Promoting, Prescribing, and Pushing Pills: Understanding the Lessons of Antipsychotic Drug Litigation

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PROMOTING, PRESCRIBING, AND PUSHING PILLS:
UNDERSTANDING THE LESSONS
OF ANTIPSYCHOTIC DRUG LITIGATION

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ABSTRACT

Ineffectiveness of prescription drugs, hidden drug hazards, and advertising violations have led to several drug recalls and numerous lawsuits against pharmaceutical companies in recent years. These suits have involved several varieties of medications, but psychoactive medications have figured especially prominently. A recent $1.4 billion settlement by Eli Lilly & Company related to improper promotion of its top-selling drug olanzapine included the largest individual corporate criminal fine in U.S. history.

Improper promotion is far from the sole reason why olanzapine and other “second-generation” antipsychotic (SGA) drugs have become so successful. Rather, the widespread adoption of SGAs represents a collective
judgment error by the medical profession. For policymakers, the olanzapine litigation is important because it provides an impetus for learning what makes certain drugs successful and for understanding processes that determine medication choices, physicians' judgments, and expenditures for drugs. Litigation will not solve problems with these processes, so understanding them is crucial if regulatory agencies and other entities wish to avert future medical judgment errors and suboptimal uses of healthcare dollars.

To promote this understanding, we first describe the rapid switch from older drugs to SGAs and summarize recent evidence suggesting that the switch was improvident. We then review the lawsuits brought against Lilly, which exemplify the many types of liability claims that drugs may generate. We next describe marketing techniques that drug companies use to get physicians to prescribe their products, the special features of SGAs that have contributed to their huge success, and the ways that pharmaceutical companies exercise virtually total control over the information doctors use to prescribe drugs. We suggest that funding more independent, comparative effectiveness studies and giving pharmaceutical companies incentives to generate and disclose more information about their products’ flaws might produce better medications, help physicians make better treatment decisions, and improve patient safety.

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I. INTRODUCTION

In recent years, numerous popular press accounts have reported on ineffectiveness of prescription drugs, hidden drug hazards, drug recalls, and repeated violations of advertising regulations by pharmaceutical companies. Other reports have described the methods that pharmaceutical sales forces use to influence, "corrupt," or "bribe" physicians who prescribe their products. These stories report on problems with several types of medications and on marketing to practitioners of several medical specialties. But psychoactive medications—the types of drugs typically prescribed by psychiatrists to treat mental disorders—have figured especially prominently in stories reporting large judgments against pharmaceutical companies and unsavory links between physicians and commercial interests.

For example, the recent settlement in which Eli Lilly & Company agreed to pay $1.415 billion dollars in civil and criminal penalties related to

improper promotion of the psychotropic drug olanzapine\(^8\) represented “a record sum for so-called corporate whistle-blower cases”\(^9\) and the largest individual corporate criminal fine in U.S. history.\(^10\) A recent book review that describes how drug makers influence physicians highlighted the behavior of three nationally prominent psychiatrists\(^11\) whose objectivity and ethics have been questioned following revelations about their extensive financial connections to pharmaceutical firms.\(^12\)

Popular press reports focus on events that are remarkable, sensational, or extreme, and they often oversimplify outcomes of complex processes. Litigation focuses on rectifying or punishing perceived wrongs by one party against another, rather than on the various forces that induce the alleged misbehavior. Understandably then, published stories about drug litigation and physicians’ susceptibility to drug company blandishments typically paint a picture of evil actions caused by moral turpitude. But while drug makers and physicians surely deserve criticism and even vilification for some of their behavior, responses to their behavior should not end with condemnation alone. Some actions of drug companies have violated public

\(^8\) In accordance with the usual practices of academic publications, this Article usually refers to specific medications using their “generic” or nonproprietary names (e.g., olanzapine), rather than their trade names (e.g., Zyprexa®).


\(^11\) Angell, supra note 5 (discussing psychiatrist Joseph Biederman, Alan Schatzberg, and Charles Nemeroff).

\(^12\) One such instance received front-page coverage in The New York Times. Gardiner Harris, Top Psychiatrist Didn’t Report Drug Makers’ Pay, Files Show, N.Y. TIMES, Oct. 4, 2008, at A1, available at 2008 WLNR 18884180 (reporting that in 2000-07, “One of the nation’s most influential psychiatrists,” Dr. Nemeroff, “earned more than $2.8 million in consulting arrangements with drug makers” that he did not report to his employer, Emory University).
trust, but violating public trust cannot be their main intent. Drug makers’
self-interest lies in selling good, safe, effective products, not bad ones.
Similarly, a few doctors may be evil or corrupt, but the vast majority—
including the many physicians who have accepted meals, lecture fees, and
other favors from drug companies—want to better the lives and health of
their patients.

This Article provides legal audiences with a detailed examination of
the uses and prescribing patterns of olanzapine and other “second-
generation” antipsychotic medications, a group of drugs which, since their
introduction in the 1990s, have come to account for a huge share of all
money spent on all pharmaceuticals. This huge market success is not justi-
ﬁed by markedly superior treatment results; older and cheaper medications
might do just as well (or poorly).

Though Eli Lilly may have improperly promoted olanzapine, improper
promotion is far from the sole reason why olanzapine and similar drugs
have become so successful. Rather, the widespread adoption of these new
drugs represents a collective judgment error by the medical profession,
something that litigation has very limited power to remedy. Legal audi-
ences need to understand that sensational reports about drug company ﬁnes
and physicians’ dubious actions arise from a larger context in which sales-
manship has acquired a dominant role in determining medical practice and
patient/consumer choices about treatment. For policymakers, the potential
value of the olanzapine litigation is that the drug’s success offers a window
into the complex, interacting processes that inﬂuence medication use, medi-
cal decision-making, treatment choices, and expenditures for drugs. An ac-
curate understanding of these processes is crucial if regulatory agencies and
funding entities wish to develop mechanisms and processes that might avert
future mass medical judgment errors and suboptimal uses of healthcare dol-

We proceed as follows. In Part II, we review the introduction into the
American pharmacopeia of two waves of antipsychotic medication, describe
why psychiatrists switched from the ﬁrst to the second type, and summarize
recent evidence that suggests that the switch was improvident. In Part III,
we summarize the olanzapine-related litigation brought against the drug’s
manufacturer, which exempliﬁes the various legal claims for which product
liability suits can be brought. In Part IV, we describe the costly but suc-

13. We explain the meaning of “generation” infra, note 62. The ﬁrst- and
second-generation antipsychotic medications are discussed in Part II.
14. See infra, note 119 and accompanying text.
cessful marketing techniques that drug companies have used to get physicians to prescribe their products. We also describe several other factors that have been crucial to the huge success of second-generation antipsychotic drugs. In Part V, we show why pharmaceutical companies enjoy virtually total control of the information practicing physicians use in prescribing medications. We suggest that enhanced funding for independent drug studies and incentives for pharmaceutical companies to generate and disclose more information about their products’ flaws might produce better medications, help physicians make better treatment decisions, and improve patient safety.

II. FIRST- AND SECOND-GENERATION ANTIPSYCHOTIC DRUGS

Olanzapine is one of several medications that physicians call “antipsychotic drugs” and that physicians have used since the 1950s to treat psychoses. A psychosis is

[A] mental disorder characterized by gross impairment in reality testing as evidenced by delusions, hallucinations, markedly incoherent speech, or disorganized and agitated behavior, usually

15. This section focuses on the medical features of these medications. For a summary of legal contexts in which antipsychotic drugs figure importantly, see Douglas Mossman, Unbuckling the “Chemical Straitjacket”: The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis, 39 SAN DIEGO L. REV. 1033, 1035-37 (2002) (discussing legal categories and citing main cases); see also Sell v. U.S., 539 U.S. 166, 180-81 (2003) (describing conditions under which involuntary medication to restore trial competence is permissible, and noting, “Different kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success”).

16. Generic names of other antipsychotic medications mentioned in this Article include fluphenazine, perphenazine, trifluoperazine, haloperidol, loxapine, molindone, thiothixene, clozapine, risperidone, olanzapine, quetiapine, ziprasidone, and aripiprazole.

17. The first of these drugs was chlorpromazine, more commonly known by its proprietary name, Thorazine®. Its discovery and initial use is mentioned in Williams v. U.S., 133 F. Supp. 319 (E.D. Va. 1955), which notes “an interesting article appearing in Time magazine (Mar. 7, 1955) involving the use of new drugs referred to as chlorpromazine and reserpine which have been very effective in certain types of schizophrenia cases.” Id. at 322.
without apparent awareness on the part of the patient of the incomprehensibility of his behavior.  

Psychoses, or psychotic disorders, are a group of psychiatric syndromes each of which reflects “different aspects of the various definitions of psychotic.” Psychotic symptoms occur in several mental disorders, and antipsychotic drugs have varying levels of effectiveness in quelling manifestations of these conditions. Because of their mood-stabilizing and anti-anxiety properties, antipsychotic drugs are also useful treatments for conditions in which psychotic symptoms do not occur, including manic episodes, refractory depression, dementia with severe agitation, and severe anxiety. In several cases, drugs first approved for treatment of psychoses have received subsequent approval for treatment of other psychiatric conditions.

For simplicity of exposition, we focus here on the role of antipsychotic medications in treating schizophrenia. Schizophrenia is a logical choice for three reasons. First, recent advances in understanding schizophrenia typify psychiatrists’ current thinking about many severe mental disorders. Second,

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18. DORLAND’S ILLUSTRATED MEDICAL DICTIONARY 1489 (29th ed. 2000) [hereinafter DORLAND’S]. A delusion is:

[A] false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person’s culture or subculture (e.g., it is not an article of religious faith).

AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS 821 (4th ed., text rev. 2000) [hereinafter DSM-IV-TR]. A hallucination is “[a] sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ.” Id. at 823.

19. Id. at 827.

20. A partial list: psychotic disorders caused by general medical conditions, id. at 334-38; psychotic disorders induced by medications or intoxicants, id. at 338-43; schizophreniform disorder, id. at 317-19; schizoaffective disorder, id. at 319-23; mood disorders with psychotic features, id. at 411-17; delusional disorder, id. at 323-29; and brief psychotic disorder, id. at 329-32.


22. We discuss the use of newer antipsychotic drugs to treat other conditions infra, Part II.D.3.
schizophrenia frequently is the principal condition for which new antipsychotic drugs undergo efficacy testing prior to receiving FDA approval.\textsuperscript{23} Third, the clinical manifestations of schizophrenia—that is, the types of symptoms experienced and the signs of illness exhibited by persons with the disorder—make it a paradigmatic instance of the role that pharmacotherapy plays in the treatment of a psychotic disorder.

\textit{A. Schizophrenia}

Schizophrenia affects approximately 1 out of 200 persons,\textsuperscript{24} and usually makes its appearance in a person’s late teenage years or young adulthood. The classic signs of schizophrenia are hallucinations, delusions, and disorganized speech or behavior.\textsuperscript{25} Over the last two decades, however, it has become increasingly clear that impaired cognition, loss of emotionality, diminished speech production, and reduced initiative explain much of the disability caused by schizophrenia.\textsuperscript{26}


\textsuperscript{24} Dinesh Bhugra, \textit{The Global Prevalence of Schizophrenia}, 2 \textit{PLoS MED.} e372 (2006) (citing study results of 0.0046 for point prevalence, 0.0033 for period prevalence, and 0.0072 for lifetime morbid risk).

\textsuperscript{25} These are often termed “positive” symptoms because they involve the presence of something pathological. Schizophrenia is diagnosed when an individual has experienced positive symptoms for six months or longer and has undergone marked deterioration in his social or occupational functioning, provided that the diagnostician can rule out other conditions—including medical conditions, intoxicants, and mood disorders—that might be potential causes of the symptoms. DSM-IV-TR, supra note 18, at 312.

\textsuperscript{26} See, e.g., Victoria Villalta-Gil et al., \textit{Neurocognitive Performance and Negative Symptoms: Are They Equal in Explaining Disability in Schizophrenia Outpatients?} 87 \textit{SCHIZOPHRENIA RES.} 246, 246 (“[n]egative symptoms are the major source of disability of our sample”). These features are termed “negative” symptoms because they reflect the absence of normal psychological features.
Like most mental disorders, schizophrenia is an illness with biological, psychological, and social causes. Evidence of substantial biological causation includes:

- rates of schizophrenia among relatives that suggest a substantial genetic contribution to the illness;\(^{27}\)
- gene variations that influence the probability of developing schizophrenia;\(^{28}\)
- seasonal variation, i.e., people born in winter or spring are more likely to develop schizophrenia;\(^{29}\)
- the impact of \textit{in utero} exposure to certain infections;\(^{30}\)
- the ability of cannabis to trigger the onset of schizophrenia;\(^{31}\)
- the capacity of some pharmaceuticals to induce symptoms that mimic schizophrenia in persons who do not have the disorder;\(^{32}\)


\(^{28}\) See, e.g., Xiao-Wei Chen et al., \textit{DTNBP1, a Schizophrenia Susceptibility Gene, Affects Kinetics of Transmitter Release}, 181 J. CELLULAR BIOLOGY 791 (2008) (schizophrenia-dysbindin gene link offers possible causal mechanism for the illness).


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- differences in brain configurations\textsuperscript{33} and neural activity\textsuperscript{34} among people diagnosed with schizophrenia;
- the impact of medications—especially drugs that block the brain’s dopamine D\textsubscript{2} receptor—on some symptoms of schizophrenia.\textsuperscript{35}

Though biological factors create individual vulnerability, social and individual psychological factors influence the risk of developing schizophrenia and the impact of the illness:
- urban settings, poverty, and minority status increase the risk of developing schizophrenia;\textsuperscript{36}
- childhood abuse or trauma influences the severity of schizophrenia later;\textsuperscript{37}
- unsupportive family relationships increase risk for relapse following an episode of psychosis.\textsuperscript{38}

36. Jim van Os, \textit{The Schizophrenia Envirome}, 18 CURRENT OPINION PSYCHIATRY 141 (2005) (discussing evidence for increased risk and suggesting biological pathways that may mediate or transmit impact of environment).
impaired capacity to appreciate one’s own and other persons’ mental states adversely affects social competence of persons with schizophrenia;\textsuperscript{39}

- depressed mood, low self-esteem, and negative attitudes correlate with severe, preoccupying persecutory delusions;\textsuperscript{40}

- some symptoms of schizophrenia can be viewed as biased cognitive or emotional states and may be amenable to verbal therapies.\textsuperscript{41}

Contemporary psychiatry’s view of schizophrenia reflects the perspective of Eugen Bleuler, a Swiss psychiatrist who coined the term “schizophrenias” early in the twentieth century.\textsuperscript{42} The term’s Greek roots, \textit{schizein} and \textit{phren},\textsuperscript{43} connote a mind divided or torn apart, or, as Bleuler put it, a “splitting of the psychic functions.”\textsuperscript{44} For the past century, psychiatry's view of schizophrenia has evolved, but Bleuler's insights continue to inform our understanding of this complex disorder.

\textsuperscript{39} M. Brüne et al., \textit{Mental State Attribution, Neurocognitive Functioning, and Psychopathology: What Predicts Poor Social Competence in Schizophrenia Best?} 92 \textit{SCHIZOPHRENIA RES.} 151 (2007).

\textsuperscript{40} B. Smith et al., \textit{Emotion and Psychosis: Links Between Depression, Self-Esteem, Negative Schematic Beliefs and Delusions and Hallucinations}, 86 \textit{SCHIZOPHRENIA RES.} 181 (2006).


\textsuperscript{42} Eugen Bleuler, \textit{Dementia Praecox oder Die Gruppe der Schizophrenien} (\textit{Dementia Praecox; Or the Group of Schizophrenias}, Joseph Zinkin trans., Int’l U. Press 1950). The plural form “schizophrenias”—“schizophrenien” in German—reflects the multiple manifestations of the illness.

\textsuperscript{43} 2 \textit{THE COMPACT EDITION OF THE OXFORD ENGLISH DICTIONARY} 2159, 2664 (1971).

\textsuperscript{44} Bleuler, \textit{supra} note 42, at 9. His description, which still rings true, continues:

In every case we are confronted with a more or less clear-cut splitting of the psychic functions. . . . Often ideas are only partially worked out, and fragments of ideas are connected in an illogical way to constitute a new idea.

. . . This results in associations which normal individuals will regard as incorrect, bizarre, and utterly unpredictable. Often thinking stops in the middle of a thought; or in the attempt to pass to another idea, it may suddenly cease altogether, at least as far as it is a conscious process (blocking). Instead of continuing the thought, new ideas crop up which neither the patient nor the observer can bring into any connection with the previous stream of thought.
trists have used “schizophrenia” to denote a severe, debilitating disorder characterized by a pervasive impairment in thinking, behavior, and interpersonal relationships. Modern psychiatrists still endorse Bleuler’s approach to understanding schizophrenia because of its emphasis on “an underlying cognitive process” rather than often-variable outward manifestations.

In the current U.S. diagnostic system, schizophrenia is divided into five subtypes. Persons with the paranoid subtype retain normal displays of emotion, and their speech, behavior, and thinking are usually organized and coherent. When symptomatic, however, they typically have delusions of persecution and fear potential harm by their putative persecutors. The other four subtypes of schizophrenia usually are much more disabling, and nonclinicians often recognize that sufferers with these subtypes of schizophrenia are having severe mental problems. In disorganized schizophrenia, persons exhibit disorganized speech and behavior, along with inappropriate emotional responses. Persons with catatonic schizophrenia have motor immobility, stupor, rigid posturing, mutism, stereotyped and repetitive movements, or excessive-but-poorly-organized activity (“catatonic excitement”). Persons with undifferentiated schizophrenia hallucinate and have disorganized thinking and lack initiative or interest in extended, determined activity. Individuals with residual schizophrenia display reduced verbal production, initiative, and impaired motivation, though they do not experience pronounced delusions or hallucinations.

Although schizophrenia manifests itself in disturbances of thought and action, Bleuler conceptualized the condition as a medical disorder: he thought schizophrenia could be understood by cataloging patients’ signs,

. . . In the severest cases emotional and affective expressions seem to be completely lacking.

Id. at 9–10.


47. That is, the form of their thoughts and behavior are normal. The content of their thoughts can be quite irrational, and their actions may be motivated by delusional ideas.


49. Id. at 313-17.
symptoms, clinical course, and ultimate outcomes. By the end of the twentieth century, scientific evidence had provided overwhelming support for this viewpoint. Psychiatrists now recognize that persons with schizophrenia do not act irrationally because they have unusual, socially inappropriate, or crazy beliefs. Rather, the core problem in schizophrenia is malfunctioning brain circuitry.

Decades of accumulated evidence has shown that schizophrenia is a brain-based condition that can be addressed effectively, though not cured, with pharmacological agents that alter neuronal functioning. By continuing to take antipsychotic medication after initial remission of symptoms, persons with schizophrenia can greatly reduce their risk of having a relapse.


51. For a discussion of the various perspectives extant in the 1960s, see Mossman, supra note 15, at 1047-48 (reviewing viewpoints).

52. As psychiatrist Nancy Andreasen observes,

The symptoms and signs of schizophrenia are very diverse, and they encompass the entire range of human mental activity. . . . These symptoms and signs occur in patterns that may not overlap; one patient may have hallucinations and affective flattening, whereas another has disorganized speech and avolition [lack of motivation]. The diversity and nonoverlapping pattern of symptoms and signs suggest a more basic and unifying problem: abnormalities in neural circuits and fundamental cognitive mechanisms.


For additional discussion of the significance of this shift in perspective, see Mossman, supra note 15, at 1056-59 (discussing current conceptualization of schizophrenia as malfunctioning neurocircuitry).

53. For a summary of early research, see Jonathan O. Cole et al., Phenothiazine Treatment in Acute Schizophrenia, 10 ARCHIVES OF GEN. PSYCHIATRY 246 (1964). For more recent summaries concerning older antipsychotic medications, see John M. Davis et al., Important Issues in the Drug Treatment of Schizophrenia, 6 SCHIZOPHRENIA BULL. 70 (1980); and John M. Kane, Treatment of Schizophrenia, 13 SCHIZOPHRENIA BULL. 133 (1987) (noting both pooling and summarizing studies showing that antipsychotic drugs are effective for approximately seventy percent of patients in acute episodes of schizophrenia).

54. The word “neuronal” means “pertaining to a neuron or neurons.” DORLAND’S, supra note 18, at 1212. Neurons are “the conducting cells of the nervous system.” Id. at 1211.
of symptoms. Research also shows that individual psychotherapy, behavioral treatments, and family therapy are very useful: these nonpharmacological interventions help many patients and their families cope with the consequences of schizophrenia and reduced symptoms that medication alone does not completely alleviate. However, antipsychotic medication is the “mainstay” of current treatment for schizophrenia.

55. See, e.g., Patricia L. Gilbert et al., Neuroleptic Withdrawal in Schizophrenic Patients: A Review of the Literature, 52 ARCHIVES OF GEN. PSYCHIATRY 173 (1995) (after 9.7 months, patients who continued to take antipsychotic drugs had 16% relapse rate; 53% of patients not taking medication relapsed); Delbert Robinson et al., Predictors of Relapse Following Response From a First Episode of Schizophrenia or Schizoaffective Disorder, 56 ARCHIVES OF GEN. PSYCHIATRY 241 (1999) (stopping antipsychotic medication therapy hazard ratio for relapse by almost 5 times).

The relapse studies generally refer to recurrence of delusions, hallucinations, and disorganized thought. These are often termed “positive symptoms” because they involve the presence of abnormal clinical findings or “distortions of normal functioning.” Samuel J. Keith, Pharmacologic Advances in the Treatment of Schizophrenia, 337 NEW ENG. J. MED. 851, 851 (1997). By contrast, the “negative symptoms” of schizophrenia—social withdrawal and apathy—involve the absence of normal findings or “the loss of normal functioning.” Id. at 851. Relapse studies focus primarily on reduction and control of positive symptoms; negative symptoms are much less responsive to medication.


57. For years, medical publications have consistently referred to antipsychotic medications as the “mainstay” of schizophrenia treatment. See, e.g., John M. Kane, Treatment of Schizophrenia, 13 SCHIZOPHRENIA BULL. 133, 133 (1987) (“Antipsychotic medication remains a mainstay of treatment in both acute and chronic schizophrenia”); Robin McCreddie, Schizophrenia: What’s New? 6 ADVANCES IN PSYCHIATRIC TREATMENT 81, 81 (2000) (“Drugs have always been a mainstay of treatment of schizophrenia”); Mahesh B. Jayaram et al., Risperidone Versus Olanzapine for Treatment of Schizophrenia, 33 SCHIZOPHRENIA BULL. 1274, 1274 (2007) (“Antipsychotic medication is a mainstay of treatment for schizophrenia”); DAVID GILL & JENNIFER BARRACLOUGH, HUGHES’ OUTLINE OF MODERN PSYCHIATRY 61 (5th ed. 2007) (“Antipsychotic drugs remain the mainstay of treatment”); Peter B. Jones et al., Randomized Controlled Trial of the Effect on Quality of Life of Second- vs First-Generation Antipsychotic Drugs in Schizophrenia: Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study (CUtLASS 1), 63
B. Development of “First-Generation” Antipsychotic Drugs

Symptoms of psychotic disorders were recognized in antiquity, but effective and specific pharmacological treatments for these conditions only became available in the 1950s, when scientists and clinicians recognized that chlorpromazine alleviated symptoms of psychosis. Within just a few years, pharmaceutical companies had produced several other phenothiazine derivatives and other medications with different chemical structures but similar actions.

ARCHIVES OF GEN. PSYCHIATRY 1079 (2006) (“Antipsychotic drugs have been the mainstay of schizophrenia treatment for almost 50 years.”).

58. See, e.g., I Samuel 21:11–22:1, which describes David’s successful effort to feign a severe mental disorder. The account, whether factually true or not, implies that madness was recognized at the time of Saul or at the latest when the books of Samuel were set down. Current biblical scholarship places Saul’s reign in the latter half of the eleventh century B.C.E., 10 NEW ENCYC. BRITANNICA 475 (15th ed. 1998), and places the writing of I Samuel in the sixth century B.C.E., id. at 381–82. See also THE AMERICAN PSYCHIATRIC PUBLISHING TEXTBOOK OF PSYCHIATRY 408 (Robert E. Hales et al., eds. 2007) (citing recent authors who believe that what we now call schizophrenia was widely by the first century C.E.) and FREDERICK K. GOODWIN ET AL., MANIC-DEPRESSIVE ILLNESS: BIPOLAR DISORDERS AND RECURRENENT DEPRESSION 3-5 (2nd ed. 2007) (reviewing ancient descriptions of severe mental illness).


60. Phenothiazine antipsychotic drugs all share a basic tricyclic structure. ROSENBAUM ET AL., supra note 21, at 6. Among the better known phenothiazines are fluphenazine (marketed as Prolixin®), perphenazine (marketed as Trilafon®), and trifluoperazine (marketed as Stelazine®).

61. In the 1980s, commonly prescribed non-phenothiazine antipsychotic compounds included haloperidol (Haldol®), loxapine (Loxitane®), molindone (Moban®), and thiothixene (Navane®). ROSENBAUM ET AL., supra note 21, at 9-10. Though older antipsychotic drugs differ in potency (and therefore in their typical dosages), “each … has been found to be equally effective in treating psychotic disorders.” Id. at 8.
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Until this “first generation” of antipsychotic drugs became available, “most individuals with schizophrenia were destined to spend their entire adult lives within large, often remote psychiatric hospitals.” In 1955, U.S. state mental hospitals housed more than 550,000 persons, many of whom had psychotic disorders. Patients often spent years or decades at these facilities living in wretched conditions. Today, fewer than 55,000 persons are committed to state and county psychiatric hospitals. Though several factors have contributed to the reduced census of public sector hospitals, “the


In the 1990s, it was common to contrast “standard,” “conventional,” “typical,” or “traditional” antipsychotics—that is, the antipsychotic drugs used in the U.S. before the late 1980s—with “newer,” “novel,” or “atypical” antipsychotics that had just come into use. The appellations “first-generation” and “second-generation” were first applied to antipsychotic drugs around the turn of the present century. See, e.g., Hubert H. Fernandez & Joseph H. Friedman, The Role of Atypical Antipsychotics in the Treatment of Movement Disorders, 11 CNS Drugs 467, 476 (1999) (one of the first articles that refers to “first-generation antipsychotics”) and Eric T. Edgell et al., Olanzapine versus Risperidone: A Prospective Comparison of Clinical and Economic Outcomes in Schizophrenia, 18 Pharmacoeconomics 567, 568 (2000) (describing and contrasting “first-generation” and “second-generation” antipsychotic medications).


64. H. Richard Lamb & Linda E. Weinberger, Persons With Severe Mental Illness in Jails and Prisons: A Review, 49 Psychiatric Services 483, 486 (1998) (stating that 559,000 patients were in state psychiatric hospitals in 1955).

65. GARY MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS 328 (3d ed. 2007). In 1955, the U.S. population numbered 166 million, http://www.infoplease.com/year/1955.html (last visited Nov. 16, 2008), and in 2007, the U.S population was estimated at 301,621,157. http://factfinder.census.gov/servlet/SAFFPopulation (last visited Nov. 16, 2008). Thus, over 50 years, the U.S. per capita rate of public sector psychiatric hospitalization fell nearly 95%, from 3.3 to 0.18 persons per 1,000 population.

66. In 1963, Congress passed the Community Mental Health Centers Act, which recognized that community services was a preferable treatment alternative for
new drugs made the wholesale removal of patients from hospitals imaginable and then possible.\textsuperscript{67} As a 1961 report by the Joint Commission on Mental Illness and Health put it, "Unquestionably, the drugs have delivered the greatest blow for patient freedom, in terms of nonrestraint, since Pinel struck off the chains of the lunatics in the Paris asylum 168 years ago."\textsuperscript{68}

\subsection*{C. Limitations of Early Antipsychotic Drugs}

Though it was quickly apparent \textit{that} the first antipsychotic drugs quelled psychosis, what these compounds did—\textit{why} they helped—was not clear. One hypothesis, which suggested that schizophrenia resulted from excessive dopamine,\textsuperscript{69} drew support from findings that high doses of drugs that increase brain levels of dopamine mimic some symptoms of schizophrenia.\textsuperscript{70} Also, the potency of the first-generation antipsychotics (FGAs) was directly proportional to their blockade of the dopamine $D_2$ receptor.\textsuperscript{71}

many mentally ill persons. In the 1970s, Medicare, Medicaid and Social Security laws created financial support for mentally ill persons to receive community-based care; also, new civil commitment laws made involuntary psychiatric hospitalization contingent on dangerous behavior rather than need for treatment. In the 1990s, managed care organizations used financial pressures to get physicians to shorten hospitalizations. Mossman, \textit{supra} note 15, at 1033.

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\textsuperscript{67} JOHNSON, \textit{supra} note 59, at 45-46.
\textsuperscript{68} Id. at 46, quoting JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH, ACTION FOR MENTAL HEALTH 39 (1961).
\textsuperscript{69} See Arvid Carlsson & Margit Lindqvist, \textit{Effect of Chlorpromazine and Haloperidol on Formation of 3-Methoxytyramine and Normetanephrine in Mouse Brain}, 20 \textit{ACTA PHARMACOLOGICA ET TOXICOLÓGICA} 140 (1963) (finding that after administration of antipsychotic drugs, extracellular dopamine was not increased, but its metabolites were, which suggested that the drugs blocked dopamine receptors and activated feedback pathways); GOODMAN AND GILMAN’S \textit{THE PHARMACOLOGICAL BASIS OF THERAPEUTICS} 389 (17th ed. 1985).
\textsuperscript{70} Id. at 168, 553–54. The long-term impact of methamphetamine on dopamine transporter density, and its relationship to psychotic symptoms, is discussed in Yoshimoto Sekine et al., \textit{Methamphetamine-Related Psychiatric Symptoms and Reduced Brain Dopamine Transporters Studied With PET}, 158 AM. J. PSYCHIATRY 1206 (2001).
\textsuperscript{71} Aspects of the dopamine hypothesis remain valid. For confirmatory findings from brain imaging studies, see Anissa Abi-Dargham et al., \textit{Increased Baseline Occupancy of $D_2$ Receptors by Dopamine in Schizophrenia}, 97 PROC. NAT’L ACAD. SCI. U.S. 8104, 8109 (2000) (also showing “direct \textit{in vivo} evidence
Over subsequent decades, however, it was recognized that other types of drugs—including phencyclidine (PCP) and the anesthetic ketamine—could induce florid psychoses even though they have little direct effect on brain dopamine activity.\(^72\) Also, psychiatrists recognized that “negative” symptoms—deficits in interest in surroundings, volume of communication, and social relationships—often influenced the long-term functioning of persons with schizophrenia far more than the positive symptoms—delusions and hallucinations—that high doses of dopaminergic drugs could induce.\(^74\)

that schizophrenia is associated with excessive stimulation of D\(_2\) receptors by dopamine (as opposed to excess dopamine simpliciter), and that this dysregulation is predictive of good treatment response to antipsychotic drugs); Oliver D. Howes et al., *Elevated Striatal Dopamine Function Linked to Prodromal Signs of Schizophrenia*, 66 ARCHIVES OF GEN. PSYCHIATRY 13, 18 (2009) (dopaminergic abnormality particularly evident in the associative striatum, which regulates information flow to and from the prefrontal cortex; this provides a plausible link to prefrontal dysfunction in schizophrenia and indicates why dopamine-blocking drugs attenuate symptoms of prodromal schizophrenia).

72. In 1979, the ability of ketamine and phencyclidine to mimic psychoses was found to be related to interaction by the drugs with a unique receptor; once bound to this receptor, phencyclidine is not displaced by dopamine or other chemically similar neurotransmitters. J. P. Vincent et al., *Interaction of Phencyclidine (“Angel Dust”) with a Specific Receptor in Rat Brain Membranes*, 76 PROC. NAT’L ACAD. SCI. U.S. 4678, 4678 (1979); S. R. Zukin & R. S. Zukin, *Specific \(^3\)HPhencyclidine Binding in Rat Central Nervous System*, 76 PROC. NAT’L ACAD. SCI. U.S. 5372, 5372 (1979). For this reason, antipsychotic drugs do not reverse the psychotic symptoms induced by phencyclidine. For a recent study comparing and distinguishing the actions of ketamine and phencyclidine, see Wulf Hevers et al., *Ketamine, But Not Phencyclidine, Selectively Modulates Cerebellar GABA\(_A\) Receptors Containing \(\alpha_6\) and \(\delta\) Subunits*, 28 J. NEUROSCIENCE 5383 (2008) (both induce analgesia, psychosis-like behavior, and a catatonic unconsciousness, but ketamine’s better anesthetic properties relate to unique actions on specific receptors).

73. One of the first articles to contrast positive and negative symptoms states, “Positive schizophrenia is characterized by prominent delusions, hallucinations, positive formal thought disorder, and persistently bizarre behavior; negative schizophrenia, by affective flattening, alogia, avolition, anhedonia, and attentional impairment.” Nancy C. Andreasen & Scott Olsen, *Negative v. Positive Schizophrenia*, 39 ARCHIVES OF GEN. PSYCHIATRY 789, 789 (1982).

Indeed, negative symptoms also seemed related to a relative lack of dopamine activity in some areas of the brain. The benefits of FGAs came with significant drawbacks. FGAs do not help all patients who have schizophrenia or other psychotic disorders; ten to fifty percent of patients who take FGAs experience only partial remission of positive symptoms or no response at all, and many patients see little improvement in their cognition or negative symptoms. FGAs also consist-

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ropsych Subtypes. II. Positive and Negative Symptoms and Long-Term Course, 48 ARCHIVES OF GEN. PSYCHIATRY 978, 978 (1991) (negative symptoms are linked to poorer functioning prior to onset of illness and a “progressive course leading to permanent disability”).

75. See David Pickar et al., Neurochemical and Neural Mechanisms of Positive and Negative Symptoms in Schizophrenia, in 24 MODERN PROBLEMS OF PHARMACOPSYCHIATRY 124–51 (Nancy C. Andreasen ed., 1990) (linking deficit symptoms to functional frontal dopamine dysfunction); Terry E. Goldberg et al., Cognitive and Behavioral Effects of the Coadministration of Dextroamphetamine and Haloperidol in Schizophrenia, 148 AM. J. PSYCHIATRY 78, 78 (1991) (finding that the addition of amphetamine, a dopaminergic drug, to schizophrenic patients’ medication regimen improved some aspects of cognition, motivation, and affect); Jonathan D. Cohen & David Servan-Schreiber, A Theory of Dopamine Function and its Role in Cognitive Deficits in Schizophrenia, 19 SCHIZOPHRENIA BULL. 85 (1993) (noting that a computer model suggests that dopamine deficiency is responsible for cognitive deficits observed in persons with schizophrenia); Kenneth L. Davis et al., Dopamine in Schizophrenia: A Review and Reconceptualization, 148 AM. J. PSYCHIATRY 1474 (1991) (suggesting “that schizophrenia is characterized by abnormally low prefrontal dopamine activity (causing deficit symptoms) leading to excessive dopamine activity in mesolimbic dopamine neurons (causing positive symptoms”)).

76. Studies reviewing FGAs typically reported that fifty to seventy-five percent of schizophrenic patients have “a moderate to excellent response and up to ninety percent of patients show[] some response.” Daniel P. Van Kammen & Stephen R. Marder, Dopamine Receptor Antagonists, in 2 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY/VI, at 1877 (Harold I. Kaplan & Benjamin J. Sadock eds., 6th ed. 1995). This implies that 10 to 50 percent of patients show no response or only a partial one.

tently cause “extrapyramidal symptoms,” such as stiffness, diminished facial expression, tremors, and restlessness. Such side effects were among the reasons that patients often quit taking FGAs. In addition, many patients who take FGAs develop permanent and sometimes disabling neuromotor syndromes such as tardive dyskinesia (TD), and a few patients develop “neuroleptic malignant syndrome,” a severe and sometimes fatal reaction to the drugs.

78. The term “extrapyramidal” refers to those neurons that control movements outside the “pyramidal tracts.” DORLAND’S, supra note 18, at 638. The pyramidal tract “provides for direct cortical control and initiation of skilled movements, especially those related to speech and involving the hand and fingers.” Id. at 1861. “Extrapyramidal system” is “an imprecise term referring to a functional rather than an anatomical part of the central nervous system,” including brain structures that “control and coordinate especially the postural, static, supporting, and locomotor mechanisms.” Id. at 1776.

79. Keith, supra note 55, at 851. The pronounced effects of these drugs on the nervous system led to their being termed “neuroleptics,” a combination of the Greek words neuron (nerve) and leptis (to take hold). DORLAND’S, supra note 18, at 1210. The French psychiatrists Delay and Deniker coined the term “neuroleptic” in 1955. JOHNSON, supra note 59, at 40.

80. The classic study on this topic is Theodore Van Putten, Why Do Schizophrenic Patients Refuse to Take Their Drugs?, 31 ARCHIVES OF GEN. PSYCHIATRY 67, 70 (1974) (antipsychotic noncompliance strongly associated with extrapyramidal involvement, especially akathisia, the subjective experience of restlessness).

81. TD rarely occurs in young individuals who have been exposed to neuroleptics for fewer than three months. ROSENBAUM ET AL., supra note 21, at 45. Approximately one-fifth of patients undergoing long-term treatment with FGAs develop TD; the risk of developing TD is roughly five percent per year of FGA exposure. Dilip V. Jeste and Michael J. Caligiuri, Tardive Dyskinesia, 19 SCHIZOPHRENIA BULL. 303 (1993) (mean prevalence of TD among long-term FGA patients is approximately 24 percent; annual incidence in young adults is 4-5 percent.). The risk for elderly patients is much higher. See, e.g., Robert A. Sweet et al., Duration of Neuroleptic Treatment and Prevalence of Tardive Dyskinesia in Late Life, 52 ARCHIVES OF GEN. PSYCHIATRY 478 (1995) (29 percent risk in 3-12 months of drug exposure).

82. This syndrome occurs in one-tenth to one percent of persons receiving neuroleptics, and includes development of fever, muscle stiffness, unstable vital signs, altered consciousness, elevated muscle enzymes, and elevated white blood cell count.” Herbert Y. Meltzer & S. Hossein Fatemi, Treatment of Schizophrenia, in THE AMERICAN PSYCHIATRIC PRESS TEXTBOOK OF PSYCHOPHARMACOLOGY 760–61 (Alan F. Schatzberg & Charles B. Nemeroff eds., 2d ed. 1998); see also ROSENBAUM ET AL., supra note 21, at 43.
D. Arrival of “Second-Generation” Antipsychotic Drugs

The FDA’s approval of clozapine in late 1989\(^3\) paved the way for a striking change in psychiatrists’ prescribing over the next decade. Clozapine was the first really new antipsychotic medication to become available in thirty-five years. Clozapine was distinctive—or “atypical”—because it could alleviate psychotic symptoms without inducing the extrapyramidal side effects that usually accompanied treatment with FGAs. Moreover, clozapine worked better than FGAs: thirty to sixty percent of schizophrenic patients who had not responded to FGAs improved when they took clozapine.\(^4\) Also, the incidence of extrapyramidal side effects with clozapine was


\(^{4}\) Michael J. Owens & S. Craig Risch, Atypical Antipsychotics, in THE AMERICAN PSYCHIATRIC PRESS TEXTBOOK OF PSYCHOPHARMACOLOGY 323, 333 (Alan F. Schatzberg & Charles B. Nemeroff eds., 2d ed. 1998). In 1993, psychiatrist Jeffrey Lieberman suggested that the following characteristics defined an atypical or second-generation antipsychotic drug: (1) “pre-clinical” (that is, laboratory findings often worked out in animals) evidence of efficacy and nontoxicity, (2) effectiveness in reducing psychotic symptoms, (3) low incidence of extrapyramidal symptoms and TD, and (4) no elevation of prolactin (a hormone involved in breast milk production, secretion of which is increased in men and women who take typical antipsychotics). Jeffrey A. Lieberman, Understanding the Mechanism of Action of Atypical Antipsychotic Drugs: A Review of Compounds in Use and Development, 163 BRIT. J. PSYCHIATRY 7–18 (Supp. 22, 1993).

\(^{5}\) The landmark study reporting clozapine’s efficacy in patients who had failed to benefit from neuroleptics is John Kane et al., Clozapine for the Treatment-Resistant Schizophrenic: A Double-Blind Comparison with Chlorpromazine, 45 ARCHIVES OF GEN. PSYCHIATRY 789, 789–96 (1988) (demonstrating improvement in thirty percent of previously refractory patients over a six-week period, compared with just four percent of patients who received chlorpromazine). Subsequent studies looking at treatment refractory patients treated with clozapine for longer periods have yielded higher estimated rates of improvement. See, e.g., John M. Kane et al., Clozapine and Haloperidol in Moderately Refractory Schizophrenia: A 6-Month Randomized and Double-Blind Comparison, 58 ARCHIVES OF GEN. PSYCHIATRY 965 (2001) (showing a fifty-seven percent response rate); Jeffrey A. Lieberman et al., Clinical Effects of Clozapine in Chronic Schizophrenia: Response to Treatment
much lower, as was the likelihood of the damaging neuromotor syndromes associated with FGAs. 86

Patients who take clozapine for extended periods incur a small risk of developing a potentially fatal side effect involving a loss of the white blood cells responsible for fighting bacterial infections. 87 Therefore, when clozapine was released in the U.S., it was “bundled” 88 by its manufacturer with a mandatory monitoring system that included weekly blood tests. 89 The combined cost of the drug plus was initially around $9,000 a year. 90


87. Though clozapine had been available for prescription in other countries, it “had not been marketed [in the U.S.] because it carried approximately a 1% risk of potentially lethal agranulocytosis.” ROSENBAUM ET AL., supra note 21, at 5-6. Clozapine was introduced for use in several European countries in the 1970s. J. Idän-pääin-Heikkilä et al., Agranulocytosis During Treatment with Clozapine, 11 EUROP. J. CLINICAL PHARMACOLOGY 1432 (1976). Agranulocytosis is a potentially fatal side effect in which the bone marrow stops making the white blood cells responsible for fighting bacterial infections. http://www.nlm.nih.gov/medlineplus/ency/article/001295.htm (last visited Jan. 3, 2009).


Clozapine therapy was subsequently “unbundled” (allowing testing by a variety of agencies). Because Sandoz’s bundling had made the drug very expensive in the United States, the program had been assailed by physicians, patient advocacy groups, and Congress. Milt Freudenheim, Maker of Schizophrenia Drug Bows to
Costs, blood testing, medical risks, FDA restrictions, and initial

Pressure to Cut Cost, N.Y. TIMES, Dec. 6, 1990, at A1, available at 1990 WLNR 2991484. Blood testing frequency has been reduced, and generic versions of the compound are now available. However, clozapine remains available only through monitoring protocols under which pharmacists dispense the medication only when they have determined that a patient’s blood has been tested and that the laboratory values are satisfactory. For a discussion of current monitoring requirements, see Yael Waknine, Clozaril Monitoring Schedule Modified to Include ANC Reporting, Medscape Alert, Jan. 17, 2006, available at http://www.clozaril.com/pdfs/Monthly Monitoring.pdf (last visited Jan. 3, 2009).

91. In 1997, Keith estimated the cost of clozapine to be “about $6,000 a year at [his] institution—and the additional cost of the weekly blood monitoring [was] about $1,000 a year.” Keith, supra note 55, at 852. In a study conducted at VA facilities, per capita pharmacy costs in clozapine treated patients were $3,199 a year. Robert Rosenheck et al., A Comparison of Clozapine and Haloperidol in Hospitalized Patients with Refractory Schizophrenia, 337 NEW ENG. J. MED. 809, 812 (1997).

92. Clozapine has several other potential adverse effects. Risk of seizures was known when the drug was released in the U.S., as were other less serious but potentially troublesome problems (e.g., sedation and drooling). Medical Letter, Inc., Clozapine for Schizophrenia, 32 MED. LETTER DRUGS & THERAPEUTICS 3–4 (1990). Potential for weight gain and associated medical problems (for example, diabetes mellitus and hyperlipidemia) became better appreciated after several years of the drug’s use. Michael Davidson, Risk of Cardiovascular Disease and Sudden Death in Schizophrenia, 63 J. CLINICAL PSYCHIATRY 5, 6–8 (Supp. 9, 2002) (summarizing results of studies); David C. Henderson et al., Clozapine, Diabetes Mellitus, Weight Gain, and Lipid Abnormalities: A Five-year Naturalistic Study, 157 AM. J. PSYCHIATRY 975, 979 (2000) (reporting high rates of weight gain, diabetes, and hyperlipidemia in patients who take clozapine for extended periods).

93. The FDA “required a demonstration of efficacy in patients whose disease was refractory to treatment with standard antipsychotic drugs. No other antipsychotic drug had ever been required to meet such a standard.” Keith, supra note 55, at 852. The Physicians’ Desk Reference still contains a black-box warning to reserve clozapine therapy for “USE IN (1) THE TREATMENT OF SEVERELY ILL PATIENTS WITH SCHIZOPHRENIA WHO FAIL TO SHOW AN ACCEPTABLE RESPONSE TO ADEQUATE COURSES OF STANDARD ANTIPSYCHOTIC DRUG TREATMENT, OR (2) FOR REDUCING THE RISK OF RECURRENT SUICIDAL BEHAVIOR IN PATIENTS WITH SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDER WHO ARE JUDGED TO BE AT RISK OF RE-EXPERIENCING SUICIDAL BEHAVIOR.” Physician’s Desk Reference 2008, 2193 (62nd ed. 2007) [hereinafter PDR]. However, clozapine has proved useful in treating other serious mental conditions, including refractory bipolar disorder, psychotic depression, and psychosis in Parkinson’s Disease, see RONALD W. PIES, HANDBOOK OF ESSENTIAL
reluctance of third-party payers have meant that psychiatrists would prescribe clozapine only to patients who could not benefit from or tolerate other available antipsychotic drugs. In the early 1990s, these drugs included only FGAs, which remained the primary drug therapy for schizophrenia. But clozapine’s arrival made both psychiatrists and patients realize that antipsychotic drugs could be more effective and less neurotoxic than the preceding decades had led them to assume.

1. Second-Generation Antipsychotics for “First-Line” Use

In January 1994, risperidone entered the U.S. pharmacopeia, allowing U.S. psychiatrists to prescribe a second-generation antipsychotic (SGA) as initial therapy for schizophrenia. Over the next twelve years, five more SGAs—olanzapine, quetiapine, ziprasidone, aripiprazole, and pal-

PSYCHOPHARMACOLOGY 189-90 (2nd ed. 2005), and borderline personality disorder. K. N. Roy Chengappa et al., Clozapine Reduces Severe Self-Mutilation and Aggression in Psychotic Patients with Borderline Personality Disorder, 60 J. CLINICAL PSYCHIATRY 477, 483 (1999); George F. Parker, Clozapine and Borderline Personality Disorder, 53 PSYCHIATRIC SERVICES 348-49 (2002).

94. After some state Medicaid programs were initially to financially support clozapine therapy, courts ruled that Medicaid programs were obligated to make clozapine available to beneficiaries when doctors felt that the drug was medically necessary. Visser v. Taylor, 756 F. Supp. 501, 507 (D. Kan. 1990); Alexander L. v. Cuomo, 588 N.Y.S.2d 85, 88 (N.Y. Sup. Ct. 1991).


96. Risperidone is the nonproprietary name for the product originally marketed as Risperdal® by Janssen Pharmaceutica. PDR, supra note 93, at 1715.


100. Aripiprazole received FDA approval in November 2002. Bristol-Meyers Schizophrenia Drug Receives Approval, N.Y. TIMES, Nov. 16, 2002, at C4,
peridone—received marketing approval in the U.S. and became available for first-line use. None of these SGAs carry a substantial risk of agranulocytosis, and their recipients do not need medical monitoring as intensive as is required for clozapine.

Through the early years of the 21st century, psychiatrists were confident that SGAs had several advantages over FGAs. Based on premarketing studies used to achieve FDA approval, the SGAs appeared to treat positive symptoms as effectively as did FGAs, but with a lower incidence of noxious neuromotor side effects, including TD. Psychiatrists thought that pa-

available at 2002 WLNR 4100623. The compound is marketed as Abilify® by Bristol-Meyers. PDR, supra note 93, at 872.


102. In the 1990s, psychiatrists believed very little medical monitoring was necessary absent indications of problems. Marvin I. Herz et al., Practice Guideline for the Treatment of Patients with Schizophrenia, 154 AM. J. PSYCHIATRY 20-23 (Supp. Apr. 1997). By 2004, however, the risk of weight gain and metabolic problems with SGAs had been recognized. See infra Part II.E.1.

103. For examples of studies from the 1990s, see Mossman, supra note 15, at 1073-74, n. 201. For a more recent study, see Christoph U. Correll et al., Lower Risk for Tardive Dyskinesia Associated With Second-Generation Antipsychotics: A Systematic Review of 1-Year Studies, 161 AM. J. PSYCHIATRY 414, 419 (2004) (mean annual TD risk with SGAs was below 1%, compared to a 5% risk with FGAs).

These studies usually compared SGAs to 20-mg/day doses of the high-potency FGA haloperidol that are well above patients’ “neuroleptic threshold,” that is, the minimum dose needed to produce modest extrapyramidal side effects. In an important study of the neuroleptic threshold dosing, McEvoy and colleagues found that the average dose needed to treat patients with schizophrenia was just 3.7 mg/day. Joseph P. McEvoy et al., Optimal Dose of Neuroleptic in Acute Schizophrenia: A Controlled Study of the Neuroleptic Threshold and Higher Haloperidol Dose, 48 ARCHIVES OF GEN. PSYCHIATRY 739 (1991). Some writers recognized that the side effect evidence might have been less favorable to SGAs had the studies used lower haloperidol doses. Shitij Kapur et al., Clinical and Theoretical Implications of 5-HT2 and D2 Receptor Occupancy of Clozapine, Risperidone, and Olanzapine in Schizophrenia, 156 AM. J. PSYCHIATRY 286, 291-92 (1999). However, the full significance of this has been appreciated only in the last few years. See infra note 181, note 353, and accompanying test.
patients preferred SGAs\textsuperscript{104} and were “better off” for taking them.\textsuperscript{105} Psychiatrists also believed that SGAs left patients less affected by negative symptoms than did FGAs\textsuperscript{106} and were better than FGAs at ameliorating cognitive deficits in schizophrenia.\textsuperscript{107}

Why SGAs are novel drugs, that is, why they cause fewer neurological side effects than the FGAs, is still not agreed upon. One explanation: SGAs “clinically help patients by transiently occupying D\textsubscript{2} receptors and then rapidly dissociating to allow normal dopamine neurotransmission.” Philip Seeman, \textit{Atypical Antipsychotics: Mechanism of Action}, II Focus 48 (2004). For other theories, see Herbert Y. Meltzer, \textit{What’s Atypical about Atypical Antipsychotic Drugs?} \textit{A CURRENT OPINION IN PHARMACOLOGY} 53, 56 (2004) (discussing effects on serotonin, acetylcholine, and N-methyl-D-aspartate receptors). Aripiprazole derives its atypicality from being a mixed agonist-antagonist of the dopamine-D\textsubscript{2} receptor. Kevin D. Burris et al., \textit{Aripiprazole, a Novel Antipsychotic, Is a High-Affinity Partial Agonist at Human Dopamine D\textsubscript{2} Receptors}, 302 \textit{J. PHARMACOLOGY AND EXPERIMENTAL THERAPEUTICS} 381 (2002).


\textsuperscript{105} A. George Awad & Lakshmi N.P. Voruganti, \textit{Quality of Life and New Antipsychotics in Schizophrenia: Are Patients Better Off?} 25 \textit{INT’L. J. SOC. PSYCHIATRY} 268 (1999). Subsequent studies have suggested that SGAs may not contribute to loss of gray matter volume in the way that FGAs apparently do. See, e.g., Jeffrey A. Lieberman et al., \textit{Antipsychotic Drug Effects on Brain Morphology in First-Episode Psychosis}, 62 \textit{ARCHIVES OF GEN. PSYCHIATRY} 361 (2005) (in first-episode psychosis, haloperidol treatment was associated with reduced gray matter volume, but olanzapine treatment was not; findings could be due to haloperidol-associated toxicity or therapeutic effects of olanzapine).

\textsuperscript{106} Steven R. Hirsch et al., \textit{A 28-Week Comparison of Ziprasidone and Haloperidol in Outpatients with Stable Schizophrenia}, 63 \textit{J. CLINICAL PSYCHIATRY} 516, 519 (2002) (reporting that in previously stable patients, ziprasidone reduced negative symptoms more than did haloperidol); Beng-Choon Ho et al., \textit{A Comparative Effectiveness Study of Risperidone and Olanzapine in the Treatment of Schizophrenia}, 60 \textit{J. CLINICAL PSYCHIATRY} 658 (1999) (reporting that olanzapine and risperidone reduced negative symptoms). However, some authors thought SGAs merely avoided the neurological side effects of FGAs. William T. Carpenter et al., \textit{Patient Response and Resource Management: Another View of Clozapine Treatment of Schizophrenia}, 152 \textit{AM. J. PSYCHIATRY} 827 (1995) (“Treatment of primary negative symptoms is not supported by the current experimental data.”).

\textsuperscript{107} See Mossman, \textit{supra} note 15, at 1075-76 n. 207 (citing studies).
Because the SGAs seemed to offer a clear pharmacological advance in the treatment of psychoses, most psychiatrists eventually felt that these drugs had created new standards for treatment of psychotic disorders. In the mid-1990s, psychiatrists began suggesting that the SGAs should be psychiatrists’ first choice when selecting an antipsychotic therapy, and a few years later, this view became dominant. One can appreciate how rapid

More recent studies question these findings. See, e.g., Terry E. Goldberg, *Cognitive Improvement After Treatment With Second-Generation Antipsychotic Medications in First-Episode Schizophrenia: Is It a Practice Effect?* 64 ARCHIVES OF GEN. PSYCHIATRY 1115 (2007) (findings that cognitive improvements appeared attributable to practice—exposure, familiarity, and/or procedural learning—rather than SGA therapy; differences between risperidone and olanzapine were small); Richard S. E. Keefe et al., *Neurocognitive Effects of Antipsychotic Medications in Patients With Chronic Schizophrenia in the CATIE Trial*, 64 ARCHIVES OF GEN. PSYCHIATRY 633, 641-42 (2007) (after 2 months of treatment, both recipients of SGAs and the FGA perphenazine showed small but significant improvement in cognition; reasons may have included broad inclusion criteria and more reasonable dosing of FGA compared with previous studies). The latter study contains approximately forty earlier references (nos. 10 and 15-53) asserting improved cognition with SGAs.


and dramatic this change was by noting that (1) in a 1995 psychopharmacology handbook, discussion of risperidone occupies less than one page in a 38-page chapter on antipsychotic medications; and (2) in its 1997 guideline for treating schizophrenia, the American Psychiatric Association (APA) states that “conventional antipsychotic medications and risperidone are all reasonable first-line medications for patients in acute phases of schizophrenia …” In the APA’s 2004 version of the schizophrenia guideline, however, the preference for SGAs seems clear: “The second-generation antipsychotics should be considered as first-line medications for patients in the acute phase of schizophrenia, mainly because of the decreased risk of extrapyramidal side effects and tardive dyskinesia. . .”

2. Changes in Prescribing Patterns and Drug Expenditures

These changes in official treatment recommendations merely followed the prescribing patterns of American psychiatrists, who, by the late 1990s, had made SGAs their first-line choice for antipsychotic therapy. In the

110. STEVEN E. HYMAN ET AL., HANDBOOK OF PSYCHIATRIC DRUG THERAPY 30 (3d ed. 1995). This edition is a predecessor of ROSENBAUM ET AL., supra note 55.

111. Herz, supra note 102, 3.

early 1990s, most FGAs were off-patent; many were available in “generic” form, and the daily cost for an oral FGA was sometimes just a few pennies. The costs of SGAs were up to 100 times higher, depending on the specific drug and dosage. Accordingly, annual expenditures for antipsychotic drugs rose substantially in the years during which SGAs were introduced. In 1994, when risperidone became available, annual U.S. expenditures for all antipsychotic medication was $1.4 billion, and only a small fraction of patients with schizophrenia were taking SGAs. A decade later, about 90% of patients with schizophrenia received SGAs at a cost exceeding $10 billion. In 2006, U.S. total sales of SGAs reached $11.5 billion.

Because schizophrenia is such a debilitating illness, most sufferers of the condition do not work; family members and/or public health funds pay most of their health care expenses. Between 1994 and 2003, the number of individuals receiving Social Security benefits for schizophrenia increased from 400,000 to 550,000. Between 1993 and 2001, as use of SGAs by schizophrenic Medicaid beneficiaries climbed from 0 to 69%, annual drug costs climbed from $586 to $2,854 per patient with schizophrenia. In 2002, the Medicaid program spent $3.73 billion on antipsychotic medica-

113. For examples, see Douglas Mossman & Douglas S. Lehrer, Conventional and Atypical Antipsychotics and the Evolving Standard of Care, 51 PSYCHIATRIC SERVICES 1528, 1529 (2000). Justifications for higher prices included the high expectations for SGAs (that is, that they were more effective, less toxic drugs), cost-savings from lower uses of other healthcare resources, and the costs of drug development. See infra notes 121-124, notes 351-358, and accompanying text.


116. Rosenheck, supra note 91 at 1074 (citing Pamela Mazerski, Associate Commissioner, Social Security Administration, written communication, 2004).

Risperidone, olanzapine, and quetiapine accounted for 88% of these dollars, and the costs for these SGAs ranked first, second, and fourth, respectively, among all prescription drugs paid for by Medicaid. By 2001, antipsychotic medications accounted for more government spending than any other category of drugs, as a result of a 610% increase in Medicaid spending fueled largely by the switch to SGAs.

At the time, the switch and the added costs seemed justified, given what psychiatrists believed. The arrival of the SGAs was accompanied by dozens of studies that reported lower rates of adverse effects, better patient acceptance, and greater effectiveness—and by concerted, elaborate promotional efforts by the pharmaceutical companies that manufactured and sold SGAs. The FGAs had produced relatively modest benefit (and did

118. Id. at 2. This includes uses of these drugs to treat not just schizophrenia, but bipolar disorder, dementia, and other conditions. We discuss expanded prescribing of SGAs for FDA indications and “off-label” infra, Part IL.D.3.


120. Id. at 13.

121. See, e.g., Correll et al., supra note 103, at 414.

122. See, e.g., John M. Davis et al., A Meta-Analysis of the Efficacy of Second-Generation Antipsychotics, 60 ARCHIVES OF GEN. PSYCHIATRY 553 (2003) (reviewing 124 studies and concluding that four SGAs—clozapine, amisulpride, risperidone, and olanzapine—are more efficacious than FGAs).

123. Commenting on this, one observer noted,

[A] number of the … studies [comparing FGAs and SGAs] that have been published were developed and sponsored by the pharmaceutical companies whose medications were being evaluated, raising concerns about potential sources of bias in experimental design or interpretation of outcomes.

David A. Lewis, Atypical Antipsychotic Medications and the Treatment of Schizophrenia, 159 AM. J. PSYCHIATRY 177 (2002). Two schizophrenia researchers commented:

[A]ggressive marketing by pharmaceutical companies and their pervasive involvement in continuing medical education has contributed to some confusion among clinicians about how available pharmacologic strategies compare and what they can realistically accomplish. Industry-sponsored drug trials are the major source of clinical trial information, and because Phase IV trials are conducted at least in part for marketing purposes, resulting biases can compromise their utility.
not seem to reduce disability a great deal), so treating schizophrenia had often been relegated to the unglamorous wards of state hospitals. The SGAs gave clinicians reason to feel more hopeful about the prognoses of schizophrenia’s sufferers, and effective, intensive marketing of SGAs got psychiatrists’ attention and helped spur interest in treating schizophrenia. The higher prices of SGAs seemed justified by studies maintaining that prescribing SGAs did not raise (and might even reduce) overall costs for patient care compared with the overall costs incurred by patients treated with FGAs.¹²⁴

3. Off-Label Uses

By the early years of the twenty-first century, use of SGAs had expanded rapidly and extended well beyond treating schizophrenia and closely related psychotic disorders.¹²⁵ This made sense: what made SGAs appealing choices for treating patients with schizophrenia also made SGAs attractive for treating both patients who had other conditions for which psychiatrists used FGAs and patients who might have benefited from FGAs were it not for their neuromotor side effects.

¹²⁴ See, e.g., Susan H. Hamilton et al., Clinical and Economic Outcomes of Olanzapine Compared with Haloperidol for Schizophrenia. Results from a Randomised Clinical Trial, 15 PHARMACOECONOMICS 469, 470 (1999) (higher olanzapine costs were offset by significantly lower inpatient and outpatient costs; study was sponsored by Eli Lilly and Company, which marketed olanzapine); Dennis A. Revicki, The New Atypical Antipsychotics: A Review of Pharmacoeconomic Studies, 1 EXPERT OPINION ON PHARMACOTHERAPY 249 (2000) (evidence suggests that clozapine was cost effective treatment for patients who did not respond to FGAs; risperidone and olanzapine may be cost-neutral compared to FGAs). For a review of additional studies available by 2002, see Mossman, supra note 15, at 1080-88.

¹²⁵ See Mossman, supra note 15, at 1043-44, nn.49-50 (describing indications as of 2002 for SGAs, but reporting these additional uses: clozapine for treatment-refractory mania, SGAs for acute mania and bipolar disorder, SGAs for schizoaffective disorder, olanzapine for treatment-resistant psychotic mood disorders, risperidone for borderline personality disorder, and quetiapine for mood disorders).
The rapid rise in expenditures for SGAs was due, in part, to physicians’ prescribing more than one of these drugs at a time\textsuperscript{126} and to prescribing them “off-label.”\textsuperscript{127} Off-label use—that is, prescribing a medication or using a medical device outside the scope of its FDA-approved labeling\textsuperscript{128}—is, in general, a perfectly legal practice\textsuperscript{129} that is very common\textsuperscript{130} and well

\begin{enumerate}
\item The practice is termed “polypharmacy,” and though quite common, it has little empirical support. Constantin Tranulis et al., \textit{Benefits and Risks of Antipsychotic Polypharmacy: An Evidence-Based Review of the Literature}, 31 DRUG SAFETY 7, 18 (2008) (reviewing studies of frequency, studies supporting such usage, and concluding that published scientific evidence does not support “[t]he pervasive practice of antipsychotic combination treatment for patients with schizophrenia spectrum disorders”).
\item Marisa Elena Domino & Marvin S. Swartz, \textit{Who Are the New Users of Antipsychotic Medications?} 59 PSYCHIATRIC SERVICES 507, 509 (2008) (population prevalence of SGA use increased sevenfold between 1997 and 2005, partly explained by high constant rate of off-label use).
\item Though off-label use most commonly refers to prescribing medications for conditions other than their FDA-approved indications, other meanings include prescribing drugs, at unapproved doses, in unapproved formats (e.g., opening and mixing a capsule’s contents with applesauce to aid swallowing), outside approved age groups (e.g., to children), longer than approved intervals, or at different dose schedules (e.g., all at bedtime, rather than two or three times a day).
\item FDA approval permits drugs to be \textit{marketed} in specific ways, but as each edition of the Physicians’ Desk Reference states, “Once a product has been approved for marketing, a physician may prescribe it for uses or in treatment regimens or patient populations that are not included in approved labeling.” \textit{PDR, supra} note 93, forward. FDA approval does not “limit or interfere with the authority of a health care practitioner to prescribe” approved drugs or devices “for any condition or disease.” Food, Drug and Cosmetic Act, 21 USC §396. Court endorsements of off-label use include an appellate decision’s comment that, “[b]ecause the pace of medical discovery runs ahead of the FDA’s regulatory machinery, the off-label use of some drugs is frequently considered to be ‘state-of-the-art’ treatment.” Richardson v. Miller, 44 S.W.3d 1, 14, n.11 (Tenn. Ct. App. 2000). The U.S. Supreme Court has stated that off-label prescribing “is an accepted and necessary corollary of the FDA’s mission to regulate.” Buckman Co. v. Plaintiffs’ Legal Comm., 531 U.S. 341, 350 (2001).
\item Sharon Conroy et al., \textit{Survey of Unlicensed and Off Label Drug Use in Paediatric Wards in European Countries}, 320 BRIT. MED. J. (79) (46% of prescriptions were off-label); David C. Radley et al., \textit{Off-label Prescribing Among Office-Based Physicians}, 166 ARCHIVES OF INTERNAL MED. 1021 (2006) (21% of prescriptions were off-label).
\end{enumerate}
accepted throughout medicine. It takes years for new drugs to win FDA approval and additional time for already-approved products to receive approvals for additional indications—if pharmaceutical manufacturers decide to invest the time and funds required to achieve a new approved indication. But patients have illnesses that need treatment “today,” and their physicians can address these problems only with available drugs. Often, off-label prescribing practices receive confirmation through scientific publications that endorse what physicians have been doing for years. In re-

131. David S. Baldwin and Nick Kosky, Off-label Prescribing in Psychiatric Practice, 13 ADVANCES IN PSYCHIATRIC TREATMENT 414 (2007) (acknowledging that “most authorities agree that use of drugs outside the terms of their licence is a necessary part of psychiatric practice”).

132. Stuart L. Nightingale, Off-Label Use of Prescription Drugs, 68 AM. FAM. PHYSICIAN 425 (2003) (“Off-label use is legal and, with important qualifications, generally embraced by physicians and other health care providers, health care institutions, insurers, pharmaceutical companies, and even the FDA.”).


cent years, however, off-label use has received increasing scrutiny because in many instances, such prescribing occurs with little scientific rationale.\footnote{Becky A. Briesacher et al., The Quality of Antipsychotic Drug Prescribing in Nursing Homes, 165 Archives of Internal Med. 1280 (2005) (more than one-fourth of nursing home residents received antipsychotic medications; many prescriptions were off-label and/or exceeded dosage guidelines); Radley, supra note 132, at 1025 (though many off-label drug mentions represented logical extensions of FDA-approved indications, “[n]o more than 30% of the off-label [uses] … were supported by strong scientific evidence”).}

In significant part, however, increased prescribing of SGAs was for uses—particularly treatment of mood disorders—that were once off-label but that subsequently received FDA approval.\footnote{Domino & Swartz, supra note 129, at 511 (2008).} As of early 2009, approved indications for SGAs included:

- aripiprazole: schizophrenia (adults and in adolescents ages 13-17 years); bipolar disorder (by itself and in combination with mood-stabilizing drugs, for adults and children ages 10-17 years); as an add-on therapy with antidepressants; agitation associated with schizophrenia or bipolar disorder\footnote{http://www.fda.gov/cder/foi/label/2008/021436s026s021729s012,021713s019,021866s013lbl.pdf at 4 (last visited Jan. 9, 2009).}
- clozapine: treatment-resistant schizophrenia; to lower suicide risk in people with schizophrenia or schizoaffective disorder\footnote{http://www.fda.gov/cder/drug/InfoSheets/patient/clozapinePIS.htm (last accessed Jan. 9, 2009).}
- olanzapine: schizophrenia; bipolar disorder (as monotherapy, in combination therapy with mood stabilizers, and to prevent relapse); agitation associated with schizophrenia or bipolar disorder,\footnote{http://www.fda.gov/cder/foi/label/2007/020592s042s043,021086s022s023,021253s026lbl.pdf at 7 (last visited Jan. 8, 2009).} bipolar depression\footnote{In Symbyax®, a combination drug with fluoxetine. http://www.fda.gov/cder/foi/label/2008/021520s017lbl.pdf at 7 (last visited Jan. 9, 2009).}
- quetiapine: schizophrenia, bipolar depression and mania, and adjunctive maintenance treatment in mania\footnote{http://www.fda.gov/cder/foi/label/2008/020639s025s037s038s040lbl.pdf at 4 (last visited Jan. 8, 2009).}
- risperidone: schizophrenia in adults and adolescents ages 13-17 years; bipolar disorder in adults and children ages 10-17 years; ag-
gression and moodiness in children ages 5-16 years with autistic disorder. 142

- ziprasidone: schizophrenia; agitation in schizophrenia (intramuscular injections); bipolar mania. 143

E. Medical and Scientific Reconsideration

The last few years have witnessed a major reconsideration of the risks, benefits, and costs associated with SGAs, such that psychiatrists are not nearly as confident about their value and superiority as they were at the turn of the 21st century.

1. Risks of SGAs

As we noted earlier, the SGAs seemed to be a significant pharmacological advance because of their apparent capacity to counteract pathological nervous system functioning—that is, to reduce psychosis—without incurring nearly the risk that FGAs posed to other parts of the nervous system in the form of extrapyramidal side effects and TD. By the late 1990s, however, clinicians recognized that SGAs caused other side effects that might, in the long run, be nearly as serious. Individuals with schizophrenia have a substantially lower life expectancy than average, chiefly because of coronary heart disease. 144 Weight gain is a recognized risk associated with FGA treatment, but the weight gain associated with SGAs appears even more significant. 145 By 2002, several other reports 146 had emerged showing that, in

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144. Charles H. Hennekens et al., Schizophrenia and Increased Risks of Cardiovascular Disease, 150 AM. HEART J. 1115 (2005) (causes include cigarette smoking, obesity leading, dyslipidemia, diabetes, hypertension, less access to and use of medical care, and not following health regimens).

145. David B. Allison et al., Antipsychotic-Induced Weight Gain: A Comprehensive Research Synthesis, 156 AM. J. PSYCHIATRY 1686, 1690 (1999) (reporting more weight gain with clozapine, olanzapine, and risperidone than with haloperidol or placebo; several FGAs associated with weight gain as well, but generally less than with SGAs).

146. See, e.g., Michael J. Sernyak et al., Association of Diabetes Mellitus With Use of Atypical Neuroleptics in the Treatment of Schizophrenia, 159 AM. J.
addition to weight gain, SGAs\textsuperscript{147} were associated with abdominal obesity, elevated blood lipids, high blood pressure, and elevated fasting glucose—a “metabolic syndrome”\textsuperscript{148} that substantially heighten the risk of cardiovascular disease. In 2004, new guidelines were published for monitoring the weight, blood pressure, blood sugar, blood lipids, and blood pressure of patients taking SGAs.\textsuperscript{149}

Doctors faced with having to manage disturbed elderly patients with dementia have no good pharmacologic options, yet doing nothing and allowing the agitation to continue may put patients and others at risk. SGAs successfully reduce aggression in elderly patients with dementia.\textsuperscript{150} Al-

\begin{itemize}
  \item \textsuperscript{147} Recent data suggest that clozapine and or olanzapine often induce substantial weight gain, lipid abnormalities, and type 2 diabetes mellitus; risperidone and quetiapine often induce moderate increases in weight; and aripiprazole and ziprasidone induce the least weight gain and relatively little risk adverse metabolic problems. John W. Newcomer, \textit{Second-Generation (Atypical) Antipsychotics and Metabolic Effects: A Comprehensive Literature Review}, 19 CNS DRUGS 1 (Supp., Jan. 2005).
  \item \textsuperscript{148} Scott M. Grundy et al., \textit{Diagnosis and Management of the Metabolic Syndrome: An American Heart Association/National Heart, Lung, and Blood Institute Scientific Statement}, 112 CIRCULATION 2735 (2005).
\end{itemize}
though SGAs never received approval for this use, doctors often prescribed SGAs for this purpose because they posed a much lower risk of TD than did FGAs.\textsuperscript{151} Physicians believed this was a benign practice until studies showed that SGAs were associated with serious adverse events and excess mortality risk.\textsuperscript{152} Since then, the FDA has a required inclusion of “black box” warning for all SGAs discouraging the use of SGAs in elderly demented patients with behavioral disturbances.\textsuperscript{153}

2. Doubts about Superiority

Despite the growing evidence about adverse metabolic effects, psychiatrists still felt confident that SGAs, as a group, posed less risk of TD and other neuromotor side effects than did FGAs.\textsuperscript{154} This feature of SGAs and the belief that SGAs were more effective than FGAs\textsuperscript{155} seemed to justify higher prices through savings on hospitalization costs.\textsuperscript{156} Although a few scholars and researchers questioned these views,\textsuperscript{157} their views repre-
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Presented a decided minority. Since 2005, however, a series of studies have led increasing numbers of psychiatrists to question whether SGAs are as advantageous as they once thought.

Much of the evidence supporting the superiority of SGAs had come from studies sponsored by pharmaceutical manufacturers under restrictive conditions which, though suitable for comparing a test drug to a placebo, did not replicate what happens in real-world psychiatric practice. To address this knowledge gap, the National Institute of Mental Health (NIMH) commissioned and funded the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study. This study undertook a double-blind comparison of then-available SGAs and a moderately-dosed FGA (perphenazine) under typical outpatient treatment conditions. To be eligible for the CATIE study, patients were required to have schizophrenia, but many of the customary exclusion criteria in clinical trials (e.g., substance abuse or medical problems) were not imposed. Data for the study, in which patients were followed for up to 18 months, were collected in 2001-04, and publications of results began appearing in 2005.

MED. J., 1371–76 (2000) (meta-analysis of 52 studies suggests that compared to moderately dosed FGAs, SGAs “had no benefits in terms of efficacy or overall tolerability,” though SGAs caused fewer neuromotor side effects).


In addition, psychiatrists did not know whether one of the SGAs might be superior to the others. Available industry-sponsored studies almost always showed that the sponsor’s drug was superior. See Heres et al., *supra* note 112, at 187-89 (discussing outcomes and possible sources of bias). The CATIE study offered the potential to provide an independent comparison of the SGAs.


160. Patients were randomly assigned to receive olanzapine, quetiapine, risperidone, perphenazine, or (after its introduction in 2002) ziprasidone. These drugs were placed in identical-appearing capsules so that neither patients nor their doctors knew which drug was being administered. Doctors could adjust doses from one to four capsules a day based on their judgments about patients’ needs. Jeffrey A. Lieberman et al., *Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia*, 353 N. ENG. J. MED. 1209, 1211 (2005) [hereinafter Lieberman, *Effectiveness*]. In contrast to using high doses of the high-potency FGA haloperidol, the CATIE study chose “perphenazine because of its lower potency and moderate side-effect profile.” *Id.* at 1215.


The chief measure of overall effectiveness used in by the first CATIE publication was time to all-cause discontinuation. Essentially, this criterion asked, “How long did patients continue taking each medication?”

By this measure, olanzapine outperformed the risperidone and quetiapine—but not perphenazine. No medication did very well, though—only a minority of patients remained on their original medication after 18 months. Moreover, olanzapine’s apparent edge in effectiveness was counterbalanced by the drug’s causing the most weight gain and metabolic problems. Most notably, the researchers found no differences among the medications in rates of neuromotor side effects—the driving rationale for preferring SGAs.

Commenting on these findings, two CATIE researchers stated, “The lack of difference between the new second-generation antipsychotics and perphenazine surprised … us. However, such surprises are why double-blind randomized clinical trials like CATIE are needed.”

Reactions to this initial publication were varied and consistent with expectable interests of their sources. Pharmaceutical companies used se-

163. The rationale for this criterion:

[S]topping or changing medication is a frequent occurrence and major problem in the treatment of schizophrenia. In addition, this measure integrates patients’ and clinicians’ judgments of efficacy, safety, and tolerability into a global measure of effectiveness that reflects their evaluation of therapeutic benefits in relation to undesirable effects.

Id. at 1211.

164. 74 percent of patients stopped their original study medication in within 18 months. Time to discontinuation was longest for olanzapine, but the difference reached statistical significance only when compared to risperidone and quetiapine. Id. at 1209, 1212-16.

165. Id. at 1215. See also Del D. Miller et al., Extrapyramidal Side-Effects of Antipsychotics in a Randomised Trial, 193 Brit. J. Psychiatry 279 (2008) (finding no significant differences in neuromotor side effects or TD when comparing SGAs with perphenazine or with each other).

166. Jeffrey A. Lieberman and John K. Hsiao, Interpreting the Results of the CATIE Study, 57 Psychiatry Services 139 (2006). The CATIE study’s designers expected that their results would spell the end of FGA usage by providing definitive evidence that SGAs were superior to FGAs. As Dr. Lieberman told an audience at the American Psychiatric Association’s 58th Institute on Psychiatric Services, “I want to emphasize, we didn’t expect the results to turn out this way. We said, ‘Let’s put the final nail in that coffin.’” Karla Harby, Schizophrenia Drugs Found Similar in Efficacy, Medscape Medical News, Oct. 9, 2006, available at http://www.medscape.com/viewarticle/545738 (last visited Feb. 3, 2009).
lected aspects of the CATIE findings to point out superiorities of their own products.\textsuperscript{167} Patient advocacy groups feared that the CATIE results might be used to restrict access to certain SGAs.\textsuperscript{168} The CATIE study’s lead author felt that the findings suggested that the medications had significant differences and that treatment should be individualized. Yet “the results of the CATIE study do not appear to justify the current 95 percent market share for second-generation agents. They simply aren’t that much better.”\textsuperscript{169} A \textit{New York Times} editorial concluded that “[t]he nation [had been] wasting billions of dollars on heavily marketed drugs that have never proved themselves in head-to-head competition against cheaper competitors.”\textsuperscript{170}

Since publication of the initial CATIE report, subsequent studies have continued to undermine the view that SGAs are superior to FGAs. All the medications used in the CATIE study appear to improve cognitive functioning equally after two months of treatment;\textsuperscript{171} after 18 months, CATIE patients taking perphenazine appeared to have benefited the most.\textsuperscript{172} SGAs did no better than perphenazine at improving psychosocial functioning\textsuperscript{173} or overall quality of life,\textsuperscript{174} but overall treatment expenditures in CATIE patients who received perphenazine were lower because of the medication’s

\begin{itemize}
\item \textsuperscript{167} Marvin S. Swartz, Introduction to the CATIE Special Section, 59 \textit{Psychiatry Services} 497 (2008) (observing that “too much of the well-deserved debate and discourse on CATIE was thinly veiled industry spin”).
\item \textsuperscript{168} Jeffrey A. Lieberman, \textit{What the CATIE Study Means for Clinical Practice}, 57 \textit{Psychiatry Services} 1075 (2006).
\item \textsuperscript{169} \textit{Id.}
\item \textsuperscript{170} \textit{Comparing Schizophrenia Drugs}, N.Y. \textit{Times}, Sep. 21, 2005 at A24, available at 2005 WLNR 14853155.
\item \textsuperscript{171} Richard S. E. Keefe et al., \textit{Neurocognitive Effects of Antipsychotic Medications in Patients With Chronic Schizophrenia in the CATIE Trial}, 64 \textit{Archives of Gen. Psychiatry} 633, (2007)
\item \textsuperscript{172} \textit{Id.} at 641. Noting that these results differed from those previously reported, the authors commented that “findings from prior reports may not generalize well to … everyday clinical practice,” and that “previous studies … used high dosages of [FGAs], … creating an unfair comparison.” \textit{Id.}
\item \textsuperscript{173} Marvin S. Swartz et al., \textit{Effects of Antipsychotic Medications on Psychosocial Functioning in Patients With Chronic Schizophrenia: Findings From the NIMH CATIE Study}, 164 \textit{Am. J. Psychiatry} 428 (2007) (all groups improved; no differences among treatment groups at 6, 12, or 18 months).
\item \textsuperscript{174} Robert A. Rosenheck et al., \textit{Cost-Effectiveness of Second-Generation Antipsychotics and Perphenazine in a Randomized Trial of Treatment for Chronic Schizophrenia}, 163 \textit{Am. J. Psychiatry} 2080 (2006).
\end{itemize}
lower cost. All the medications lowered the risk of violence, but again, SGAs were not superior to perphenazine.

The Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study (CUtLASS), a non-commercial study funded by the British National Health Service, yielded similar results: patients who received FGAs did no poorer that did recipients of SGAs in terms of quality of life, symptoms, or associated costs; if anything, it was FGA recipients who showed some signs ("a trend") toward great improvement in symptoms and quality of life. A subsequent CUtLASS publication reported that, as was found in the CATIE study, overall costs were lower but quality of life was better in the FGA-treated British patients. That the findings of these studies were valid derived support from a previous study, funded by the U.S. Department of Veterans Affairs, showing no advantage of the olanzapine over moderately-dosed haloperidol.

The most recent meta-analysis on this topic suggests that the SGAs are not identical and that some appear superior to other antipsychotic drugs. The authors of this meta-analysis note, however, that most of the studies they reviewed compared SGAs to haloperidol and focused on short-term efficacy under relatively constrained conditions, whereas CATIE and CUtLASS “focused on real-world effectiveness” of SGAs compared to lower

175. Id. (total monthly health care costs averaged 20-30% less in perphenazine group).
177. Peter B. Jones et al., Randomized Controlled Trial of the Effect on Quality of Life of Second- vs First-Generation Antipsychotic Drugs in Schizophrenia: Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study (CUtLASS 1), 63 ARCHIVES OF GEN. PSYCHIATRY 1079 (2006). Again, the study design allowed use of moderate doses of a lower potency FGA. Id. at 1085.
potency FGAs. Finally, a study of treatment for early-onset psychosis in adolescents, which showed that olanzapine and risperidone were not superior to the FGA molindone, led investigators to “question the nearly exclusive use of second-generation antipsychotics to treat early-onset schizophrenia and schizoaffective disorder.”

Commenting on the findings in the studies they conducted, the chief investigators of the CATIE and CUtLASS studies concluded:

[F]irst-generation drugs, if carefully prescribed, are as good as most second-generation drugs in many if not most patients with established schizophrenia. This is good news as it increases the range of choices of antipsychotic drugs. Careful prescribing of first-generation antipsychotics means using lower doses than was often done in the past and avoiding high-potency drugs.

Two researchers in schizophrenia put their conclusions quite succinctly: “Bottom line: the dichotomy between first- and second-generation antipsychotics is not supported by efficacy data (and now, effectiveness data), and only clozapine has documented superiority in treatment-resistant cases.”

F. Advertising; Response of Medical Organizations

A growing number of medical authorities now believe that “the time has come to abandon the terms first-generation and second-generation antipsychotics, as they do not merit this distinction,” and that psychiatrists were “beguiled” into thinking otherwise. Thus far, however, the impact of these findings has been modest. A study of prescribing practices in New

181. Id., at 40.
York state public hospitals found that use of perphenazine and clozapine increased following publication of the major CATIE results, suggesting “that CATIE’s findings may not have fallen entirely on deaf ears.” However, increases in uses of these two drugs were modest, and patients receiving of risperidone, olanzapine, quetiapine, and haloperidol far out-numbered those taking perphenazine.  

A few psychiatrists have attempted to explain the disparity between what was believed a few years ago and what appears now to be the sobering truth. CATIE’s lead investigator has noted that real-world trials of medications almost always show less benefit than do trials designed to satisfy approval requirements of the FDA. But in addition,

[T]he claims of superiority for the SGAs were greatly exaggerated. This may have been encouraged by an overly expectant community of clinicians and patients eager to believe in the power of new medications. At the same time, the aggressive marketing of [SGAs] may have contributed to this enhanced perception of their effectiveness in the absence of empirical evidence.

Three psychiatrists with expertise in public policy matters agree that financial incentives played an important role: “the rapid adoption of the second-generation antipsychotics was hastened by the high degree of profitability of these medications, which helped to promote a belief … that these drugs represented ‘best practice’ treatments.”

Two British psychiatrists were a bit more blunt: “The spurious invention of the atypicals can now be regarded as invention only, cleverly manipulated by the drug industry for marketing purposes and only now being exposed.”

187. Leslie Citrome et al., Did CATIE Influence Antipsychotic Use? 59 PSYCHIATRY SERVICES 476 (2008) (after CATIE publications, patients taking perphenazine increased from 1.2% to 2.6%, but Figure 1 shows that nearly 30% of patients still received risperidone, 26% received olanzapine, 22% received quetiapine, and 18% received haloperidol).

188. Jeffrey A. Lieberman, Comparative Effectiveness of Antipsychotic Drugs, 63 ARCHIVES OF GEN. PSYCHIATRY 1069 (2006) [hereinafter Lieberman, Comparative Effectiveness] (citing T. Scott Stroup et al., Clinical Trials for Antipsychotic Drugs: Design Conventions, Dilemmas and Innovations, 5 NATURE REVIEWS DRUG DISCOVERY 133 (2006)).

189. Lieberman, Comparative Effectiveness, supra note 190, at 1070.


The recognition of marketing’s contribution to the ascendancy of SGAs comes at a time when all medical specialties are recognizing that commercial product promotion can have a pernicious effect on patient care and clinical decision-making. We return to this topic in Part IV, but we first summarize how litigators have responded to the harms and costs of SGAs.

III. LEGAL RESPONSES: HOLDING DRUG COMPANIES RESPONSIBLE

A. Litigation Concerning Olanzapine: An Illustrative Case

Over the past decade, Eli Lilly & Company has born the brunt of legal actions filed by various parties with grievances about SGAs. In Lilly’s case, the accusations have centered on allegations of failure to disclose side effects and off-label marketing of the highly successful SGA olanzapine, which Lilly markets under the trade name Zyprexa®. Resolution of this litigation continued as we completed this Article, and fully chronicling these cases with appropriate depth is thus impossible. Even were all the litigated concluded, however, providing a comprehensive summary would take us far beyond our intended scope. Here, we only highlight Lilly’s recent legal predicaments, which illustrate the array of legal consequences that pharmaceutical manufacturers can face if they are not cognizant of or if they knowingly circumvent regulations on the promotions of their products.

The successful of promotion and sale of effective, safe pharmaceutical products is in drug companies’ ultimate self-interest. We can think of no reason why pharmaceutical manufacturers should not realize this. We therefore believe that the most plausible explanations for their behavior—even when that behavior clearly skirts regulations—should emphasize the companies’ belief that their products are useful and will help people. None-

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192. Various states have also initiated lawsuits against the manufacturers of SGAs aripiprazole (Abilify®, Bristol-Myers Squibb), risperidone (Risperdal®, Johnson & Johnson), and quetiapine (Seroquel®, AstraZeneca). PsychSearch.net, State Lawsuits – Atypical Antipsychotics, http://www.psychsearch.net/lawsuits.html (last visited Feb. 19, 2009).

193. In addition to the substantive state and federal legal claims that we focus on here, the litigation has often raised complex jurisdictional and procedural issues that, for purposes of exposition, we largely ignore.
theless, as this section explains, the potential litigation losses for manufacturers who fail to “play by the rules” can run into several billion dollars.  

Lawsuits have been filed by both state attorney general offices and olanzapine users themselves, asserting that Lilly failed to warn the public of problematic health conditions linked to the use the drug and illegally marketed the drug for off-label uses.

1. States Cases

In March 2008, Lilly settled its first state-initiated, olanzapine-related lawsuit for $15 million. The suit, filed in April 2006 by the Alaska Attorney General’s Office, alleged that Lilly had known about olanzapine’s potential to cause high blood sugar, weight gain, diabetes, and pancreatitis, and nonetheless failed to warn both the FDA and the public about such risks. The complaint also stated that Lilly had failed to mention these risks in its nationwide olanzapine marketing campaign and had even instructed its salespeople (or, to use physicians’ term, “drug reps”) to downplay the drug’s side effects. Much like the complaints filed by other states’ attorneys general, the Alaska complaint set forth the following counts:

- strict products liability for failure to warn
- strict products liability for design defect
- fraudulent and negligent misrepresentation
- general negligence, and
- violations of the state’s unfair trade practices and consumer protec-


197. Elliott, supra note 6. Dr. Elliott is physician and ethicist at the University of Minnesota.

According to news sources, Alaska believed the suit to be worth some $200 million dollars.

As of early 2009, other states that had filed suit against Lilly included Connecticut, Louisiana, Mississippi, Montana, New Mexico, Pennsylvania, South Carolina, Utah, Vermont, and West Virginia; these lawsuits were filed between 2005 and 2008, with Connecticut’s being the most recent in March 2008. The Connecticut complaint also alleged that Lilly had knowingly misrepresented olanzapine’s harmful side effects, including diabetes, weight gain, and cardiovascular problems, thereby causing the Connecticut Medical Assistance Program (CMAP) to incur financial injury, and state consumers to suffer medical injury. Yet unlike the Alaska complaint, the Connecticut complaint was filed in the United States District Court for the Eastern District of New York—the location of the multidistrict Zyprexa litigation (MDL; also referred to as the “Zyprexa litigation”)

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199. Id. at 9-13.
200. See Goldstein, supra note 195.
201. See PsychSearch.net, supra note 192. Although they did not file lawsuits, other states have taken investigative steps against Lilly regarding olanzapine. Id. For instance, California, Florida, and Illinois each subpoenaed Lilly for documents relating to the drug. Id. Lilly’s October 21, 2008 SEC filing reports that 30 states were “part of a multistate investigative effort being coordinated by an executive committee of attorneys general” that was investigating the company. Eli Lilly & Co., U.S. Securities and Exchange Commission filing, Form 10-K/A, at 35 and 75, available at http://www.sec.gov/Archives/edgar/data/59478/000095013708012864/c46966ae10vkza.htm (last visited Feb. 19, 2009).
203. Id. at 5.
204. Multidistrict litigation is outlined in 28 U.S.C. §1407, which explains when such litigation may be appropriate and procedures that follow once the involved cases have been consolidated:

When civil actions involving one or more common question of fact are pending in different districts, such actions may be transferred to any district for coordinated or consolidated pretrial proceedings. Such transfers shall be made by the judicial panel on multidistrict litigation . . . upon its determination that transfers for such proceedings will be for the convenience of parties and witnesses and will promote the just and efficient conduct of such actions. Each action so transferred shall be remanded by the panel at or before the conclusion of
MDL”). In addition, Connecticut’s complaint contained claims for violations of the Racketeering Influenced and Corrupt Organizations Act (RICO) against Lilly for unlawful marketing practices.

2. Recipient-Initiated Lawsuits

Individual recipients of olanzapine—most of whom presumably suffer from significant mental illness—are personally affected by the drug’s side effects. Their claims against Lilly have been similar to those asserted by the states. But until the October 2008 and January 2009 settlements discussed below, there had been much more action by Lilly to settle patients’ claims.

In April 2004, the federal Zyprexa MDL was consolidated in the United States District Court for the Eastern District of New York for common fact and discovery purposes. At consolidation, six user-initiated such pretrial proceedings to the district from which it was transferred unless it shall have been previously terminated: Provided, however, That the panel may separate any claim, cross-claim, counter-claim, or third-party claim and remand any of such claims before the remainder of the action is remanded.


206. See 18 U.S.C. §1962 (West 2008). RICO provides a private right of action, resulting in treble damages, for those “injured in their business or property” through another’s racketeering activities. Michael R. Flaherty, Cause of Action for Treble Damages for Violation of the Racketeer Influenced and Corrupt Organizations Act, 11 CAUSES OF ACTION 2d 627 (2008). In addition to proving a violation of the RICO statute—which includes proving an element of criminal activity—plaintiffs must also prove that they “have been injured in [their] business or property by reason of the violation.” Id.


208. Transfer Order at 1, In re Zyprexa Products Liability Litigation, No. 1:04-MD-1596 (E.D.N.Y. 2004). In 2005, an MDL was also created to handle
lawsuits from federal districts in California, Kentucky, Louisiana, North Carolina, Ohio, and Tennessee “share[d] allegations concerning the safety of Zyprexa.”209 But more lawsuits were both pending and anticipated even then. As the court’s transfer order explained, “Given the geographic dispersal of current and anticipated constituent actions, no district stands as the focal point for this wide-ranging litigation.”210 The Zyprexa MDL has included—and continues to include—claims filed by state attorneys general, injured recipient-plaintiffs, insurance companies, and labor unions.211 In mid-2005, Lilly agreed to pay $700 million to more than 7,000 of these plaintiffs.212

209. Id. at 2.
210. Id. at 3.
211. The MDL claims against Lilly by insurance companies and labor unions have been based on both state and federal law—the latter alleging specifically that the drug company violated RICO in marketing Zyprexa. Mark Fass, Narrow Zyprexa Class Certified, Sealed Files Released, LAW.COM, Sep. 8 2008, available at http://www.law.com/jsp/article.jsp?id=1202424340649. In July 2008, District Judge Jack Weinstein proposed class action status for the MDL RICO claims against Lilly, hoping that the threat would spur Lilly to settle, which he himself encouraged, explaining:

A global settlement . . . is desirable. Legal disputes of this nature should be resolved as quickly and comprehensively as possible so that government, the medical profession, and drug manufacturers can get on with their main job—protecting the people’s health effectively at the cheapest practicable cost.

Class Action Certification Draft Discussion at 290, In re Zyprexa Products Liability Litigation, No. 1:04-MD-1596 (E.D.N.Y. 2008). In September 2008, Judge Weinstein granted class action status to “third-party payors” involved in the Zyprexa litigation, including labor unions and insurance companies. Fass, supra note 213. However, Judge Weinstein limited the status strictly to those involving RICO. Id.

In addition to the “quasi-class action” settlement just described, olanzapine recipients have also filed a number of non-“class action” lawsuits, alleging products liability claims centered on Lilly’s failure to warn about the drug’s harmful side effects. For instance, Lilly settled 18,000 lawsuits for $500 million in early 2007, bringing the total at that time to “at least $1.2 billion [paid to] 28,500 people who said they were injured by the drug.” Lilly settled another 900 individual user suits later that year. But even after that settlement, the drug company was still “face[d] with product liability lawsuits from about 750 [olanzapine] patients.”

3. Recent Developments

a. October 2008 Settlement

In early October 2008, Lilly announced that it had agreed to settle consumer protection claims with 33 states for $62 million. The settlement came in the midst of an investigation by the Illinois and Oregon attorneys general into Lilly’s marketing of olanzapine for non-approved, off-label uses. The settlement exceeded “the $58 million that Merck paid to settle

213. At the Mass Tort Litigation Blog, Professor Howard M. Erichson has in this way characterized Judge Weinstein’s attitude towards the Zyprexa MDL with regard to settlements, explaining that the Zyprexa MDL’s technically non-class aggregate settlements set it apart from other mass tort cases where settlements were achieved for traditional class actions. Howard M. Erichson, Zyprexa Settlements: Round Two, Mass Tort Litigation Blog, Jan. 4, 2007, http://lawprofessors.typepad.com/mass_tort_litigation/2007/01/zyprexa_settlem.html.

214. Berenson, supra note 194.


219. Id.
similar allegations about rofecoxib—thus becoming the largest settlement of its kind—even though eleven other states chose not to participate.

In November 2008, Judge Weinstein granted Lilly and the six states participating in the MDL “a month off to hammer out a [settlement] agreement.” According to the judge, who had encouraged settlement in the past, “It would be useful to settle all pending attorney general claims at the same time since the issues in each are much the same.”

b. January 2009 Settlement: Criminal Implication

In early January 2009, news outlets broke the story that Lilly would plead guilty to a misdemeanor charge concerning its marketing of olanzapine, implying an admission of wrongdoing by the drug company. In addition to paying a $515 million criminal fine, Lilly also announced that it would pay some $438 million to the federal government and $362 million to the states. In all, the settlement totaled $1.415 billion.

In conjunction with the settlement announcement, Lilly’s CEO, John C. Lechleiter, stressed that the company “deeply regret[ted] the past ac-

220. Id. Vioxx® is the proprietary name for rofecoxib, a nonsteroidal prescription pain reliever that was withdrawn from the U.S. market in September 2004. http://www.medicinenet.com/rofecoxib/article.htm (last visited Feb. 19, 2009).

221. O’Brien, supra note 217. The 11 states include Arkansas, Connecticut, Idaho, Louisiana, Mississippi, Montana, New Mexico, Pennsylvania, South Carolina, Utah, and West Virginia. While the suits by Connecticut, Louisiana, Mississippi, Montana, New Mexico, and West Virginia are before Judge Weinstein in the Zyprexa MDL, the suits by the remaining states are pending in state courts. Id.

222. Id.

223. Judge Weinstein further explained that “[i]n view of the applicable statute of limitations, it is unlikely that any new cases can be brought successfully. A global settlement of all cases, including those pending in state courts, is desirable.” Id.


225. These payments are related to the federal government’s investigation, which thirty or so states joined, into Lilly’s promotion of the drug. Lilly, however, would “not admit to . . . civil allegation[s] connected to improperly promoting Zyprexa.” Id. Instead, it stated that it would settle for “business reasons.” Id.
tions covered by the misdemeanor plea,’” and that Lilly “‘take[s] seriously [its] business practices, and . . . realize[s] that [it] ha[s] a tremendous responsibility to . . . patients and health-care professionals.’” 226 Notably, the settlement incorporates changes in the company’s business practices: Lilly will have its employees undergo additional training on government regulations, have an independent auditor assess its business operations, and continue an in-house governmental compliance monitoring program. 227 This settlement represents a giant step toward resolving olanzapine-related litigation—and in implementing reforms in promotion methods. But outstanding lawsuits remain. The status of the claims by those states remaining in the MDL, for instance, is still up in the air. 228

4. Concluding Thoughts

In aggregate, states’ and recipients’ claims have made olanzapine-related litigation a prominent legal event over the past few years. For Lilly, the litigation has been both financially costly and has repeatedly generated negative publicity about the company in popular press accounts and in legal, medical, and corporate publications.

B. Antipsychotic Drug Litigation: Areas of Law

Having summarized the outcomes of complaints filed against Lilly as of early 2009, we next provide a summary of potential and actual claims against an SGA manufacturer.

1. Products Liability

The products liability claims made against Lilly and olanzapine have been primarily based on the strict liability theories of design and warning defects. The doctrine of “strict” products liability involving defects developed in the mid-twentieth century, with the aid of the Greenman v. Yuba

226. Id.
227. Id.
2009] PUSHING PILLS

Products, Inc.\textsuperscript{229} decision and the American Law Institute’s (ALI) Restatement (Second) of Torts Section 402A.\textsuperscript{230}

a. Design Defect

Most states have adopted Section 402A.\textsuperscript{231} Under that section, product manufacturers are liable for injuries caused by products found to be “in a defective condition unreasonably dangerous to the user or consumer.”\textsuperscript{232} A claim based on design defect of a product alleges that the \textit{entire} line of that product is defective. However, the courts have diverged when it comes to addressing the issue of whether a product is “unreasonably dangerous” be-

\begin{footnotesize}
\begin{enumerate}
\item[229.] 377 P.2d 897 (Cal. 1963). In \textit{Greenman}, Justice Traynor found a combination power tool manufacturer strictly liable for a defect in the product that injured the plaintiff. \textit{Id.} at 901-902. In abandoning contract theories in favor of strict liability, Justice Traynor explained that “rules defining and governing warranties that were developed to meet the needs of commercial transactions cannot properly be invoked to govern the manufacturer’s liability to those injured by their defective products unless those rules also serve the purposes for which such liability is imposed.” \textit{Id.} at 901.

\item[230.] Under the \textit{Restatement (Second) of Torts (1965) §402A, Special Liability of Seller of Product for Physical Harm to User or Consumer:}

\begin{enumerate}
\item[1.] One who sells any product in a defective condition unreasonably dangerous to the user or consumer is subject to liability for physical harm thereby caused to the ultimate user or consumer, or to his property, if
\begin{enumerate}
\item[(a)] the seller is engaged in the business of selling such a product, and
\item[(b)] it is expected to and does reach the user or consumer without substantial change in the condition in which it is sold.
\end{enumerate}
\item[2.] The rule stated in Subsection (1) applies although
\begin{enumerate}
\item[(a)] the seller has exercised all possible care in the preparation and sale of his product, and
\item[(b)] the user or consumer has not bought the product from or entered into any contractual relation with the seller.
\end{enumerate}
\end{enumerate}

\textit{Restatement (Second) of Torts §402A (1965).}


\item[232.] \textit{Supra} note 231.
\end{enumerate}
\end{footnotesize}
cause of its design. Some courts, for example, employ a consumer expectations test. “[F]or a plaintiff to recover [using that test], the defect in a product which causes his injuries must not be one which the plaintiff, as an ordinary consumer, would know to be unreasonably dangerous to him.”

Other courts employ a “risk-utility” test, which asks whether or not “a reasonable person would conclude that the danger-in-fact, whether foreseeable or not, outweighs the utility of the product.”

In the 1990s, the ALI took a different approach to strict products liability. With the Restatement (Third) of Torts: Products Liability, the ALI not only “ma[de] a tripartite-type division” between manufacturing, design, and warning defects, but also adopted the risk-utility test outright. Nota-

233. Another approach has also surfaced following Section 402A in design defect cases “because [the section] gave no guidance as to what to do in a design defect case”: a combination of both the consumer expectations and risk-utility tests. Sorenson, supra note 231, at 264.

234. Sperry-New Holland v. Prestage, 617 So. 2d 248, 254 (Miss. 1993) (Mississippi Supreme Court explicitly abandons the consumer expectations test in strict products liability cases in favor of the risk-utility test).

235. Id. The risk-utility test has been equated with Judge Learned Hand’s Carroll Towing formula for determining when negligence should be implied. See David G. Owen, Design Defects, 73 Mo. L. Rev. 291, 312-314 (2008). Additionally, many courts invoke the so-called “Wade Factors” when assessing risk-utility in a design defect case. See id. at 315-322 (listing the factors and describing their history). See also David G. Owen, John E. Montgomery, & Mary J. Davis, PRODUCTS LIABILITY AND SAFETY 226-299 (5th ed. 2007).

236. Sorenson, supra note 231 at 266.

237. Id. In addition to the risk-utility test described above, the Restatement (Third) of Torts: Products Liability requires that a plaintiff demonstrate the existence of a reasonable alternative design for the particular product. See RESTATEMENT (THIRD) OF TORTS: PRODUCTS LIABILITY §2(b), and cmt. e-f (1998). As comment b points out, “[Section] 2(b) . . . reflects the substantial body of case law suggesting that reasonable alternative design is the predominant, yet not exclusive, method for establishing defective design.” Id. at cmt. b.

A products liability lawsuit, particularly one employing a risk-utility test where a reasonable alternative design is required, will often involve (and potentially hinge on) expert testimony. See Richard L. Cupp, Jr., Believing in Products Liability: Reflections on Daubert, Doctrinal Evolution, and David Owen’s Products Liability Law, 40 U.C. DAVIS L. REV. 511 (2006). As a result, the evidentiary standards for expert testimony set forth in Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579 (1993)—or a state’s interpretations of those or other factors—will become a crucial element of the underlying tort case itself. See id.
ble for our purposes, however, is a specific section in the 1998 *Restatement (Third) of Torts: Products Liability* concerning drugs and drug manufacturers,238 which articulates a steeper burden for plaintiffs alleging design defect(s) of a prescription drug:

A prescription drug or medical device is not reasonably safe due to defective design if the foreseeable risks of harm posed by the drug or medical device are sufficiently great in relation to its foreseeable therapeutic benefits that reasonable health-care providers, knowing of such foreseeable risks and therapeutic benefits, would not prescribe the drug or medical device for any class of patients.239

But while Section 6 of the *Restatement (Third) of Torts: Products Liability* favors drug manufacturers, the group ultimately desires even greater protection. In *Wyeth v. Levine* for example,240 a case soon-to-be-decided by the Supreme Court,241 Wyeth Pharmaceuticals has argued for the preemption of tort liability for manufacturers whose medications or devices have been deemed marketable by the FDA.242

b. Warning Defect

Under Section 402A’s comment j., “In order to prevent [a] product from being unreasonably dangerous, the seller may be required to give directions or warning, on the container, as to its use.”243 A product may be deemed defective, then, when an injured plaintiff can show that its warning

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239. *Id.* at §6(c).
label or instructions were inadequate in some way\textsuperscript{244} or absent.\textsuperscript{245} The elements involved in a warning defect case include:

\begin{itemize}
\item [T]hat the defendant manufacturer . . . knew or should have known of the dangers related to the product’s intended use;
\item (2) the product’s user/consumer was reasonably unaware of those dangers;
\item (3) the defendant manufacturer . . . failed to exercise reasonable care to notify the user/consumer of the products unsafe condition or facts which make the product prone to be dangerous; and
\item (4) the risk and degree of harm was large enough to justify that a warning should have been provided.\textsuperscript{246}
\end{itemize}

The success of a warning defect case is tied to the element of proximate cause.\textsuperscript{247} Plaintiffs in such cases must show that the warning(s) they argue for would have prevented the injuries sustained.\textsuperscript{248}

Interestingly, the Restatement (Third) of Torts: Products Liability Section 6(d) carves out a specific duty for manufacturers of “[a] prescription drug or medical device” to properly instruct or warn prescribers (to help them make the best decisions for their patients)\textsuperscript{249} and patients (for “drugs that are dispensed . . . without the personal intervention or evaluation of a health-care provider”)\textsuperscript{250} of “foreseeable risks” associated with use.\textsuperscript{251} The

\begin{itemize}
\item \textsuperscript{244} See e.g., Restatement (Third) of Torts: Products Liability §2(c).
\item However, a plaintiff’s manufacturing or design defect claim will not be defeated simply by a manufacturer supplying a warning. J. Scott Dutcher, Comment, Caution: This Superman Suit Will Not Enable You To Fly—Are Consumer Product Warning Labels Out of Control?, 38 Az. St. L. J. 633, 635 (2006). Additionally, although “strict” liability-based, warning defects claims have been equated with negligence claims. See id. at 635, n.11.
\item \textsuperscript{245} Dutcher, supra note 244 at 637.
\item \textsuperscript{246} Id. at 636.
\item \textsuperscript{247} See id.
\item \textsuperscript{248} See id.
\item \textsuperscript{249} Restatement (Third) of Torts: Products Liability §6(d)(1).
\item \textsuperscript{250} Id. at §6(d)(2).
\item \textsuperscript{251} The section reads in full,
\item (d) A prescription drug or medical device is not reasonably safe due to inadequate instructions or warnings if reasonable instructions or warnings regarding foreseeable risks of harm are not provided to:
\item (1) prescribing and other health-care providers who are in a position to reduce the risks of harm in accordance with the instructions or warnings; or
\end{itemize}
section also notes that a claim of warning defect "is the major basis of liability for manufacturers of prescription drugs and medical devices." In terms of developing adequate warning labels for their products under this provision, then, drug manufacturers ultimately must seek to meet the informational needs of both doctors and patients.

* * *

Concerning the products liability claims alleged against Lilly, it cannot be denied that olanzapine has helped many thousands of people with treating schizophrenia, bipolar disorder, and other mental illnesses. As one Lilly-employed psychiatrist explained in a letter to the St. Petersburg Times,

While the potential side effects for any medication must be taken into consideration when evaluating treatment options, it is equally important not to lose sight of the benefits. More than 22 million people have taken Zyprexa. For many, it’s helped them obtain employment, maintain housing, and re-establish relationships. Like olanzapine, SGAs have helped a multitude of patients around the world. The SGAs clearly have drawbacks, but so do the alternatives (FGAs, or no drug treatment at all). As we have seen, even those psychiatrists who regard FGAs and SGAs as equivalent overall acknowledge that for individual patients one type of drug may be far more useful and acceptable than others. It is therefore hard to conclude that SGAs are defective products \textit{simpliciter}, especially under a risk-utility theory or under Section 6 of the \textit{Restatement (Third) of Products Liability}.

2. Corporate Law Implications: SEA §10(b) and SEC Rule 10b-5

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(2) the patient when the manufacturer knows or has reason to know what health-care providers will not be in a position to reduce the risks of harm in accordance with the instructions or warnings.

\textit{Id.} at §6(d).

252. \textit{Id.} at cmt. d.

253. Other possible defenses in a strict products liability case could include unforeseeable misuse of the product by a plaintiff, alterations to the product, or assumption of the risk.

In addition to recipients and purchasers of SGAs, shareholders in pharmaceutical companies are potentially affected by extensive and costly litigation. In 2007, Lilly shareholders sued the corporation in the Eastern District of New York for its behavior regarding olanzapine.\(^\text{255}\) The shareholders alleged violations of the Securities Exchange Act of 1934 (SEA) §10(b),\(^\text{256}\) and the Securities and Exchange Commission’s Rule 10b-5, which the SEC created to enforce §10(b);\(^\text{257}\) these provisions relate to shareholder communication.\(^\text{258}\) Under Rule 10b-5, it is “unlawful for any person, directly or indirectly,”\(^\text{259}\) to employ a mechanism to defraud, make untrue statements of material facts, omit material facts that would make a statement no longer misleading, or engage in an act that “would operate as fraud or deceit upon any person.”\(^\text{260}\) Nonetheless, Rule 10b-5 is only applicable to shareholder communications that were made “in connection with the purchase or sale of any security.”\(^\text{261}\) The shareholder class action, as a result, was limited to those persons who had purchased Lilly stock between March 28, 2002 and December 22, 2006.\(^\text{262}\)

The crux of this lawsuit was a claim that Lilly misrepresented olanzapine’s side effects to shareholders through its marketing campaigns.\(^\text{263}\) The suit also claimed that Lilly marketed olanzapine for uses that were not FDA approved in violation of FDA marketing regulations.\(^\text{264}\) Approximately a year after it was filed, Judge Weinstein dismissed the shareholder suit for

\(^{255}\) Lawsuit Filed Against Eli Lilly by Grant & Eisenhofer P.A., OBESITY, FITNESS & WELLNESS WEEK, Apr. 21, 2007, at 307, available at 2007 WLNR 7008003 [hereinafter Grant].


\(^{257}\) See 17 C.F.R. §240.10b-5; see also 69A AM. JUR. 2D Securities Regulation--Federal §1514 (2009) (explaining the ability of the SEC to adopt rules to carry out the intent of certain federal securities laws).

\(^{258}\) The lawsuit also made allegations under SEA §20(a), which discusses the availability of joint and several liability for SEA violations. See Grant, supra note 255.

\(^{259}\) 17 C.F.R. §240.10b-5.

\(^{260}\) Id.

\(^{261}\) Id.

\(^{262}\) See Grant, supra note 255.

\(^{263}\) Id.

\(^{264}\) See id.
exceeding the SEA’s statute of limitations. His dismissal explained that “‘[f]or years before the statute of limitations barred this suit, the red triangular flags of an incipient hurricane had been figuratively hoisted over Lilly and Zyprexa,’” and so “‘[t]he reasonable investor [could not] blink away what the market [had] see[n].’”

Interestingly, a similar issue continues to survive in still-ongoing rofecoxib litigation. Though Merck has settled a number of claims related to the side effects of its prescription pain reliever, the Third Circuit Court of Appeals reversed the dismissal of a shareholder lawsuit against the company related to the medication in September 2008, four years after the company took the drug off the U.S. market. The lawsuit, which contended that Merck misled and omitted information related to rofecoxib-associated risks of heart attacks and strokes, had previously been dismissed by the district court for exceeding the statute of limitations. According to the Third Circuit, the plaintiff-shareholder class made a timely filing of its lawsuit, because “amid early signs of trouble with Vioxx, Merck was still reassuring investors about the safety of [the drug] and financial analysts were projecting growth in sales.”

a. Elements of a Rule 10b-5 Claim

If not for dismissal under the statute of limitations, Lilly shareholders meeting Rule 10b-5’s standing requirement (being either purchasers or sellers of Lilly stock) in the lawsuit referenced above would have addition-
ally needed to show elements of materiality, *scienter*, reliance, economic loss, and loss causation in order for their cause of action to survive.\textsuperscript{272} Under the Private Securities Litigation Reform Act of 1995 (PSLRA), class action plaintiffs invoking Rule 10b-5 must plead their cases “with particularity.”\textsuperscript{273} Materiality can be illustrated via the importance of the information at issue. In *TSC Industries, Inc. v. Northway*,\textsuperscript{274} the U.S. Supreme Court explained that “[a]n omitted fact is material if there is a substantial likelihood that a reasonable shareholder would consider it important in deciding how to vote.”\textsuperscript{275} Olanzapine has been Lilly’s number one selling drug,\textsuperscript{276} and information relating to harmful side effects arguably could have been something its shareholders would have found important.

To illustrate reliance (also known as transaction causation) in a securities class action, the “fraud on the market” theory—where “reliance is pre-

\textsuperscript{272} Dura, 544 U.S. at 341-42. Another interpretation of the elements is as follows:

While the elements of an action under §10(b) of the [SEA] and SEC Rule 10b-5 thereunder have been variously stated by the courts, it is generally agreed that there must be proven: (1) use of the means or instrumentalities of interstate commerce; (2) to implement a deceptive or manipulative practice; (3) with the requisite scienter; (4) in connection with; (5) the offer or sale; (6) of a security; (7) causing; (8) damages.

\textsuperscript{273} 15 U.S.C. §78u-4(b)(1). The PSLRA altered the pleadings requirements for securities class actions. See Jonathan C. Dickey, *Current Trends in Federal Securities Litigation*, SM101 ALI-ABA *725, *731 (2007). According to the PSLRA, where a material omission or false statement has been alleged, “[T]he complaint shall specify each statement alleged to have been misleading, the reason or reasons why the statement is misleading, and, if an allegation regarding the statement or omission is made on information and belief, the complaint shall state with particularity all facts on which that belief is formed.” *Id.* A similar pleading requirement exists for causes of action which hinge “on proof that the defendant acted with a particular state of mind.” *Id.* at §78u-4(b)(2). For more on issues related to interpreting the PSLRA’s requirements, including pleading the elements of *scienter* and loss causation for a Rule 10b-5 claim discussed in this section, see Dickey, supra.

\textsuperscript{274} 426 U.S. 438 (1976).

\textsuperscript{275} *Id.* at 449. Although *TSC* actually revolved around an SEC Rule 14a-9 issue, the materiality standard under both provisions is the same.

assumed when the statements at issue become public”—is typically invoked.277 Lilly’s marketing campaigns for olanzapine, thus, could have been employed to show impact on the plaintiff-shareholders. As for Rule 10b-5’s *scienter* requirement, plaintiffs in general must show something greater than negligence, such as recklessness.278

Finally, Rule 10b-5 plaintiffs must allege and ultimately show an economic loss of some sort,279 as well as loss causation, which mirrors the “proximate cause” requirement seen in basic tort law.280 Pleading loss causation is a sticky issue for courts in securities litigation,281 but put most simply, there must be “a causal connection between the material misrepresentation [alleged] and the loss.”282

3. Claims Under Federal Off-Label Prohibitions

During the rofecoxib litigation, the FDA came under heavy fire for failing to withdraw the drug more quickly after its harmful cardiovascular side effects came to light.283 FDA-related issues concerning olanzapine and other SGAs arose after litigation began and have focused on promotion of these drugs for unapproved, off-label uses—most notably, in the case of olanzapine, for depression.

Under the now-expired Food and Drug Administration Modernization Act284 (FDAMA), a 1997 series of amendments to the Food, Drug & Cos- metic Act (FDCA),285 a drug manufacturer could disseminate information

278. *See Dura*, 544 U.S. at 341-42. With regard to the PSLRA and *scienter*, as Dickey notes, “the majority of Circuits have held that the court must consider all reasonable inferences to be drawn from the allegations, including inferences unfavorable to the plaintiffs.” Dickey, *supra* note 273, at *741.
279. *See Dura*, 544 U.S. at 342.
280. *See id.*
282. *Id.*
concerning a drug’s off-label uses\textsuperscript{286} to a limited group: health care practitioners, pharmacy benefit managers, health insurance issuers, group health plans, or a Federal or State Government agency.\textsuperscript{287} Before the FDAMA, the FDCA prohibited drug manufacturers from engaging to even this extent in off-label promotion.\textsuperscript{288} The FDAMA expired in 2006, however.\textsuperscript{289} As Professor Ausness has commented, in the wake of the FDAMA’s expiration, the FDA has provided “a draft guidance document entitled ‘Good Reprint Practices.’”\textsuperscript{290} This document “identifies how drug manufacturers should distribute scientific or medical journal reprints, articles, or reference works” concerning off-label uses; ultimately, “the FDA retains its power to determine whether distribution of an article or publication constitutes promotion of an unapproved ‘new use’ or whether such a product may be considered misbranded or adulterated under the [FDCA].”\textsuperscript{291} Of course, physicians are not bound by off-label restrictions\textsuperscript{292} and “may use FDA-licensed drugs or medical devices in any way they believe will benefit their patients and are not limited to approved uses.”\textsuperscript{293}

\textbf{HEALTH L.} 295, 297 (2003). In brief, the FDCA performs the following statutory function:

[A]fter introductory chapters defining the terms used and listing general prohibitions and enforcement methods, deals successively with foods, drugs, and cosmetics. It defines adulteration and misbranding for each, and meets peculiar problems in each area by special regulatory provisions such as definition and standardization of foods and pre-shipment control of new and untested drugs. It then prescribes the administrative procedure to be employed, and finally sets forth specific provisions governing imports and exports.


286. See O’Reilly, \textit{supra} note 285, at 295-96.

287. 21 U.S.C. §360aaa(a)(1)-(5); see also Richard C. Ausness, “There’s Danger Here, Cherie!”: \textit{Liability for the Promotion and Marketing of Drugs and Medical Devices for Off-Label Uses}, 73 \textit{Brook. L. Rev.} 1253, 1259-60, and accompanying footnotes (2008).


289. \textit{Id.}

290. \textit{Id.} at 1261-62.

291. \textit{Id.}

292. \textit{Id.} at 1259.

293. \textit{Id.}
Turning to the state complaints still pending against Lilly, those in the MDL contend that the drug company knowingly marketed olanzapine for off-label uses in violation of federal law. Montana,\textsuperscript{294} for instance, alleged that “Lilly created a 280-person sales force to promote Zyprexa exclusively for off-label uses, specifically for Long Term Care (“LTC”) facilities to maximize off-label use of Zyprexa sales in elderly population,”\textsuperscript{295} that “Lilly management participated, encouraged, and authorized the unlawful payment of illegal kickbacks to physicians in order to continue generating sales of Zyprexa,”\textsuperscript{296} and that “Lilly marketed Zyprexa off-label because the drug’s on-label uses were far too narrow to achieve the blockbuster revenues Lilly had planned for the drug.”\textsuperscript{297} Connecticut’s complaint alleged that “to gain additional sales and to compete with other antipsychotics[,] … Lilly undertook a scheme to market and promote Zyprexa for off-label purposes,”\textsuperscript{298} including for unapproved uses in the treatment of children and elderly persons.\textsuperscript{299}

The allegations of off-label marketing against Lilly, if ever proved, could result in both civil and criminal penalties against the corporation under the FDCA.\textsuperscript{300} Civil and criminal penalties could similarly arise under RICO for off-label marketing if the requisite “predicate acts” of racketeering were established.\textsuperscript{301}

4. The Quest for Solutions

A variety of potential legal claims serve as potential deterrents to prevent pharmaceutical companies from marketing faulty products or promoting those products for unapproved uses. In the case of litigation against the manufacturer of olanzapine, litigation has resulted in compensation to re-

\textsuperscript{294} Although its complaint was originally filed in state court, Montana is now part of the Zyprexa MDL pending in the District Court for the Eastern District of New York. See O’Brien, \textit{supra} note 219.


\textsuperscript{296} \textit{Id}. at 10.

\textsuperscript{297} \textit{Id}.

\textsuperscript{298} Complaint at 32, Conn v. Eli Lilly & Co., No. CV-08-955 (E.D.N.Y. Mar. 6, 2008).

\textsuperscript{299} \textit{Id}. at 35-37.

\textsuperscript{300} See 21 U.S.C. § 333 (West 2008).

\textsuperscript{301} See Ausness, \textit{supra} note 287 at 1264-65.
recipients-victims, civil and criminal financial penalties, and a promise by Lilly to desist from certain promotion practices. Although the payouts by Lilly have been extraordinary, drug manufacturers regard a certain amount of product liability litigation as “normal to our business,” as a risk against which they may insure themselves, or as something they may factor into drug prices. More importantly, however, litigation has had little impact on drug sales and physicians’ prescribing practices, and therefore seems an imperfect, at-best-incomplete response to collective medical judgment errors reflected in physicians’ over-enthusiastic adoption of SGAs. In the next Part, we examine other factors that illustrate how medical judgment occurs.

IV. RESPONSIBILITY AND VULNERABILITY OF PHYSICIANS

A. Drug Company Blandishments

The promotion techniques used by drug reps and pharmaceutical companies have received substantial publicity over the past few years. Pharmaceutical companies also have employed physicians in various promotional capacities, including efforts to encourage forms of off-label prescribing that those physicians believe are effective. Physicians are often needed to assist pharmaceutical companies in the development of their products, but they have served as spokespersons for products, too. Accepting this role—often by becoming a member of a company’s “speaker’s

303. See id. at 12 (describing “difficulties in obtaining product liability insurance due to a very restrictive insurance market” and expectation “that we will continue to be largely self-insured for future product liability losses”). Lilly’s capacity and willingness to pay large olanzapine-related claims may be a reflection of the fact, reported in the company’s latest SEC filing, that “Zyprexa sales of $4.76 billion represented 26 percent of our revenues in 2007.” Id. at 11.
bureau”—and accepting payments from pharmaceutical companies is not illegal for physicians, but these “entanglements” are actually “common in the medical industry” and appear to have compromised medical education.

The incentivizing of psychiatrists gained media attention in 2008 when Iowa Senator Charles Grassley began investigating payments made by pharmaceutical companies to psychiatrists. The Grassly investigation revealed the previously undisclosed sum of $500,000 given by drug manufacturer GlaxoSmithKline to the chair of Emory University’s psychiatry department for speaking engagements that promoted the company’s products. Along with the federal probe, states have also investigated the tactic. A report released by the Vermont Attorney General’s Office found that psychiatrists received twenty percent of all pharmaceutical money paid to its state’s physicians.

Medical schools were once relatively insulated from the influence and lure of pharmaceutical money. But as other sources of funding for research and education have dried up, financial entanglements have tied many academic doctors to drug companies. By and large, academic recipients of

306. Full disclosure: the first author, who claims no moral superiority over his colleagues, acknowledges having been on drug makers’ speakers bureaus.
307. Ramshaw, supra note 305.
308. Id.
310. Angell, supra note 5. Two other instances mentioned by Dr. Angell: (1) Drug companies paid psychiatrist Joseph L. Biederman $1.6 million in consulting and speaking fees between 2000 and 2007 to advocate treatments for childhood bipolar disorder when studies demonstrating drugs’ effectiveness were lacking. (2) Psychiatrist Alan F. Schatzberg controlled more than $6 million worth of stock in a company he co-founded that was testing a drug to treat psychotic depression; Dr. Schatzberg was also the principal investigator on a National Institute of Mental Health grant that included research on the drug. Id.
311. Gever, supra note 309.
312. Eric G. Campbell et al., Institutional Academic–Industry Relationships, 298 JAMA 1779 (2007) (60% of department chairs had some personal relationship with the pharmaceutical industry [e.g., serving as a consultant, paid speaker, or member of the board of directors; 67% of academic departments had relationships
drug companies’ largesse do not see their relationships with industry as influencing their professional activities or biasing their training, particularly if the gifts are small.\textsuperscript{313} Apparently, drug companies are more savvy about research showing that small gifts influence behavior even when they are not linked to explicit requests.\textsuperscript{314}

The ethical problems stemming from physicians’ acceptance of money and favors have been recognized for several years,\textsuperscript{315} but recently, the volume of gifts and money spent on advertising to practicing physicians has increased substantially.\textsuperscript{316} Drug companies do promotions for resident and medical students as well, for these groups represent beginning and future prescribers of companies’ products.\textsuperscript{317} Until just recently, however, regulations on such promotions had not been implemented by either the federal government or the pharmaceutical companies themselves.\textsuperscript{318}

1. The Breadth of Inducements

\begin{itemize}
  \item with drug companies; many also received moneys for training residents and continuing medical education).
  \item 313. \textit{Id.} at 1785.
  \item 314. Jason Dana & George Loewenstein, \textit{A Social Science Perspective on Gifts to Physicians From Industry}, 290 JAMA 252, 253 (2003) (citing studies and providing examples).
  \item 315. See Alexander C. Tsai, \textit{Policies to Regulate Gifts to Physicians from Industry}, 290 JAMA 1776 (2003) (noting that Congressional hearings were held on the topic of drug company marketing in both the early 1970s and 1990s).
  \item 316. Marc-André Gagnon & Joel Lexchin, \textit{The Cost of Pushing Pills: A New Estimate of Pharmaceutical Promotion Expenditures in the United States}, 5 PLoS Med. e1 (2008) (describing hearings in the 1950s, and describing new activities, such as medical meetings and “seeding trials”).
  \item 317. See e.g. Michael Eisman, M.D., \textit{Medical Student Exposure to Drug Company Interactions}, 295 JAMA 281 (2006).
  \item 318. See Tsai, \textit{supra} note 315. As Tsai explains, the American Medical Association enacted “voluntary ethical guidelines on pharmaceutical gifts” in 1990. \textit{Id.} But while these guidelines were endorsed by the now-titled Pharmaceutical Research and Manufacturers of America (PhRMA), “[A]n abatement of marketing abuses ... was short-lived. Within a few years, commercial detailers and physicians continued to exhibit behavior inconsistent with the guidelines.” \textit{Id.} As discussed below, however, some state legislatures have taken action to address the problem themselves. \textit{Id.}
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The American Medical Association’s *Ethical Guidelines for Gifts to Physicians from Industry* describes “modest items”—including office supplies, teaching materials, and meals provided during research meetings—as “acceptable” under the group’s guidelines on gifts to physicians.319 On the other hand, “lavish dinners, free trips, offers of cash and other inducements . . . are clearly not in compliance.”320

Physicians, including physicians in training, have regarded themselves as immune from advertising, insisting that drug companies’ trinkets (pens, notepads, etc.) and other favors do not influence the treatment of their patients. Doctors maintain (and sincerely believe) that because they are not paid per prescription, their decisions to prescribe only reflect what is best for their patients.321 Empirical evidence has shown otherwise,322 however,


320. *Id.*


322. Former drug company sales representatives have also spoken out about tactics they say they were told to use by their employers. Shahram Ahari, a former sales representative for Lilly, gained exposure through a YouTube video addressing the marketing of Zyprexa. (The video is available at http://www.youtube.com/watch?v=nj0LZZzrcrs.) When he testified before the Senate Aging Committee in March 2008, Ahari explained not only downplaying side effects of drugs, but gift giving as well. *See* Marcus Baram, *Ex-Drug Sales Rep Tells All*, ABCNEWS.COM, available at http://abcnews.go.com/Health/Story?id=4438095&page=1 (last visited Jan. 24, 2009). Ahari’s Letter to Congress (available at http://aging.senate.gov/events/hr190sa.pdf ) commented about the purpose behind gifts to physicians specifically:

> Whether pens, pads, clip boards, or anatomical models, companies take great pains to make their gifts vibrantly colored and clearly logo’ed. The strategy behind these gifts is to draw attention to the pharmaceutical products and to serve as reminders of the company’s generosity. These reminders generate a conscious or subconscious desire to return the “favor.” Referred to as “reciprocity” (a well known term in psychology and marketing), this desire is cultivated by drug reps with whom doctors have a social bond.
including contexts where psychiatrists have done the prescribing. Figures from Minnesota, for instance, revealed that psychiatrists who received more than $5,000 from SGA manufacturers wrote more prescriptions of the drugs for children than did other psychiatrists.\(^{323}\) As Dr. Jerome P. Kassirer, a professor at the Tufts University School of Medicine, commented in an article from ABCNews: “‘One important question: why would the drug industry spend so much money advertising if they didn’t think they were influencing physicians? The notion that this is all for physician education is nonsense.’”\(^{324}\)

Gift-giving by pharmaceutical companies affects future medical professionals as well. A 2005 study published in the *Journal of American Medical Association* concluded that medical students were “at risk for unrecognized influenced by marketing efforts.”\(^{325}\) In reaching that conclusion, the study revealed an average of one sponsored activity attended or one gift received per week, per student.\(^{326}\) Additionally, the study found that:

Most students perceive that they are entitled to gifts. Many simultaneously think that sponsored educational events are likely to be biased, but are helpful. Most think that their prescribing is not likely to be influenced by these interactions and that their colleagues are more likely to be influenced.\(^{327}\)

In response to such findings, a 2006 article from JAMA recommended that medical schools and teaching hospitals implement a ban on individual doctors’ accepting any meals, gifts, books, or other favors from pharmaceutical

\(^{323}\) Id.

\(^{324}\) Baram, *supra* note 322.

\(^{325}\) Federick S. Sierles et al., *Medical Students’ Exposure to and Attitudes About Drug Company Interactions: A National Survey*, 294 JAMA 1034 (2005). The study tracked third-year medical students at eight schools: Case Western Reserve University, George Washington University, the Mayo Clinic College of Medicine, Ohio State University, Rosalind Franklin University, State University of New York Upstate Medical University, University of California at San Francisco, and University of Nebraska. Id. at 1035.

\(^{326}\) Id. at 1038. The survey included everything from free lunches and dinners, to snacks, to utensils, to sponsored ground rounds, to workshops, to waived registration fees paid by drug companies. Id. at 1036.

\(^{327}\) Id. at 1040.
companies,\textsuperscript{328} echoing the ban on all gifts and marketing by pharmaceutical companies to medical students that the American Medical Students Association had recommended in 2002.\textsuperscript{329} A few institutions are implementing such bans.\textsuperscript{330}

2. Others Restrictions on Advertising

Some states have decided to track or halt the efforts of pharmaceutical companies when it comes to providing incentives to physicians.\textsuperscript{331} In 2002, Vermont became the first state to do so,\textsuperscript{332} passing a bill that now requires pharmaceutical companies to report such items as travel expenses and other payments to physicians.\textsuperscript{333} (Items of \textit{de minimis} value, less than $25, are excused from the reporting requirement.\textsuperscript{334}) Under newly-enacted Massachusetts law, set to go into effect on July 1, 2009, pharmaceutical companies will not only be required to report the sums paid to physicians, but will also be banned or severely restricted from giving “most gifts and dinners.”\textsuperscript{335} Interestingly, some commentators have viewed state legislation as mere redundancy in “an industry that is already adequately regulated by the FDA and the U.S. Department of Justice, which ‘enforces fraud, abuse, and anti-
kickback laws.” Looking at aspects of the litigation on olanzapine, however, raises questions about whether the federal government does in fact adequately regulate physician inducements.

Strikingly, pharmaceutical companies, through the Pharmaceutical Research and Manufacturers of America, have responded to adverse publicity about advertising with new guidelines that became effective January 1, 2009. The guidelines, which approximately 40 pharmaceutical companies have agreed to follow, limit the distribution of office items (such as pens, mugs, and staplers), and prohibit drug company sales reps from paying for physicians’ and other health care professionals’ meals. Because of the newness of these guidelines, their effect on doctors’ prescribing and their willingness to prescribe new drugs is not yet known.

3. Non-Marketing Factors

Though doctors have been slow to recognize it, evidence now establishes that they are as susceptible as other human beings to marketing techniques. Physicians have a fiduciary duty to insulate themselves from the effect such techniques have on their practice decisions, and medical organizations have finally taken steps to fulfill this obligation. Having finally acknowledged their susceptibility to drug advertising, it seems sensible that physicians should take steps to limit (or ban) their exposure to favors, meals, trinkets, and other blandishments from pharmaceutical manufacturers. Physicians should base prescribing decisions primarily on scientifically

336. Peck, supra note 333.
338. Id.
339. Id. The ban does not affect meals given to health care professionals while sales representatives are “pitching their products,” or from drug companies paying for CMEs. Id.
340. Dana & Loewenstein, supra note 314, at 253-254 (citing studies and providing examples).
341. David J. Rothman & Susan Chimonas, New Developments in Managing Physician-Industry Relationships, 300 JAMA 1067 (2008) (noting that recently, “policies governing the relationship between physicians and pharmaceutical and device companies have undergone remarkable changes,” including recommendations from the Association of American Medical Colleges to prohibit all gifts and prohibit food provided by industry).
grounded beliefs about what will conduce to patients’ welfare, not on how well they like particular drug reps or on what they have heard while consuming expensive restaurant meals.\textsuperscript{342}

However, aggressive (and occasionally overly aggressive) promotion is far from the only reason that psychiatrists so rapidly and enthusiastically switched to prescribing SGAs between 1995 and 2000. Here, we describe other factors that contributed to the rapid FGA-to-SGA prescribing transition.

a. Avoiding Malpractice Liability

One distinctive advantage of the SGAs—an advantage that recent studies still support—is their lower propensity to cause TD. Although it is difficult to find documentary evidence of this, a desire to avoid putting patients at unnecessary risk of developing TD was a major factor in many psychiatrists’ preference for the SGAs. This was partly an ethical decision (fulfilling the Hippocratic dictum to “do no harm”) and partly a reflection of litigation fear.\textsuperscript{343} Though some professional groups regard negligence suits as a mere “cost of doing business,” physicians do not.\textsuperscript{344} Actual lawsuits involving TD have been relatively uncommon, but psychiatrists knew about them and were intensely concerned about them even when the only drugs available to treat psychotic patients were FGAs.\textsuperscript{345} When the arrival

\textsuperscript{342} Brennan et al., supra note 328 (arguing that academic medical centers should lead the way in eliminating drug advertising in which “physicians have motives or are in situations for which reasonable observers could conclude that the moral requirements of the physician’s roles are or will be compromised”).

\textsuperscript{343} See, e.g., Mossman and Lehrer, supra note 115, at 1531 (quoting other physicians discussion of potential liability).

\textsuperscript{344} The professional socialization of physicians instills an ideal of error-free practice and a belief that good physicians are virtually infallible. David Hilfiker, \textit{Facing Our Mistakes}, 310 NEW ENG. J. MED. 118 (1984). Legalistic and self-critical thinking has led physicians to believe that medical error only occurs because of negligence. Physicians often personalize this even further, concluding (consciously or unconsciously) that medical errors reflect underlying character flaws. Lucian L. Leape, \textit{Error in Medicine}, 272 JAMA 1851, 1852 (1994).

\textsuperscript{345} Perhaps the best known case is Clites v. State, 322 N.W.2d 917 (Iowa App. 1982). Tim Clites’s development of TD was compounded by poor monitoring and lack of consent, but these details often escaped clinicians’ notice. By the mid-1980s, more than a decade after the recognition TD, just ten TD-related lawsuits had been identified. Phil Brown & Steven C. Funk, \textit{Tardive Dyskinesia: Barriers to the Professional Recognition of an Iatrogenic Disease}, 27 J. HEALTH SOC. BEHAVIOR
of SGAs gave doctors an alternative to prescribing FGAs, many psychiatrists felt that to prescribe an FGA was to invite a lawsuit. 346 Suicide and violence by patients are major liability concerns for psychiatrists, so literature supporting the superior effectiveness of SGAs at reducing violence risk provided yet another reason for prescribing the newer drugs and avoiding the older ones. 347

b. Physicians’ Mental Limits

Problems with SGAs and limitations of studies supporting their superiority were becoming apparent in the late 1990s—the very point at which psychiatrists were switching to the newer drugs. Why did this anti-SGA information have so little impact on what psychiatrists were doing? The short answer is that physicians have cognitive limitations.

Practicing physicians can devote only so much time to assessing and weighing of probabilistic information. Like all other human beings, doctors use “fast and frugal” heuristics to make decisions. 348 Because most physicians cannot make their own informed judgments about drugs’ relative advantages, the pharmaceutical reps who visit physicians’ offices often become the key sources of information about medications. Doctors often fail to recognize that the goal of these salesmen are to promote their compa-
nies’ interests or, if doctors realize that reps’ information is biased, they mistakenly believe they are immune to marketing techniques.  

Physicians can examine only a tiny sliver of the findings and minutiae published in journals concerning just their own specialty, and most read only summaries of most articles that they hear about. If one looks only at the abstracts of studies on SGAs from the 1990s, those studies really seem to show that SGAs are better than FGAs. In general, prior to the CATIE study, most psychiatrists had little basis for thinking that these advantages did not translate into real-world benefits. The research details that might have alerted psychiatrists to SGA limitations—for example, using a high-potency FGA (usually haloperidol) as the comparator drug and dosing it high enough to induce many side effects, or selecting nonrepresentative patients as subjects for studies—were easy to miss.


351. Teresa Jones et al., What British Psychiatrists Read: Questionnaire Survey of Journal Usage Among Clinicians, 185 BRIT. J. PSYCHIATRY 251, 253 (2004) (only two journals read by most psychiatrists); Sanjay Saint et al., Journal Reading Habits of Internists, 15 J. GEN. INTERNAL MED. 881 (2000) (“most internists rely heavily on abstracts”); Mary F. Burke et al., Reading Habits of Practicing Psychiatrists, 81 AM. J. PHYS. MED. & REHABILITATION 779 (2000) (“most physicists only scan the table of contents and read the most important abstracts”).

352. See, e.g., see Richard L. Borison et al., ICI 204,636, an Atypical Antipsychotic: Efficacy and Safety in a Multicenter, Placebo-Controlled Trial in Patients with Schizophrenia, 16 J. CLINICAL PSYCHOPHARMACOLOGY 158 (1996) (“treatment with [quetiapine] did not induce” extrapyramidal side effects); Guy Chouinard et al., supra note 103, at 25 (1993) (risperidone at least as effective as haloperidol with far lower incidence of EPS); Donald C. Goff et al., An Exploratory Haloperidol-Controlled Dose-Finding Study of Ziprasidone in Hospitalized Patients with Schizophrenia or Schizoaffective Disorder, 18 J. CLINICAL PSYCHOPHARMACOLOGY 296 (1998) (risperidone at least as effective as haloperidol with far lower incidence of EPS); and Gary D. Tollefson et al., Olanzapine Versus Haloperidol in the Treatment of Schizophrenia and Schizoaffective and Schizophreniform Disorders: Results of an International Collaborative Trial, 154 AM. J. PSYCHIATRY 457 (1997) (olanzapine at least as effective as haloperidol with far lower incidence of EPS).

353. See supra note 103.

354. To avoid confounding variables that would make results difficult to interpret statistically, studies of new medications typical exclude patients with various
The problems caused by FGAs versus SGAs differ importantly in their obviousness, timing, and salience. Many persons who take high-potency FGAs look drugged and slowed down by neuromotor side effects that quickly occur, but the movements of people who take SGAs usually are not affected much. By contrast, weight gain induced by SGAs accumulates over weeks or months, and any glucose and lipid abnormalities are usually evident only in laboratory results of blood tests. At a time when the entire American population was becoming fatter, observing weight gain in a person whose mental state was improving may not have seemed unusual or troubling. In sum, the limitations of FGAs are gross and immediately apparent, while the problems with SGAs are subtle and slower to materialize. Individual physicians have very limited ability to discern large population trends such as a higher incidence of obesity and metabolic syn-

medical problems, co-existing psychiatric problems, and substance use disorders. See, e.g., Borison et al., supra note 364, at 344 (exclusion criteria included patients with “any other psychiatric disorder, … [s]uicidal ideation within a year of trial entry, mental retardation, convulsive disorders, history of severe head trauma or suspected organic brain disease, … risk of pregnancy, … clinically significant laboratory findings or abnormal electrocardiograms”). In real-world psychiatry, however, such patients make up the vast majority of persons who receive treatment for severe mental illnesses. See Jeffrey A. Lieberman, Comparative Effectiveness of Antipsychotic Drugs: A Commentary on Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study (CU/MISS 1) and Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE), 63 ARCHIVES OF GEN. PSYCHIATRY 1069 (2006) (noting that drug approval studies are “conducted at least partially in a hospital setting, involve only a selected subsample of the population for which the drug will eventually be indicated, and exclude patients with psychiatric and medical comorbidities”).

355. See supra note 103 and accompanying text (discussing SGAs’ lower incidence of neuromotor side effects).


drome in certain patients. Movement abnormalities in an individual patient are, by contrast, easy to spot and worry about.\textsuperscript{358}

From the standpoint of a practitioner with limited time and resources, SGAs are huge time-savers. Prescribing high-potency FGAs so that they do not produce troubling side effects often requires careful dose adjustment and frequent monitoring of a patient’s response.\textsuperscript{359} By contrast, the SGAs were marketed with relatively clear dosage guidelines,\textsuperscript{360} and the margin of error between a dose that quells psychosis and the dose that causes neuro-motor side effects is much wider.\textsuperscript{361} As the effectiveness of SGAs for other conditions (e.g., mood disorders) was recognized, psychiatrists could prescribe them instead of older mood stabilizers (e.g., lithium and valproate), which also require careful dose adjustments.\textsuperscript{362} SGAs thus are an easy-to-

\textsuperscript{358} In support of this contention, see Michael J. Sernyak & Robert A. Rosenheck, \textit{Antipsychotic Use in the Treatment of Outpatients With Schizophrenia in the VA From Fiscal Years 1999 to 2006}, \textit{59 Psychiatric Services} 567, 569 (2008) (concluding that “antipsychotic prescribing patterns over an eight-year period suggests that concerns about side effects are the strongest driver of differences in medication use”).

\textsuperscript{359} See, e.g., McEvoy et al., supra note 103, at 741 (discussing every-other-day assessment of patients); and Douglas Mossman, \textit{A Decision Analysis Approach to Neuroleptic Dosing: Insights from a Mathematical Model}, \textit{58 J. Clinical Psychiatry} 66, 69-70 (1997) (discussing ranges of FGA doses and balancing of benefits with side effects). For additional information, see Peter J. Weiden et al., \textit{Translating the Psychopharmacology of Antipsychotics to Individualized Treatment for Severe Mental Illness: A Roadmap}, \textit{68 J. Clinical Psychiatry} 4, 13-19 (Supp. 7, 2007) (discussing narrow range of doses that are effective with inducing neuro-motor side effects).

\textsuperscript{360} Heres et al., \textit{supra} note 112, at 170 (noting that the SGAs were “a major step forward. For the first time antipsychotic drugs with clearly defined dose ranges were made available, while the optimum dose, even of the standard conventional antipsychotic haloperidol, is still in doubt”).


\textsuperscript{362} See \textit{Dan J. Stein et al., The American Psychiatric Publishing Textbook of Mood Disorders} 471-72 (2005) (discussing need for plasma levels and noting that lithium’s therapeutic range is 0.8-1.2 mEq/L, with toxicity at 1.5 mEq/L); S. Hossein Fatemi et al., \textit{The Medical Basis of Psychiatry} 609 (2008) (valproate dose ranges from 750 to 6,000 mg/day and requires monitoring of blood levels).
prescribe, one-drug-fits-all solution for a large fraction of the severely ill patients whom many psychiatrists treat.

Finally, the high cost of new drugs—a drawback of which doctors and payors were immediately aware—was not a factor blocking the adoption of SGAs. In most U.S. healthcare settings, neither the prescribing doctor nor the patient who takes (and benefits from) a particular drug has any personal incentive to control pharmaceutical costs. However, doctors do have ever-present incentives to avert liability, and patients have incentives to avoid side effects that they experience immediately.

For all these reasons, SGAs seemed much more attractive choices with apparently little disadvantage.

c. Outside Influences

Entities that pay for new and expensive treatments are a logical source of opposition to adopting those treatments, especially if those treatments do not clearly offset higher costs. In the early to mid-1990s, some agencies responsible for paying pharmaceutical bills attempted to limit costs by putting limits on use of SGAs. In some cases, court decisions barred large-scale efforts to do this consistently. Even after the results of CATIE, few formulary restrictions limit use of SGAs, though some state mental health directors suggest that these might be justified. Formulary restrictions have been opposed by advocacy groups, such as the National Association for the Mentally Ill, who appear to accept what pharmaceutical compa-

363. Duggan, supra note 117, at 2 (“because Medicaid recipients typically do not share in the cost of their prescription drugs, the program distorts medical care purchase decisions”).


366. Joseph J. Parks et al., Impact of the CATIE Findings on State Mental Health Policy, 59 PSYCHIATRY SERVICES 534, 536 (2008) (three medical directors who previously endorsed SGAs now feel that “neither complete open access for all patients at all times nor a uniform fail-first trial of a first-generation drug are optimal approaches”).

367. See, e.g., Dr. Fred Frese Testifies before House Veteran’s Affairs Committee, NAMI E-News, Jun. 20, 2001, available at
nies and prescribing psychiatrists believe about the advantages of SGAs.\textsuperscript{368} State legislatures and state mental health departments have also exempted SGAs from the sorts of cost controls placed on other medications.\textsuperscript{369}

d.  Lack of Good Information

A final contribution to the collective judgment error concerning SGAs is the sub-optimal quality of information that physicians receive about medications. Drug development has become very costly, but pharmaceutical companies spend twice as much on drug advertising as they do on research—$57.5 billion by one recent estimate.\textsuperscript{370} As anyone who has attended a large medical meeting knows, the most interesting “educational” events—and the ones offering meals and gifts—are those sponsored by pharmaceutical firms, at which the topics and speakers can be selected in ways that highlight advantages of products produced by those firms.\textsuperscript{371} Similarly, a glance at any medical journal quickly reveals that the most vivid, esthetically appealing pages are not those that contain scientific articles, but those that contain advertisements paid for by commercial concerns.

Physicians may underestimate their invulnerability to advertising, but they certainly know when they are attending commercially sponsored events.

\textsuperscript{368} Pharmaceutical companies have made substantial donations to NAMI. Thus, it was not just physician recipients of drug company blandishments who were convinced that SGAs were superiority treatments; patients and their advocates believed this, too.

\textsuperscript{369} Chris Koyanagi et al., \textit{Medicaid Policies To Contain Psychiatric Drug Costs}, 24 \textsc{Health Affairs} 536 (2005) (noting that although many Medicaid programs put limits on some medications, many “states have legislated exemptions from those policies for certain medications, particularly antipsychotics and antidepressants”); David Bergman et al., \textit{State Efforts to Manage The Behavioral Health Pharmaceutical Benefit}, NAT’L ACAD. STATE HEALTH POL’Y ISSUE BRIEF 3 (Mar. 2006) (noting that “no state used the fail-first strategy” to limit costs).

\textsuperscript{370} Gagnon & Lexchin, \textit{supra} note 316.

\textsuperscript{371} This problem is not restricted to psychiatry. For just two of many recent descriptions, see Arnold S. Relman, \textit{Industry Support of Medical Education}, 300 \textsc{JAMA} 1071 (2008), and Troyen A. Brennan et al., \textit{supra} note 320, at 429 (2006). This is not a recent problem. \textit{See}, \textit{e.g.}, Anthony G. Salem, \textit{Medical Education and the Pharmaceutical Industry}, 5 \textsc{J. Gen. Internal Med.} 91-92 (1990), and older sources cited therein.
or reading promotional materials. In recent years, however, pharmaceutical companies have used activities that physicians have usually regarded as independent of commercial influence to promote products, especially off-label uses. Pharmaceutical enterprises have created physician advisory boards and have organized gatherings of “consultants” (physicians identified as professionally influential), knowing that the doctors attending these functions will later discuss the companies’ products favorably with their colleagues. Companies have sponsored continuing medical education events where “thought leaders” (again, prominent physicians) spread the word about their products; often, a purpose of these events is to promulgate off-label uses of drugs, something physician speakers may do even when drug manufacturers may not.\(^{372}\) Drug companies have also hired communication companies that get articles published in medical journals.\(^{373}\) Many research studies that appear to have been proposed and designed by academic, independent researchers show evidence of “ghost authorship” by commercial concerns.\(^{374}\)

Even peer-reviewed, double-blind studies published in prestigious medical journals can spread faulty information about off-label drug uses when sponsors of these studies structure them or use statistical analyses to cast their products in a favorable light. The former editors of the *British Medical Journal* and the *Lancet* believe that these publications have unwittingly functioned as “an extension of the marketing arm”\(^{375}\) or “information-

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372. See, e.g., Michael A. Steinman et al., *Narrative Review: The Promotion of Gabapentin: An Analysis of Internal Industry Documents*, 145 *ANNALS OF INTERNAL MED.* 284, 290 (2006) (describing use of advisory boards, consultants meetings, medical education events, recruitment of local champions to communicate favorable product messages to fellow physicians, and noting that by using these “techniques … commercial interests can intrude into the practice of medicine in both visible and hidden ways”).

373. These practices are described Sergio Sismondo, *Ghost Management: How Much of the Medical Literature Is Shaped Behind the Scenes by the Pharmaceutical Industry?* 4 *PLOS MED.* e286 (2007) (noting that “medical journals have real effects upon physician prescribing behavior, which is why pharmaceutical companies invest so much in their publication”).

374. Peter C. Gøtzsche et al., *Ghost Authorship in Industry-Initiated Randomised Trials*, 4 *PLOS MED.* e19 (2007) (finding evidence of ghost authorship in 75% of trials, further evidence if acknowledgments are included, particular among the statisticians who had primary responsibility for mathematical analyses).

laundering operations” for drug companies’ indirect promotions of off-label drug uses.\(^ {376}\) Also, medical journals prefer to publish results showing that medications are effective, and manufacturers’ often decide not to submit for publication the results of studies showing lack of effectiveness. This means that even for psychotropic medications used for their FDA-approved indications, published results make drugs seem more effective than one would conclude if one knew the results of all studies.\(^ {377}\)

Conducting studies of medication is an expensive enterprise. Proving efficacy and safety of a drug under FDA guidelines usually requires experiments that involve thousands of volunteer subjects. For each of these subjects, proper monitoring may require dozens of hours of clinicians’ time and extensive laboratory testing. The result, according to one widely cited estimate, is that companies’ out-of-pocket costs are more than $800 million per FDA-approved drug.\(^ {378}\) Because relatively little money for drug studies is available from non-commercial sources, most drug studies are initiated and designed by pharmaceutical manufacturers whose understandable and perfectly reasonable goal is to improve sales of their products. Criteria for receiving FDA approval require a showing that a compound is safe and superior to placebo for treating a particular disorder.\(^ {379}\) What doctors often need to know, however, is whether a new (and usually more expensive) drug is not only effective, but better than an older (an often less expensive) already existing drug, and if so, how much better. Pharmaceutical compa-
nies currently have no obligation to conduct such costly comparison studies, and even if they wished to do so, their efforts must first be focused on meeting high-cost requirements of FDA trials. Moreover, manufacturers often have only disincentives to conduct comparison studies of their products because of the threat to sales that such adverse results might pose.

B. Concluding Thoughts

If the FGA-to-SGA prescribing transition described in Part II indeed reflects a collective judgment error by psychiatrists, it was a judgment error produced by a confluence of forces: physicians’ fears of liability, unopposed power of industry to structure scientific knowledge, promotional excesses, advocacy groups’ clamor for better treatment of devastating illnesses, and individual physicians’ limited power to perceive trends and evaluate scientific data. Limiting pharmaceutical promotional activities, restricting gifts to physicians, and punishing companies for improper (off-label) promotion are all appropriate steps. As we have seen, however, these measures do not address the huge information-dispensing advantage held by pharmaceutical companies and the collective judgment errors exemplified by psychiatrists’ over-eagerness to jettison older antipsychotic drugs.

V. THE NEED FOR BETTER INFORMATION

A. Problems with Past Responses

In describing the legal system’s responses to the costs and imperfections of SGAs, Part III has discussed what are, in essence, efforts to control future behavior by punishing undesirable past behavior. These remedies are founded on an implicit conception of pharmaceutical companies’ legal transgressions as bad decisions by many persons who, left to their own devices, would not accept and respond properly to their social responsibilities. This implicit conception also regards punishment—either in the form of tort-based compensation for victims or in monetary penalties for violating regulations—as the appropriate response to bad decisions.

We see three problems with this response. First (and most obviously, though not trivially), penalties follow disapproved-of behavior; they occur after the harm is done. An often promulgated justification of tort penalties is that they prevent harm: individuals, knowing the potential adverse consequences of certain course of action, will do what is desirable or at least not
do what is harmful. The problem with this idea, however, is that to the extent that persons rationally weigh consequences of potential courses of action, punishments only create motivations to avoid punishment. If avoiding punishment can be accomplished by means other than doing what is desired, and if avoidance is less costly or less onerous than doing what is desired because the rewards of undesirable behavior continue, then avoidance plus engaging in the disapproved-of behavior may seem like the best choice.

In the case of drug manufacturing and promotion, legal sanctions compensate plaintiffs or states for wrongdoing if the wrongdoing is detected and the litigation is successful. However, legal sanctions create incentives to avoid adverse consequences rather than to engage in desirable conduct. As experience with medical malpractice litigation suggest, the lawsuits create incentives to avoid lawsuits. Lawsuits may also promote better practices and avoid harms, but they do this only imperfectly. One might hope that the threat of litigation would make practitioners improve their performance and act more safely. However, the punitive and adversarial approaches of tort law are the opposite of the systems-oriented, cooperative strategies that leaders of the patient-safety movement believe are conducive

380. Recently, scientists have shown that avoiding aversive stimuli activates the same neural substrate—the brain’s medial orbital frontal cortex—as is activated when rewards are received. See Hackjin Kim et al., Is Avoiding an Aversive Outcome Rewarding? Neural Substrates of Avoidance Learning in the Human Brain, 4 PLOS BIOL. e233 (2006).

381. On the relationships among punishment, negative reinforcement, escape, and avoidance, see BENJAMIN J. SADOCK ET AL., KAPLAN & SADOCK’S SYNOPSIS OF PSYCHIATRY 145-46 (2007). Evasion often seems preferable to law-abiding behavior. As the popularity and sales of radar detectors attest, many fast drivers choose to retain the rewards of traveling quickly without getting a speeding ticket.

382. Richard A. Nagareda, In the Aftermath of the Mass Tort Class Action, 85 GEO. L.J. 295, 312 (1996) (noting that the tort system “transfers money in the form of damages for past injuries” but is not a system that “regulates behavior by imposing limitations upon future conduct”).

to exposing problems in systems, which are the real loci of medical errors.\footnote{384} 

Drawing lessons from the rofecoxib litigation, Jennifer Wolsing suggests that the threat of tort action actually discourages drug manufacturers from undertaking actions that might promote public welfare, such as conducting and publishing additional studies beyond the bare minimum required for FDA approval. Instead, the potential for tort litigation and other legal sanctions encourages companies to publish only the minimum necessary results, "to provide conspicuous warnings detailing every possibility of harm" and to actually "keep drugs on the market, … rather than to withdraw them abruptly, to avoid the ‘red flag’ effect of alerting plaintiffs and trial lawyers that a drug may be dangerous."\footnote{385} How manufacturers will actually respond to the recent spate of litigation is an empirical matter. But the potential profits from off-label uses of pharmaceutical remain powerful incentives for the actions that have led to lawsuits, and those profits have not been countered by incentives for other behavior that might better promote patients' welfare.

A second problem with the bad-behavior-deserves-punishment response is that it implies that drug manufacturers have no reason to behave responsibly and to sell good products other than to avoid punishment. We suspect, however, that pharmaceutical companies recognize that their long-term self-interest is in producing and selling good, effective products, and that their product promotions usually reflect sincere-if-humanly-imperfect beliefs that they are making money by doing something good—helping patients with illnesses. Viewed in this light, drug industry practices that have recently been characterized in medical journals and lay media as nefarious and corrupting—the recruitment of academic physicians as influential "thought leaders," sponsoring continuing medical education events, even selective publishing of study results—are logical responses to beliefs about the value of products and the escalating need to respond to what competitor companies have done to promote their products.

Finally, criticism and punishment of drug companies does not get at what we believe is the real problem behind over-enthusiastic adoption of SGAs: inadequate information about the value and real effectiveness of the new drugs. As Part II explains, until 2005, the best scientific data suggested


that newly available antipsychotic treatments had clear advantages over the
drugs psychiatrists previously used. Psychiatrists now understand that those
advantages emerged in the artificial, carefully controlled, placebo-
comparison studies that drug companies were (and remain) required to con-
duct to win marketing approval for their products. But when SGA-over-
FGA advantages that emerged from drug-approval studies did not translate
into real-world benefits, it surprised the investigators who designed the real-
world studies. Moreover, the adverse effects particularly associated with
SGAs—hyperlipidemia, diabetes and increased weight gain—are not un-
common in populations with serious mental illnesses and are not unique to
persons taking SGAs; they are, however, much less obvious than the neu-
romotor problems caused by high-potency FGAs that psychiatrists wanted
to avoid. The SGA side effects display a feature common to other subjects
of mass tort litigation, in which problems and injuries “emerge progress-
ively as the relevant latency periods run their course.” Mere reliance on
the tort-based sanctions or punishments for violating advertising regulations
may not be the best means to address what is really behind these latent
harm: gaps in scientific information.

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386. _See supra_ note 166 and accompanying text.
387. Nagareda, _supra_ note 373, at 315. As Professor Nagareda further ex-
plains, “[A]ny solution [regarding mass tort litigation]—at least one other than pro-
tracted litigation of thousands of claims over the span of many years—must entail
not only the disposition of present-day lawsuits but also an attempt to determine the
status of future claimants.” _Id_. The problem, he suggests, is that compensating fu-
ture victims is accomplished through the tort system rather than through institutions
better suited to the task:

[T]he job of addressing, on a prospective basis, entire categories of per-
sons at risk of disease in the future is a familiar feature of administrative
decisionmaking. Risk assessment and the selection of an appropriate
policy response are tasks within the ordinary business of many regulatory
agencies, such as the Food and Drug Administration (FDA), the
Environmental Protection Agency (EPA), and the Occupational Health
Safety and Administration (OSHA) . . . . Under current law, [however,] the
major obstacle to the use of administrative bodies lies in their tradi-
tional inability to facilitate transfers of money between private parties,
whether in the form of damages or by way of compensation prescribed
in a settlement agreement.

_Id_. at 315-16.
How, then, could regulatory and other reforms provide incentives to create and quickly promulgate information about drugs? We offer three proposals.

B. Promoting Information

1. Comparative Effectiveness Studies

As earlier portions of this Article have explained, psychiatrists developed more accurate views about the value of SGAs only after release of results from CATIE, CULASS, and similar studies sponsored by agencies independent of drug companies. These research efforts are examples of so-called “comparative effectiveness” studies, which have been championed lately as ways giving doctors and patients unbiased data that can help them “[k]now more about the effect of different health interventions, … improve the treatment of diseases, help Americans better manage and prevent illness, and … lower health care costs for everyone.”

Although definitions of what constitutes a “comparative effectiveness” study vary, the core notion is that more studies comparing outcomes of different treatments or services, relative effectiveness of treatments, and the different options available for treating particular medical condition in particular patients would lead to more effective, less costly medical care.

Currently, medical professionals have no overarching source for obtaining or accessing data on comparative effectiveness of treatments. As one commentator has noted,

The rapid growth of medical knowledge and technology means it is much harder for doctors and other health care providers to keep up to date. Indeed, the problem of information and practice transference is rendered almost impossible by the fact that health


care is now a highly statist and corporatist venture. Today, there is no such thing as a free market in health care...\textsuperscript{390}

Lack of comparative effectiveness data keeps patients from availing themselves of the best treatments and from exercising “the personal freedom … to choose the health care that, in the professional judgment of their doctors, best serves their personal needs.”\textsuperscript{391}

Amplifying the funding for and potential sources of comparative effectiveness data would help to offset the huge resources that pharmaceutical companies have available to openly promote approved uses and covertly promote unapproved uses of their products. Currently, pharmaceutical companies have shied away from conducting the time-consuming and costly studies needed to have their products approved for multiple, on-label uses. The knowledge that their products might be face increased independent scrutiny through comparative effectiveness studies might spur pharmaceutical companies to explore getting their products approved for additional indications. Pharmaceutical manufacturers also might experience less need to promote their drugs for off-label uses if they knew that doctors would learn (legally!) about their products’ value for off-label uses through comparative effectiveness studies.

The February 2009 $787 billion stimulus package contains a provision to create a Federal Coordinating Counsel for Comparative Effectiveness Research and provides the Agency for Health Research and Quality with $700 million to conduct the relevant research.\textsuperscript{392} Although some argue that federal oversight is not the best way to address all questions arising in the comparative effectiveness debate,\textsuperscript{393} the stimulus package represents a real first step towards providing new, independent sources of information about drugs.\textsuperscript{394}


\textsuperscript{391} \textit{Id.}


\textsuperscript{393} See Evans, \textit{supra} note 389.

\textsuperscript{394} To appreciate the significance, it helps to compare the recently allocated resources to those proposed must a few months ago. Had it been passed, S. 3408 would have provided total funding for fiscal year 2009 of just $5 million, with fund-
2. Information in Exchange for Litigation Protection

Even with the renewed emphasis on comparativeness effectiveness studies reflected in February 2009 legislation, relying on government funds alone is a woefully inadequate strategy to improve the quality of medical information. Even with recent increases in funding, moneys available for government-sponsored independent research are dwarfed by the funds drug companies spend on advertising and promotion. Approaches that recognize this and that incentivize companies to do more beneficial research thus stand a better chance of protecting patients than relying only on independent sources of research.

Wolsing has offered an “evidentiary reform proposal” that does just this. Under her proposal, if manufacturers conducted postmarketing studies and fully disclosed the results, the disclosure would create a rebuttable presumption that the manufacturer did not know about the adverse drug effects discovered in the study.\(^{395}\) Wolsing notes that the most common products liability claim is negligent failure-to-warn regarding which a defendant’s prior knowledge of danger is a key element.\(^{396}\) Wolsing’s proposal offers the particular advantage of motivating manufacturers—through litigation protection—to engage in vigorous monitoring after drugs receive FDA approval. This is the point in a product’s history at which the general public is exposed to undetected adverse effects, yet it follows the period during which the FDA has the most power to influence drug manufacturers. Currently, manufacturers have reasons not to initiate post-release studies of their products\(^{397}\) and to withhold data about post-approval outcomes.

\(^{395}\) Wolsing, supra note 384, at 224.


\(^{397}\) Manufacturers would fear that any such study might generate findings that would discourage doctors from prescribing their drugs. Wolsing, supra note 384, at 225.
Wolsing’s proposal counters these motives by giving drug makers “the prospect of a favorable tort position in the event of litigation.”

3. Patent Protection and FDA Exclusivity

Through the Drug Price Competition and Patent Term Restoration Act of 1984 (hereinafter “Act”; also known as the Hatch-Waxman Amendments), an amendment to the federal FDCA, the government created a non-patent system for protecting both the interests of pioneering drug manufacturers and generic drug manufacturers. Congress’s intent under the Act was to “strengthen incentives for continued innovation for research-based firms while simultaneously expediting and encouraging earlier market entry of generic drugs.” Although new drugs are expected to enjoy a longer period of market exclusivity versus their generic counterparts under the Act, the Act also encourages and enables generic manufacturers to challenge the still-valid patents of pioneering drug companies. Generic manufacturers can do this by either showing that their product does not infringe on pioneering company’s patent or by showing that the pioneering company’s patent is invalid. Invalidity, for instance, can be argued based on theories of anticipation, obviousness, or fraud during the patent application process.

398. Id.
399. For purposes of space, this Article does not discuss patent protection for pharmaceutical companies in depth. We note, however, that such “protection allows a researched-based pharmaceutical firm to recover the tremendous investment necessary to discover and develop new drugs; [and] . . . also ensures the company’s ability to further profit from its innovations before generic drug manufacturers can copy and market the drug at a greatly reduced cost.” Ashlee B. Mehl, Note & Comment, The Hatch-Waxman Act and Market Exclusivity for Generic Drug Manufacturers: An Entitlement or An Incentive?, 81 CHI-KENT L. REV. 649 (2006).
401. See supra note 399, at 350.
402. See infra note 408.
403. Mehl, supra note 399, at 350. The term “pioneering drug company” refers to the “research-based drug company,” id. at 653, that originally develops a particular drug.
404. Id.
Despite Congress’s intent under the Act, in addition to the importance behind the availability of generic drugs, the ability of generic manufacturers to undermine previously valid patents limits the financial rewards of pioneering companies that initially procured them. While market exclusivity periods exist for the pioneering manufacturers, the Act does not do much more to recognize and reward their ingenuity. If increased protection for pioneering manufacturer’s products—either in the form of strengthened patent coverage or lengthened exclusivity periods—were coupled to requirements to conduct and disclose results of post-marketing studies on side effects and real-world effectiveness, however, pharmaceutical companies might find it more attractive to develop and publish bodies of data that would knowledge about existing products.

VI. CONCLUSION

The lessons of SGA drug litigation are many. Pharmaceutical companies sometimes respond to short-term market incentives that serve neither their own long-term interests nor the interests of patients who use their products. Prescription drug makers skillfully exercise their largely unopposed control over the production, promulgation, and interpretation of information about their products. Individual physicians who make decisions about prescription drug selection respond to incentives (such as ill-placed fears of litigation, ease of prescribing, or immediate convenience) that do

manufacturer). As the Abbott court explained, “‘Anticipation’ in patent usage means that the claimed invention was previously known and described in a printed publication, explicitly or inherently.” Id. at 1345. Invoking the argument requires one to provide “documentary evidence, [that shows] every claim element and limitation … set forth in a single prior art reference, in the same form an order as in the claim.” Id. A prima facie case for obviousness, on the other hand, is present “when the ranges of a claimed composition overlap the ranges disclosed in the prior art.” In re Peterson, 315 F.3d 1325, 1329 (Fed. App. 2003).

406. 60 AM. JUR. 2D. § 919 Patents (2009).

407. See Mehl, supra note 399, at 649, n.5.

408. As Mehl explains, “the Act provides an increased term of market exclusivity on the back end of the patent term to offset the patent term lost on the front end while the pioneer awaits FDA approval.” Id. at 653-54. Ultimately, this can result in a “total extension” time of “up to five years.” Id. at 654. See also 25 AM. JUR. 2D. § 123 Drugs and Controlled Substances (2009) (noting that the length of an exclusivity period is tied to the “pharmaceutical novelty” of a particular drug.)
not necessarily coincide with their patients’ long-term health interests. Individual physicians and even larger organized groups of physicians have at-best-very-limited ability to discern general trends of and outcomes from prescription choices. Most patients and doctors have no immediate, personal incentive to make economical drug selections. Those entities and agencies that pay bills are reluctant to restrict prescription choices to control costs.

The most important lesson from SGA litigation is that viewing pharmaceutical companies as villains and doctors as unwitting, corruptible dupes ignores the circumstances of and reasons for their judgment errors. Fear of public exposure and condemnation will motivate doctors to avoid sources of these negative reinforcements but may not get them to make smarter prescription decisions. Fear of litigation may motivate drug makers to produce better products, but drug makers may conclude they can more easily avoid lawsuits by doing things that do not improve their products or the information they provide.

However, getting better information to physicians might help them to make better decisions about drugs and to avoid the types of mistakes that psychiatrists’ improvident adoption of SGAs exemplifies. Given incentives to produce information about their products’ problems and knowing that their products will undergo extensive independent scrutiny, pharmaceutical manufacturers will have clear reasons to create and promote products that further the public good. Lawsuits, fines, and public opprobrium are all appropriate responses to past misbehavior. But the best way to get drug companies and doctors to improve their future behavior is to give them unambiguous reasons to do so.