In reply

The most important error Deamer makes is his assertion that so-called me-too drugs are of little value. Me-too drugs often represent important improvements in efficacy, side-effect profile, ease of compliance, or cost-effectiveness[1]*; and the FDA's classification at the time of new drug approval was not designed to measure a drug's ultimate therapeutic value and is a poor predictor of it.*[2]

Deamer also states that in the absence of industry "promeducation," alternate sources for the dissemination of information on new drugs would arise, such as The Medical Letter *and on-line databases. But these resources are already available and are not widely used. In the real world of medical practice, education from industry sources apparently fills an important niche and has value over and above these publications and databases.*

The pharmaceutical industry agrees with the endorsement by Chambliss of the important educational role of existing desk references. But the industry should not provide these materials free to a group of professionals with incomes in the top 1% of American wage earners. On the contrary, physicians should insist on purchasing these references themselves as a statement of their independence and commitment to maintaining objectivity.

"Active transport" of new information by financially motivated parties (as opposed to "passive diffusion" by alternate sources) results in effective transfer of pharmaceutical technology. While the industry's focus is in educating about the cutting edge of progress, balance comes from physicians' ability to use the aforementioned alternate sources, their accumulated experience in using medications, and their knowledge of the individual patient.[2]

Any imbalance in emphasis on new vs older therapies is now being corrected as payers sort out the economic value of all technologies, old and new. Outcome studies comparing the clinical and economic profile of amoxicillin therapy with more advanced antibiotics will guide (or dictate) therapeutic choices in the future. The powerful market forces now transforming the dynamics of therapeutic choice will humble medicine and the pharmaceutical industry.

Goldstein and Ives desire better information on comparative costs of similar medications. But their eyes are on the wrong ball; comparison of the overall cost of disease treatment with different agents is far more important than comparison of drug costs. The highest drug cost presented by Goldstein and Ives is far lower than the added medical costs resulting from selection of the wrong agent for an individual patient.

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1. Levy RA. *Pharmaceutical Research: Therapeutic and Economic Value of Incremental Improvements.* Reston, Va: National Pharmaceutical Council; 1990.
2. Yasuda SA, Woosley RL. The clinical value of FDA class C drugs approved from 1981 to 1988. *Clin Pharmacol Ther.* 1992;52:577-582.

Editor's Note

Thank you to the readers who wrote to us about commercial company interaction with physicians. Levy says it well. Physicians use multiple sources of information about drugs, which is appropriate. Approved new drugs may be beneficial for multiple reasons. For example, a once-a-day formulation may improve compliance for a specific patient, improving outcomes.

Goldstein and Ives suggest that the *Archives of Family Medicine* require that commercial companies include the cost of drugs in their advertisements within our pages. This is an interesting idea but impractical for the individual journal as the companies produce the same advertisements to appear in multiple places. Perhaps the FDA would consider the idea for national implementation.

It takes a lot of time to keep up with the new drugs (even the old ones), including the appropriate uses for individual patients. It is also an effort that can substantially benefit our patients and is an inherent part of being a patient advocate.

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Editor