the commercial potential of the drug. At the same time, as citizens in affluent countries have become overmedicated, they are less useful as trial subjects. Drug effects are best

measured on “treatment naïve” populations. Drug companies and their subcontractors therefore take much of their research to developing countries (and to down-and-out populations in the US), where treatment naïve subjects are plentiful and cheap.

Developing country hosts may also be less equipped to enforce codes intended to safeguard research subjects. Contract research organizations (CROs) can evade ethical codes. The alleged crimes Pfizer committed in Nigeria when testing their drug Trovan in the 1990s (http://www.washingtonpost.com/wp-dyn/content/article/2006/05/06/AR2006050601338_pf.html) evoke both colonial resource extraction and the 19th-century practice of “exporting” inhumane labor practices abroad because they had been outlawed at home. In the case of clinical trial research, the practice outlawed at home was the use of prisoner populations for drug testing.

The globalization of clinical trials raises a number of thorny dilemmas. From a scientific standpoint, the use of research subjects in developing countries can be problematic because patient medical histories are often incomplete. Criteria for evaluating drug effects may vary cross-culturally, a bias associated with both how local medical partners are accustomed to making diagnoses and patient reporting habits. For drugs intended to treat neuropsychiatric conditions, for instance, the problems of cultural translation in diagnosis and results reporting can make a hash of the research.

The ethical-legal problems are more complex still. There is no clear legal precedent for foreign claimants successfully suing American or European companies when they have committed or participated in human rights violations abroad. Certainly there is no mechanism for obliging companies to make drugs affordable to the populations on which they have formerly been tested. The burden of constraining pharmaceutical research subcontractors into ethical conformity has fallen on the international community through such unenforceable entities as the Helsinki Declaration, which offers guidelines for biomedical research involving human subjects. However, the existence of a universally accepted ethical code does not by itself ensure adherence to it. The translation of an ethics code into an ethics regulation is as tricky as any other translation of theory into practice in human society. (In this connection I am always reminded of Bertrand Russell’s quip: When a theory doesn’t work in practice, it’s time for a new theory.)

Adriana Petryna has published an important paper on this subject, entitled “Ethical Variability: Drug Development and Globalizing Clinical Trials.” She argues that the variability in how ethical codes end up being applied in the

real world (as contrasted with the prescriptive certainty of the written codes) opens up an indeterminate gap into which entire populations might fall. It is a gap, moreover, that trial research companies and others can exploit for purposes of engaging in dubious ethical conduct. She says (2005:191-92):

“Ethics is used variably and tactically by all actors in a chain of interests involved in human-subjects research. Such chains now function in states where lives of citizens are not adequately protected via traditional health or welfare systems. The biological indicators of whole groups, however formed or damaged by social and economic context, are enfolded into regimes of international and local forms of protection, in which ethics becomes a ‘‘workable document.’’ The issue of human-subjects protection, thus, moves beyond scripted procedural issues of informed consent and into questions of legal capacities and the aggregate human conditions of which they are generative (Marks 2000).”

The manipulation of ethics in what Sally Falk Moore calls “moralizing strategies” is a regular feature of marketing practice, with particularly dangerous implications in the realm of pharmaceuticals and medicine.

Further Reading:

Angell, Marcia. The Body Hunters. New York Review of Books (October 6, 2005). Available at: http://www.nybooks.com/articles/18301

Elliott, Carl. Guinea-pigging. The New Yorker (January 7, 2008) Available at: http://www.newyorker.com/reporting/2008/01/07/080107fa_fact_elliott

Elliott, Carl and Roberto Abadie. Exploiting a Research Underclass in Phase 1 Clinical Trials. New England Journal of Medicine (May 29, 2008) 358(22). Available at: http://content.nejm.org/cgi/reprint/358/22/2316.pdf

Petryna, Adriana. Ethical Variability: Drug Development and Globalizing Clinical Trials. American Ethnologist (2005), 32(2):183-197.

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