

FEDERAL REGULATION OF PRESCRIPTION DRUG ADVERTISING AND LABELING

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In recognition of the potentially hazardous nature of certain medicines, the Food and Drug Administration (FDA) was authorized by Congress in 1938 to monitor the manufacture, promotion, and sale of drugs.¹ FDA regulation, following the pattern which has recently prevailed in the control of product and environmental hazards, has shifted from reliance primarily on sanctions imposed after the fact of injury attributable to drug use, toward the establishment of specific preventive regulations. The Kefauver-Harris Drug Amendments of 1962,² for example, the first major change in the Federal Food, Drug and Cosmetic Act of 1938,³ conferred on the FDA broad discretionary powers for the issuance of such regulations.⁴ These regulations aroused more drug-industry opposition than the statutory provisions authorizing them,⁵ and have led to the first law suits challenging FDA rules since the passage of the Act.⁶

This article examines FDA jurisdiction over the advertising and labeling of prescription drugs. Both prescription and over-the-counter medicines fall within the Act's definition of "drugs"⁷ as any article intended⁸ to prevent or treat disease, or intended to affect the structure or function of the body. The Durham-Humphrey Amendment of 1951,⁹ however, established separate legal categories for prescription and non-prescription drugs. Drugs which are too hazardous for self-medication and which, therefore, can be obtained only with a doctor's prescription, are prescription or ethical drugs.¹⁰ These drugs are promoted exclu-

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¹ Federal Food, Drug, and Cosmetic Act, 52 Stat. 1040 (1938), 21 U.S.C. §§ 301-92 (1964) [hereinafter cited as Food and Drug Act].

² Drug Amendments of 1962, 76 Stat. 780 (1962), 21 U.S.C. §§ 301-92 (1964) [hereinafter cited as Drug Amendments of 1962].

³ 52 Stat. 1040 (1938), 21 U.S.C. §§ 301-92 (1964).

⁴ The 1962 Amendments give the FDA broad discretionary power to make regulations designed to be more specific than the statute. Note, *The Drug Amendments of 1962*, 38 N.Y.U.L. Rev. 1082 (1963).

⁵ Kelly, *Three Years Later*, 21 Food Drug Cosm. L.J. 21, 23-24 (1966).

⁶ Id. The suits are discussed *infra*.

⁷ Food and Drug Act, 21 U.S.C. § 321(g) (1964).

⁸ The manufacturer's intent, which may be demonstrated by advertising or labeling, is a key factor in determining whether an article is a drug. Note, *The Drug Amendments of 1962*, 38 N.Y.U.L. Rev. 1082, 1086 (1963).

⁹ 65 Stat. 648 (1951) (amended by the Drug Amendments of 1962), 21 U.S.C. § 353(b) (1964), amending Food and Drug Act, § 503(b), 52 Stat. 1051 (1938).

¹⁰ The term "ethical drug" may refer to all drugs primarily advertised to doctors,

sively to the medical profession,¹¹ while over-the-counter, or proprietary drugs are advertised and sold directly to the public. FDA regulation of the labeling of over-the-counter drugs,¹² and Federal Trade Commission (FTC) regulation of advertising for such drugs¹³ are beyond the scope of this article.

Since each piece of written material published by or on behalf of the manufacturer of a drug concerning his product is either advertising or labeling as those terms are used in the Act, this article traces separately the regulations governing prescription drug advertising and those governing prescription drug labeling. Whenever identical or similar regulations govern a particular aspect of both advertising and labeling, the significance of the issue involved is examined fully under advertising, and the regulations merely summarized under labeling. In each area where the federal government has acted, the article explores the need for regulation, the statutory scheme as proposed to deal with the problem and as finally enacted into law,¹⁴ the regulations proposed and issued to implement the statutory purposes, industry reaction, and the extent of compliance. The article concludes with an examination of the standard of care owed to the public in the promotion of prescription drugs, and an evaluation of the potential liability of physicians, drug manufacturers and the federal government in drug reaction cases.

and thus includes certain over-the-counter medicines. Finguetta, *Authority, Drugs and the Practice of Medicine*, 16 *Food Drug Cosm. L.J.* 393, 395 n.8 (1961); May, *Selling Drugs by "Educating" Physicians*, 36 *J. Med. Educ.* 1, 9 (1961).

¹¹ Prescription drugs are sometimes indirectly advertised to the lay public. Manufacturers often "plant" articles on new drugs in newspapers and magazines. S. Rep. No. 448, 87 Cong., 1st Sess. 183 (1961); Rheingold, *Products Liability—The Ethical Drug Manufacturer's Liability*, 18 *Rutgers L. Rev.* 947, 967 (1964). In fact, the FDA denounced "excessive publicity" in unnamed lay publications regarding the purported wonder-drug properties of DMSO (dimethyl sulfoxide), an experimental drug. The publicity led to the creation of a "gray market" as patients sought the drug for conditions ranging from arthritis to nervous disorders. From 20,000 to 50,000 persons received the drug from authorized and unauthorized sources while clinical trials usually involve only about 1,000 persons. The FDA suspended clinical testing of the drug. *Washington Post*, March 10, 1966, at 1, col. 5. See also *The Story of DMSO*, 192 *J.A.M.A.* 320 (1965), criticizing premature favorable reports appearing in eight major lay magazines and on one television program.

¹² Food and Drug Act, 21 U.S.C. § 352 (1964).

¹³ Federal Trade Commission Act, 15 U.S.C. §§ 52-57 (1964).

¹⁴ The legislative history of the 1962 Drug Amendments, including the four versions of the Senate bill, the two House bills, the debate in Congress and the enacted statute, has been compiled in *Pharmaceutical Mfrs. Ass'n, The Drug Amendments of 1962: Legislative History: Reports, Bills, Debate, Act* (1964). For a lively account of the behind the scene maneuvering during consideration of the Amendments, see R. Harris, *The Real Voice* (1964). For background information on the 1938 Act, see Cavers, *The Food, Drug, and Cosmetic Act of 1938: Its Legislative History and Its Substantive Provisions*, 6 *Law & Contemp. Prob.* 2 (1939).

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Part I. PRESCRIPTION DRUG ADVERTISING

A. Introduction

1. Definition of Advertising

The terms "advertising" and "labeling" as used in the Federal Food, Drug and Cosmetic Act do not totally correspond to their lay connotations of promotional and informational literature. The term "labeling" has been defined¹⁵ to include the display of written material on the immediate container of a drug presenting vital prescription information, any printed matter on a drug's containers or wrappers, and any promotional or other material "accompanying such article."¹⁶ Classified as labeling are brochures, mailing pieces, detailing pieces, literature reprints, reference publications containing manufacturer-supplied data, and similar literature disseminated to physicians.¹⁷ Any residual promotional literature concerning a drug is advertising.¹⁸

Prior to the 1962 Kefauver-Harris Drug Amendments, the Food and Drug Administration lacked jurisdiction over prescription drug advertising. As a result, that agency gave an expansive interpretation to the term "accompanying" so as to give labeling a broad construction and bring much of the informational type of drug promotion under FDA control.¹⁹ The FDA thus regulated direct mail advertising to doctors, as well as material left in doctors' offices by detail men, or drug industry salesmen.²⁰ As the definition of labeling expanded, the definition of advertising contracted to cover only newspaper and magazine advertisements and radio and television commercials.²¹ This segment of drug promotion fell under the jurisdiction of the Federal Trade Commission.²²

However narrow in definition, advertising was large in quantity and continued to play an important role in drug promotion. In 1967, for example, 42.8 percent (13.6 million) of the American Medical Association's revenue of \$31.7 million was derived from advertising, including pharmaceutical ads placed in its various publications. The

¹⁵ Food and Drug Act, 21 U.S.C. § 321(m) (1964); 21 C.F.R. § 1.2 (1969); 21 C.F.R. § 1.105(1) (1969).

¹⁶ Food and Drug Act, 21 U.S.C. § 321(k) (1964).

¹⁷ 21 C.F.R. § 1.105(e)(2) (1969).

¹⁸ Note, *The Drug Amendments of 1962*, 38 N.Y.U. L. Rev. 1082, 1124 (1963); H. Toulmin, *Law of Foods, Drugs and Cosmetics* § 24.6 (2d ed. 1963) (Supp. 1969); 108 Cong. Rec. 22040 (1962) (remarks of Senator Kefauver).

¹⁹ Note, *Drug Amendments of 1962: How Much Regulation?*, 18 Rutgers L. Rev. 101, 124 (1963). See *Alberty Food Prods. v. United States*, 194 F.2d 463 (9th Cir. 1952).

²⁰ Larrick, *Current Federal Drug Controls for Problems Old and New*, 16 Food Drug Cosm. L.J. 679, 680 (1961).

²¹ Kleinfeld, *More Legislation?*, 20 Food Drug Cosm. L.J. 623, 625 (1965).

²² Federal Trade Commission Act, 15 U.S.C. §§ 52-57 (1964).

Journal of the American Medical Association, in 1963, carried nearly 6,000 advertising pages. In 1958, the drug industry paid for 3,790,908 pages of advertisements in medical journals.²³ In 1959, industry costs for journal ads and direct mail impressions totaled \$125,000,000, up 219 percent from 1953, and only part of an aggregate \$750,000,000 spent on all forms of promotion.²⁴

2. *Deficiencies in FTC Regulation of Advertising*

Despite this enormous quantity of drug advertising, the Federal Trade Commission's power of control remained "ill-defined and seldom-used."²⁵ Advertisements directed solely at the medical profession—so long as they listed quantitative ingredient information for the drug and contained no misrepresentation of a material fact—were specifically excluded from FTC control.²⁶ This exception may have had merit prior to the prescription drug "revolution"²⁷ which occurred at the end of World War II, for until then, the number of drugs available was relatively limited, and a doctor could fend for himself in selecting medicines. He needed little protection either from the law or from regulatory agencies. The current crop of drugs, however, adds new information at a rate a doctor cannot hope to absorb while practicing his profession,²⁸ thus altering the situation and threatening to nullify his skills by antiquating his education and training. The physician's dilemma is amplified by the rule of law that members of the profession must keep abreast of the times and follow approved methods in general use.

The role of the doctor as the purveyor of drug products is of prime importance since he is the vehicle by which the prescription medication is transferred from the manufacturer to the consumer. Since the doctor cannot hope to ferret out all vital information concerning drugs for himself, he must usually obtain his knowledge from the manufacturer. As a result, most of the information concerning drug products which comes to the attention of the average physician is either heralded by the detail men of the drug companies, whose primary interest is to push their products, or gleaned from drug company advertising in one form or another. This is where the problems of both the doctor and the patient begin.

²³ R. Harris, *The Real Voice* 188 (1964).

²⁴ May, *supra* note 10, at 5, 7. See generally S. Rep. No. 448, 87th Cong., 1st Sess. 156-65 (1961).

²⁵ M. Mintz, *The Therapeutic Nightmare* 106 n.4 (1965).

²⁶ Federal Trade Commission Act, 15 U.S.C. §§ 52-57 (1964).

²⁷ M. Mintz, *supra* note 25, at 50.

²⁸ The National Library of Medicine has estimated that about 200,000 articles on drugs are published each year.

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Ninety percent of all prescriptions written by physicians today call for drugs introduced within the past 15 years.²⁹ More importantly, drug advertising today not only sells new products, but also informs the physician of the existence and claimed effectiveness of these products. An AMA study, for example, disclosed that medical journal advertising provided "perhaps the largest source of information to practitioners" about newly discovered drugs.³⁰ Forced to "contend with subtle overpowering promotion and the complexities of modern medicine," today's doctor can no longer effectively fend for himself, "especially if he is to be 'educated' by the very purveyors of products which require his prescriptions."³¹

Congressional hearings held in 1958³² revealed abuses in the advertising of tranquilizers, and uncertainty as to the extent of FTC policing powers.³³ In addition, FTC officials themselves criticized their limited jurisdiction, especially over drug ads which failed to list side effects or contraindications.³⁴ Responsible doctors also questioned the propriety of educating physicians through advertisements. Pointing out that many doctors assume that at least some reputable firms consistently disseminate reliable information, Dr. Charles D. May wrote in the *Journal of Medical Education*:

The traditional independence of physicians and the welfare of the public are being threatened by the new vogue among drug manufacturers to promote their products by assuming an aggressive role in the "education" of doctors . . . Is the public likely to benefit if practicing physicians and medical educators must perform their duties amidst the clamor and striving of merchants seeking to increase the sales of drugs by conscripting "education" in the service of promotion? Is it prudent for physicians to become greatly dependent upon pharmaceutical manufacturers for support of scientific jour-

²⁹ DeHaen, *Compilation of New Drugs*, 33 *American Prof. Pharm.* 25 (1968). In 1968, 452 drug applications were cleared by the FDA, and notices to the FDA of drug studies begun on human beings increased from 671 in fiscal year 1968 to 858 in 1969. *Annual Report of Health, Education, and Welfare* 315, 326 (1968).

³⁰ See generally 108 *Cong. Rec.* 21063-1091 (1962); S. Rep. No. 448, 87th Cong., 1st Sess. 190 (1961).

³¹ May, *supra* note 10, at 8-9.

³² See *Hearings on False and Misleading Advertising (Prescription Tranquillizing Drugs)* Before the Legal and Monetary Affairs Subcomm. of the House Comm. on Gov't Operations, 85th Cong., 2d Sess. (1958).

³³ *Id.* at 159-70.

³⁴ Moore, *Regulation of Deceptive Practices by the Federal Trade Commission*, 16 *Food Drug Cosm. L.J.* 102, 115 (1961); Williams, *The Federal Trade Commission and Food, Drug and Cosmetic Advertising*, 16 *Food Drug Cosm. L.J.* 229, 237 (1961); S. Posner, *The Federal Trade Commission* 37, 47, 69 (1970).

nals and medical societies, for entertainment, and now also for a large part of their education?³⁵

Another physician has charged, moreover, that the "persuasive propaganda of advertising literature and of visiting detail men" causes physicians to shift repeatedly and needlessly from one drug to another:

Doctors are being systematically brainwashed by expensive advertising in the pages of medical journals, by the daily influx of mountains of advertising mail, by free throw-away "educational" pamphlets published by commercial agencies for the promotion of drug sales, and by visiting detail men, who go from door to door of physicians' offices leaving elaborate samples of new drugs and valueless combinations of old drugs, together with reams of impressive but biased literature. It is utterly impossible for most busy physicians to separate the wheat from the chaff in this enormous volume of information and misinformation.³⁶

3. *Regulation of Drug Promotion Under the 1962 Amendments*

Hearings held by Senator Estes Kefauver before the Senate Subcommittee on Antitrust and Monopoly in 1961 and 1962³⁷ focused on abuses in drug advertising. Out of these hearings developed the 1962 Drug Amendments. Because advertising may constitute a substantial part of the post-graduate education of practicing physicians,³⁸ the 1962 Amendments place a greater responsibility than did the 1938 Act upon the pharmaceutical industry to present factual and undistorted information to physicians.³⁹ More importantly, the 1962 Amendments grant to the FDA jurisdiction to regulate prescription drug advertising,⁴⁰ while assigning control over non-prescription drug advertising to the FTC.⁴¹ Although FDA regulations issued under the 1962 Amendments have imposed similar disclosure and other requirements on both

³⁵ May, *supra* note 10, at 1.

³⁶ Baehr, *Drug Costs and the Consumer, Drugs in Our Society* 182 (Talaly ed. 1964).

³⁷ Hearings on S. 1552 Before the Subcomm. on Antitrust and Monopoly of the Senate Comm. on Judiciary, 87th Cong., 1st & 2d Sess. (1961-62) [hereinafter cited as Kefauver Hearings].

³⁸ Goodrich, *Responsibilities and Problems of Government, Drugs in Our Society* 146 (Talaly ed. 1964); Garland, *Dissemination of Information on Drugs to the Physician, Drugs in Our Society* 203 (Talaly ed. 1964); Dowling, *How Do Practicing Physicians Use New Drugs?*, 185 J.A.M.A. 233 (1963); Rheingold, *Products Liability—The Ethical Drug Manufacturer's Liability*, 18 Rutgers L. Rev. 947, 965-68 (1964).

³⁹ Sadusk, *Planning in the Food and Drug Administration for Regulation of Prescription Drug Advertising*, 20 Food Drug Cosm. L.J. 299 (1965).

⁴⁰ Food and Drug Act, 21 U.S.C. § 352(n) (1964).

⁴¹ Federal Trade Commission Act, 15 U.S.C. §§ 52-57 (1964). See generally Dougherty, *Current Problems in Food and Drug Advertising*, 21 Food Drug Cosm. L.J. 161 (1966).

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advertising and labeling,⁴² the distinction between the two kinds of printed drug literature remains important; for example, side effects must be fully stated in labeling, but may be summarized in advertising.⁴³

While the FDA now regulates direct mail promotion and advertising in medical journals, the statute did not specifically give the agency authority over oral promotional statements made by detail men.⁴⁴ These salesmen for the pharmaceutical industry, making an estimated 18 to 20 million calls a year on doctors and druggists,⁴⁵ are an important source of information concerning new drugs.⁴⁶ The original version of the 1962 Amendments included a provision authorizing FDA regulation of oral promises in advertising.⁴⁷ This provision would have required detailers to supply the generic name and warnings for drugs. Absent such a definitive rule, promotional statements by detailers cannot easily be categorized as either labeling or advertising.⁴⁸ The FDA does, however, have jurisdiction over literature left with doctors by detailers.⁴⁹ In addition, it could be argued that false oral claims for a drug indicate that the directions for use stated in the drug's labeling are inadequate, and that the drug is, therefore, misbranded.⁵⁰

FDA regulation of prescription drug advertising can be divided into three general areas. The first concerns the promulgation of rules controlling drug names. Related to these requirements are FDA regulations compelling disclosure of certain essential ingredient information. The second is the mandatory listing of information needed before prescribing a drug—its side effects, contraindications, and warnings. The last area concerns FDA regulation of the content of drug advertisements to insure that the limits of the drug's effectiveness are accurately portrayed.

Discussion of the requirement and the importance of full disclosure in prescription drug labeling must lead to consideration of the "brief summary" concept which applies to prescription drug adver-

⁴² Compare 21 C.F.R. § 1.105(a)-(d)(1) (1969) with 21 C.F.R. § 1.104(a), (c), (g), (h)(1) (1969).

⁴³ Contrast 21 C.F.R. § 1.106(b)(3)(i) and § 1.106(b)(4)(i) (1969) with 21 C.F.R. § 1.105(e) (1969).

⁴⁴ U.S. Department of Health, Education and Welfare, Task Force on Prescription Drugs, V Background Papers 29 (1968).

⁴⁵ Harris, *supra* note 23, at 89.

⁴⁶ Note 44 *supra* at 30.

⁴⁷ S. 1552 87th Cong., 1st Sess. § 4(a)(7) (1961) (Drug Industry Antitrust Act).

⁴⁸ Willig, *The Medical Detailer and the New Drug Amendments of 1962*, 20 Food Drug Cosm. L.J. 221 (1965).

⁴⁹ Such literature is considered labeling. Note, *The Drug Amendments of 1962*, 38 N.Y.U.L. Rev. 1082, 1124 n.353 (1963).

⁵⁰ Food and Drug Act, 21 U.S.C. § 352(f) (1964); 21 C.F.R. § 1.106(a)(1) (1969); 21 C.F.R. § 1.106(o) (1969). See also Food and Drug Act, 21 U.S.C. § 321(n) (1964).

tising.⁵¹ The brief summary concept requires a "true statement of information in brief summary relating to side effects, contraindications, and effectiveness" in all prescription drug advertisements except "reminder" advertisements and advertisements of bulk-sale drugs, or drugs used as prescription chemicals or compounding necessities, where no claim is made for the therapeutic safety or effectiveness of the drug.⁵²

In 21 C.F.R. Section 1.105(e)(1), the FDA analogized its distinction of labeling from advertising to that between the intentional torts of slander and libel. It has equated the qualities of labeling to those which determine that matter is libelous rather than slanderous. In short, where promotional and directional information proceeds from a written script, even though thereafter it achieves publication via electronic, mechanical, radio or televisory means, the initial pre-planned writing, typing or printing is considered to be within the scope of the labeling definition of the Act. This is consistent with the agency's earlier attempts to collect and inspect "canned" scripts provided by the manufacturer to detail men whose task it was to commit these scripts to memory and repeat them to their physician contacts.

Although medical or professional detailing is a form of agent representation recognized by the courts,⁵³ it is not defined as labeling or advertising. Scientific observations and testimonials rendered by doctors or other individuals not associated with the manufacturer are also exempt from FDA regulation. However, if the manufacturer should adopt the testimonials or observations, they are treated as an advertising claim rather than merely as an individual opinion.⁵⁴

Other information which may appear includes a description of the dosage form, the quantitative content of the package, its price, and the name and address of the manufacturer or individual introducing it into interstate commerce. Any other graphic, written or printed matter appearing thereon must contain no representation or suggestion concerning claims or directions for usage relating to the advertised drug.

In the case of "reminder ads," the prior rule was that so long as the advertisement was based solely on the prestige of the name of the product or of the manufacturer, and neither made a claim nor directed usage, it was exempt from regulation. Presently, however, the sphere of reminder ads is so restricted that the attractiveness of such ads to the sponsor is limited. Reminder advertisements may contain only the proprietary ("brand" or "trade") name, plus, as required, the established name and quantitative formula as they appear on the label of the drug package. The privilege of reminder ad exemption may be

⁵¹ 21 C.F.R. § 1.105(e) (1970).

⁵² *Id.*

⁵³ *Wechsler v. Hoffman-La Roche, Inc.*, 198 Misc. 540, 99 N.Y.S.2d 588 (1950).

⁵⁴ *United States v. John J. Fulton Co.*, 33 F.2d 506 (9th Cir. 1929).

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withdrawn on notice by the Commissioner if he finds that the drug as used has a propensity for fatalities or serious damage.⁵⁵

In preparing section 1.105, the FDA no doubt felt that in the interest of promulgatory tidiness, the advertising regulation should achieve a symmetry in scope with its labeling antecedent, section 1.106, and, therefore, included bulk-sale drugs. Aside from the doubtful logic, the doubtful authority is manifest. Such drugs and chemicals are advertised in the trade among scientifically knowledgeable people. If a manufacturer or other distributor feels that his process of comminution, solution, or precipitation makes for a more efficient or efficacious product, he and his statements are measured in the marketplace by his peers, and from the vantage point of their knowledge and experience. This is not the disadvantaged general consumer that legislators had in mind when section 502(n) came into being.

The courts have held that advertising copy which is so much at variance with labeling as to be false or misleading in any particular is misbranding the product.⁵⁶ Therefore, paragraphs (3), (4) and (5) contained in the new section 1.105(e) seem to be superfluous. No doubt they would have value as internal memoranda for training personnel involved in the fabrication and screening of prescription drug advertisements. However, outside of the mechanics of identification written into the basic statute and some initial regulation, the most important judgment that must be made by the ad sponsor or regulator is whether in substance and design, in its totality, this prescription drug advertisement seen by an average physician of ordinary prudence would mislead him, intentionally or not, as to its prescription or administration in terms of its safety and usefulness for his patient's needs.

Section 1.105(e)(3) states that untrue or misleading information in any part of an advertisement is not considered cured by providing in another part of the advertisement a brief statement of accurate information concerning side effects, contraindications and the effectiveness of the product. Further, since this paragraph promotes a total view of the advertisement, inadequate qualification or information with regard to any statement or theme requires, at least, concise notice to the effect that some qualification exists, and a prominent reference on each page to the fact that the reader or viewer has available a more complete discussion of such qualification or information elsewhere in the same advertisement.

Section 1.105(e)(5) redundantly assails the concept of brief summary as requiring a fair balance in the presentation of the "pros" and

⁵⁵ See Hoge, *An Appraisal of the New Drug and Cosmetic Legislation*, 6 *Law & Contemp. Prob.* 111 (1941).

⁵⁶ *United States v. Hoxsey Cancer Clinic*, 198 F.2d 273 (5th Cir. 1952).

"cons" of the drug. Imbalance is permissible, however, if by some form of measurement, the brief summary is comparable in depth and detail between such "pros" and "cons." This regulation also repeats the admonition from the labeling regulations that descriptions of the sort required here must relate to the particular advertisement, and not omit material facts required to be revealed.

Section 1.105(e)(6) describes twenty types of prescription drug advertisements which would reveal non-compliance with the regulations by the sponsor.⁶⁷ The patterns describe advertisements that are false, lacking in fair balance, or otherwise misleading or violative of Section 502(n) of the Act. With regard to specific advertisements, however, and upon petition by the manufacturer or sponsor to the FDA for a waiver, the FDA may find that despite any incidental resemblance to the patterns, the advertisement is nonetheless not false,

⁶⁷ An advertisement is in violation of the Act if it:

1. Contains representations that exceed prior approved representations and comparisons related to safety, effectiveness, or breadth of usage;
2. Makes individual drug comparisons in any particular, representing greater safety and effectiveness for the sponsor's drug, without substantial supporting evidence or clinical experience;
3. Contains outdated favorable opinions or information, or references or quotations that are unduly favorable on the basis of available information and experience;
4. Provides a false sense of safety by selective presentation of quotations and references that exclude balancing considerations;
5. Misrepresents a study report to make it appear to be a larger and more general survey than it was;
6. Misrepresents effectiveness by non-disclosure of concomitant therapy or test conditions that indicate merely a placebo effect in human trials;
7. Uses pharmacological findings in animals or in vitro studies and suggests their clinical pertinency;
8. Fails to update authoritative opinions by eminent scientists;
9. Quotes or paraphrases out of context so as to mislead;
10. Uses irrelevant quotations or references;
11. Uses literature, quotations or references for the purpose of recommending usage not included in approved labeling;
12. Broadens the spectrum of a combination drug's use by providing componential descriptions rather than adhering to the suggestions for use of that fixed combination;
13. Uses studies on normal subjects without disclosing same when the drug is not intended for use on normal individuals;
14. Pools data and statistics between unequals, thereby implying larger studies than were actually used;
15. Downgrades, omits, denies or conceals clinical differences;
16. Misrepresents by using the "pharmacological numbers game";
17. Uses data gained at other dosage levels than those indicated or approved for the drug in order to create a favorable impression, rather than merely citing this information in supplemental reports;
18. Uses headlines, subheadlines, pictorial or other graphic matter in a misleading manner;
19. Involves improper extrapolation of claims or indications to other classes of patients and disease conditions;
20. Generalizes semantically regarding side effects and contraindications rather than disclosing specific side effects, unless such general terms are in the approved labeling.

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imbalanced, misleading or noncompliant with section 502(n). Of course, this language is not new. In *United States v. Ninety-Five Barrels Alleged Apple Cider Vinegar*,⁵⁸ the Supreme Court said of the underlying purpose of section 502:

The statute is plain and direct. Its comprehensive terms condemn every statement, design or device which may mislead or deceive. Deception may result from the use of statements not technically false or which may be literally true. The aim of the statute is to prevent that resulting from indirection and ambiguity, as well as from statements which are false.⁵⁹

Section 1.105(e)(6) purports to be definite in its proscriptive details and in equating these with certain instances of non-compliance. Section 1.105(e)(7), however, describes less certain determinations: advertisements that may be false, lacking in fair balance, or otherwise misleading. Indeed, this section adds thirteen possible violations⁶⁰ to the twenty definite violations enumerated in section 1.105(e)(6). Section 1.105(1) also was amended to buttress the FDA's claim to authority and supervision as to advertisements for prescription drugs which (1) appear in published journals, magazines, other periodicals or newspapers, and (2) are broadcast through media such as radio, television, or telephone communication systems.

On the other hand, the labeling provisions of section 502 and the regulations, including those requiring and describing "full disclosure," are deemed to apply to the following where these (a) contain drug

⁵⁸ 265 U.S. 438 (1924).

⁵⁹ *Id.* at 442-43.

⁶⁰ An advertisement may be in violation of § 502 if it:

1. Is based upon favorable information gleaned from poorly fashioned studies;
2. Uses statistical connivance or artifact rather than true clinical evidence;
3. Uses a poor study design and an improper basis for statistical evaluation, thus tailoring figures to yield the desired results;
4. Uses tables and graphs with calculated disorientation to distort and misrepresent relationships, trends or other findings;
5. Evidences incorrect, invalid or inappropriate statistical methodology;
6. Makes pharmacological claims knowingly insufficiently proven without advising any such qualifications;
7. Places insufficient emphasis on side effects and contraindications by repetition and other emphasis of safety and effectiveness;
8. Obscures side effects and contraindications by printing and space techniques;
9. Fails to achieve continuity of advertisement to encourage complete readership when a following page carries the cautionary information;
10. Is meant for a selective class of patients, yet fails to emphasize adequately their dosage range and likely side effects;
11. Fails to state side effects and contraindications with equal prominence on both pages of a two-page spread;
12. In multiple page ads, fails to make prominent reference to those pages containing information on side effects and contraindications;
13. Represents as genuine, information from false or misleading reports.

information, (b) are supplied by the manufacturer, packer, or distributor of the drug, and (c) are disseminated by or on behalf of the foregoing:

1. Brochures, booklets, mailing pieces, product cards, file cards and detailing pieces;
2. Bulletins, calendars, price lists, catalogues;
3. House organs, letters;
4. Motion picture films, film strips, lantern slides;
5. Exhibits, literature and reprints;
6. Sound recordings;
7. Pieces of printed, audio or visual matter descriptive of a drug;
8. Published references (for example, the "Physicians Desk Reference") and physician, nurse and pharmacist product manuals.

Although the amendments themselves were indeed necessary, the problem remains that neither the FDA nor the FTC has enough qualified staff members to carry out the intent of the statute. The agencies will be able to coerce the industry to achieve good advertising and labeling only when they possess adequate staffing, internal and external education and training, and appropriate enforcement techniques. A staff that has the time and resources to call in the representatives of the sponsor and the advertising agency and explain to them why the advertising copy is unacceptable, the graphics potentially false or misleading, the brief summary inadequate or the format undesirable, will rarely need the enforcement weapons of seizure or criminal prosecution. As word of the agency's vigilance and determination spreads, improved ads will probably follow.

B. Regulation of Drug Names

1. Promotion of Trade Names

Regulation of prescription drug advertising begins with regulation of the names used in the promotion or description of a drug. A drug may be known by three different names. Its chemical name is a technical term which simply lists every part of a drug's molecular structure.⁶¹ Its generic or nonproprietary name abbreviates the list of components but still informs a doctor of the drug's chemical composition, from which he can determine its general effect on the body.⁶² Ordinarily a drug will have only one nonproprietary name.⁶³ Finally, a drug may be known by a trade or brand name which identifies the

⁶¹ Weitzman, *Drug, Device, Cosmetic?*, 24 Food Drug Cosm. L.J. 226 (1969).

⁶² *Id.* at 248.

⁶³ A drug may be given more than one generic name, S. Rep. No. 448, 87 Cong., 1st Sess. 223 (1961) [hereinafter cited as Sen. Rep. No. 448]; Kefauver Hearings, *supra* note 37, at 566-68.

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drug as a product of a particular manufacturer, but conveys no information concerning its nature or composition.⁶⁴ Several manufacturers often market the same chemical substance under different proprietary names⁶⁵ which may be trademarked⁶⁶ "as if it were the discovery of each distributor."⁶⁷

According to Senator Kefauver, the purpose of the vast sums spent by the drug industry on promotion was to persuade doctors to prescribe medications by trade name rather than by generic name.⁶⁸ Since the same product sold by trade name may cost several times as much as when sold by generic name,⁶⁹ advertising which planted the brand name firmly in the prescribing doctor's mind left the ultimate consumers "captives of the drug industry."⁷⁰ This promotional effort largely succeeded and, as a result, druggists rarely received prescriptions for a drug under its generic name.⁷¹ Several factors have been suggested to explain the success of this promotional campaign. The generic name was often omitted in drug advertising and labeling.⁷² The trade name was easier to pronounce, spell, and, therefore, to remember, especially since the drug company might intentionally choose awkward generic names.⁷³ In addition, detail men hinted that drugs produced by smaller companies and sold by generic names were of substandard quality.⁷⁴

2. Prescription by Generic Names

To encourage physicians to prescribe drugs by their generic names, Senator Kefauver proposed in S. 1552 that all advertising display a drug's nonproprietary name; that the government be empowered to establish new generic names and revise current ones on the basis of usefulness and simplicity; and that the FDA license all drug manufacturers, requiring them to meet strict quality control standards and open their plants to government inspection.⁷⁵

In opposing the Kefauver proposal, the drug industry contended that only by the unhampered use of trademarks "can a reputable firm

⁶⁴ Kefauver Hearings, *supra* note 37, at 327-28.

⁶⁵ E.g., Miltown and Equanil are trade names for meprobamate, which is the generic name for 2-methyl-2n-propyl-1, 3-propane-diol dicarbamate. See M. Mintz, *supra* note 25, at 340 n.1.

⁶⁶ Note, *The Drug Amendments of 1962*, 38 N.Y.U. L. Rev. 1082, 1116, n.269 (1963).

⁶⁷ May, *Selling Drugs by "Educating" Physicians*, 36 J. Med. Educ. 1, 4 (1961).

⁶⁸ See generally S. Rep. No. 448 at 105, 231-44; 107 Cong. Rec. 5638 (1961).

⁶⁹ Kefauver Hearings, *supra* note 37, at 5.

⁷⁰ *Id.*

⁷¹ See R. Harris, *supra* note 23, at 30; M. Mintz, *supra* note 25, at 340.

⁷² S. Rep. No. 448 at 231-34; 108 Cong. Rec. 16307 (1962).

⁷³ *Id.* at 233; R. Harris, *supra* note 23, at 126.

⁷⁴ Kefauver Hearings, *supra* note 37, at 5.

⁷⁵ S. 1552, 87 Cong., 1st Sess. § 4(a)(7), (13) (1961).

identify itself with its own quality products behind which stand the reputation, the careful manufacturing procedures and quality controls, and the sense of responsibility of the firm!"⁷⁶ The trademark provides the best assurance that the patient will receive exactly what the physician prescribed since equality of experience, reliability, and integrity among all companies cannot be legislated.⁷⁷ The Eastland-Dirksen version of S. 1552 adopted the drug industry's concern with trademark protection⁷⁸ and thus weakened Kefauver's envisioned statutory scheme. It required⁷⁹ an official name to be shown on labels only; did not provide guidelines for revising generic names; merely required manufacturers to file their names and addresses; and set vague standards for inspections every two years.⁸⁰

As enacted, however, the 1962 Amendments adopted neither the Kefauver nor the Eastland-Dirksen version of S. 1552. Instead, the Amendments require that a drug's "established name" appear on each advertisement⁸¹ and on all labeling.⁸² The established name is the only nonproprietary name other than the chemical name or formula that can be used to designate a drug or ingredient. It is defined as the official name designated by the FDA⁸³ under Section 508(a)⁸⁴ of the Act; or if none, its official name as given in an official compendium;⁸⁵ or if none, its common or usual name. The FDA may designate an official name if it finds: (1) that a drug's present name is not simple or useful; (2) that a drug has two or more official names; (3) that two or more substantially identical drugs have different names; or (4) that a drug has no official name.⁸⁶ Finally, the Amendments guarantee drug quality by imposing certain safeguards over manufacturing, including registration and inspection.⁸⁷

⁷⁶ Connor, *Functions of the Pharmaceutical Industry in Our Society*, *Drugs in Our Society* 129 (Talaly ed. 1964).

⁷⁷ *Id.* at 130.

⁷⁸ 108 Cong. Rec. 10108 (1962).

⁷⁹ S. 1744, 87 Cong., 2d Sess. §§ 3(a), 4, 9, 10 (1962).

⁸⁰ R. Harris, *The Real Voice* 165 (1964).

⁸¹ Food and Drug Act, 21 U.S.C. § 352(n) (1964). The regulations indicate, however, that the established name need not appear if the advertisement does not contain the drug's proprietary name. 21 C.F.R. § 1.105(b)(1) (1969).

⁸² Food and Drug Act, 21 U.S.C. § 352(e)(1) (1964).

⁸³ Food and Drug Act, 21 U.S.C. § 352(e)(2) (1964).

⁸⁴ Food and Drug Act, 21 U.S.C. § 358(a) (1964).

⁸⁵ The term "official compendium" means the United States Pharmacopoeia, the Homoeopathic Pharmacopoeia, or the National Formulary. Food and Drug Act, 21 U.S.C. § 321(j) (1964).

⁸⁶ Food and Drug Act, 21 U.S.C. § 358(c) (1964).

⁸⁷ Registration: Food and Drug Act, 21 U.S.C. §§ 331(p), 352(o), 360 (1964). Inspection: Food and Drug Act, 21 U.S.C. § 374 (1964). Control: Food and Drug Act, 21 U.S.C. § 351(a) (1964). See Giumarra, *Drug Amendments of 1962—Generic-Name Prescribing: Drug Price Panacea?*, 16 *Stan. L. Rev.* 649, 650 n.15 (1964); Council on Drugs of the American Medical Association Conference, 207 *J.A.M.A.* 1335 (1969).

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3. *Placement of Established Names*

Regulations issued under the 1962 Amendments require advertisements to carry the established name of any drug ingredient for which a proprietary name is given.⁸⁸ The established name of a drug or ingredient must be placed in "direct" conjunction with its proprietary name,⁸⁹ but not, as originally proposed,⁹⁰ in "immediate" conjunction. The change allows manufacturers to place copyright symbols and trademarks between the two names.⁹¹ To alert doctors to the exact relationship between the two designations, the established name must be surrounded by brackets or preceded by the phrase "brand of" or a similar term.⁹²

A drug which combines two or more active ingredients may not have an established name. In that case, the quantitative ingredient information which must appear in the advertisement⁹³ performs the function of calling the doctor's attention to the chemical composition of the drug. This information must be placed in direct conjunction with the most prominent display of the trade name.⁹⁴ If a combination of active ingredients present in more than one preparation has no established name, a list of the generic names of the active ingredients must similarly be placed in direct conjunction with the most prominent display of the brand name, preceded by a phrase such as "brand of."⁹⁵

4. *Prominence of Established Names*

In addition to demanding disclosure of the generic name, Senator Kefauver proposed that a drug's generic name be "printed in type at least as large and as prominent as that used for any trade or brand name. . . ."⁹⁶ This standard went beyond that then imposed by the AMA on advertisements in its scientific publications:

The full generic name . . . of each active ingredient must be shown in appropriate type size. If the generic name of a drug appears in close juxtaposition to the trade name, it should not be unduly subordinated and under no circumstances appear in less than 10 point type.⁹⁷

⁸⁸ 21 C.F.R. § 1.105(b)(1) (1969).

⁸⁹ *Id.*

⁹⁰ 28 Fed. Reg. 1448-449 (1963).

⁹¹ Note, The Drug Amendments of 1962, 38 N.Y.U. L. Rev. 1082, 1118 (1963).

⁹² 21 C.F.R. § 1.105(b)(1) (1969).

⁹³ See text at notes 170-81 *infra*.

⁹⁴ 21 C.F.R. § 1.105(c) (1969).

⁹⁵ 21 C.F.R. § 1.105(d)(1) (1969).

⁹⁶ S. 1552, 87 Cong., 1st Sess. § 4(a)(4), (a)(7) (1961). Drug advertisements which did carry the generic name sometimes printed it in type so small that it could be read only with a magnifying glass. 108 Cong. Rec. 17369 (1962) (remarks of Senator Kefauver).

⁹⁷ Advertising in the AMA Scientific Publications, 172 J.A.M.A. 453 (1960).

The Eastland-Dirksen version of S. 1552, as reported out by the Senate Judiciary Committee, required only that the drug's official name on the label be printed to comply with Section 502(c) of the 1938 Act,⁹⁸ which directs that statements on labels and labeling be "prominently placed thereon with such conspicuousness . . . and in such terms as to render it likely to be read and understood by the ordinary individual under customary conditions of purchase and use."⁹⁹ Dissatisfied with the committee report, President Kennedy suggested adoption of Section 112 of the Administration's House drug bill¹⁰⁰ which contained the present standards for type size and prominence.¹⁰¹ It also included a requirement, which was never passed in either the House or the Senate, that the generic name on the label be given "precedence in position."¹⁰²

The statute, in its final form, requires that the established name be at least one-half as large as the trade name. However, the use of bolder or thicker type, or of a different color or background for the trade name might obscure the generic name. To insure that the generic name will not go unnoticed even in a quick reading of an ad, the regulations prescribe that the established name shall "have a prominence commensurate with the prominence with which such proprietary name or designation appears. . . ."¹⁰³ In deciding whether this subjective test has been met, the advertiser or FDA reviewer must consider "all pertinent factors, including typography, layout, contrast, and other printing features."¹⁰⁴ For combination drugs lacking a generic name, the prominence of the substitute quantitative ingredient information "shall bear a reasonable relationship to the prominence of the proprietary name."¹⁰⁵ A similar test applies for the prominence of the list of active ingredients required for drugs which combine active ingredients present in more than one combination and which lack established names.¹⁰⁶

5. *The Every-Time Controversy*

In early 1963, the Food and Drug Administration issued regulations requiring that the established name of a prescription drug accompany every appearance of the drug's trade name on all labeling¹⁰⁷ and advertising¹⁰⁸ no matter how many times the brand name is repeated

⁹⁸ S. 1744, 87th Cong., 2d Sess. § 6 (1962).

⁹⁹ Food and Drug Act, 21 U.S.C. § 352(c) (1964).

¹⁰⁰ H.R. 11581, 87th Cong., 2d Sess. § 112 (1962).

¹⁰¹ See text at notes 81-82 *supra*.

¹⁰² H.R. 11581, 87th Cong., 2d Sess. § 112 (1962).

¹⁰³ 21 C.F.R. § 1.105(b)(2) (1969).

¹⁰⁴ Giumarra, *supra* note 87, at 659-60 incorrectly states that this regulation does not exist.

¹⁰⁵ 21 C.F.R. § 1.105(c) (1969).

¹⁰⁶ 21 C.F.R. § 1.105(d)(1) (1969).

¹⁰⁷ 21 C.F.R. § 1.104(g)(1) (1969).

¹⁰⁸ 21 C.F.R. § 1.105(b)(1) (1969).

on any single page. The FDA contends that the "every-time" regulations are crucial to the 1962 Amendments since they carry out the "evident intent" of Congress to popularize established names.¹⁰⁹ Arguing that the statute dictates only the manner in which the generic name must appear, and not its frequency,¹¹⁰ the Pharmaceutical Manufacturers Association (P.M.A.)¹¹¹ and 37 of its members sought a declaratory judgment in the United States District Court for Delaware invalidating the regulations as exceeding the FDA's statutory authority.

This suit marked the first legal challenge to FDA regulations since the 1938 Act.¹¹² The drug industry's concern extended beyond the estimated million-dollar cost¹¹³ of reprinting its existing labels to comply with the every-time requirement. The regulations struck at the purpose of drug promotion—the implantation of trade names in the doctor's mind.¹¹⁴ They sought to lower drug prices by educating physicians to prescribe by generic names. The industry feared, however, that increased familiarity with nonproprietary names would endanger its investment in brand names and in research for new and better products,¹¹⁵ little of which is undertaken by smaller, generic-name producers.¹¹⁶ Conspicuous disclosure of the generic name, to which the industry did not object, would apprise the physician of the drug's active ingredients. He could then choose among the various sources which produce the same or comparable chemical substances at different prices. Constant repetition of the established name, on the other hand, would make advertising and labeling less readable, to the detriment of patients who would be served by new drugs. Finally, the industry complained that the regulations would induce doctors to believe that drugs with the same established name are always and in all respects identical, when in fact, drugs with the same generic name but different proprietary names can and do differ in their therapeutic effect.

The plaintiffs attacked the regulations by focusing on the statutory

¹⁰⁹ Motion for Summary Judgment at 31, *Abbott Labs. v. Celebrezze*, 228 F. Supp. 855 (D. Del. 1964).

¹¹⁰ Brief for Appellees at 40, 42, *Abbott Labs. v. Celebrezze*, 352 F.2d 286 (3rd Cir. 1965).

¹¹¹ The P.M.A. is a trade association of approximately 140 manufacturers of prescription drugs.

¹¹² The legislative counsel for the P.M.A. stated that the two suits against the FDA are not part of a continuing FDA-industry war, nor do they show any animosity toward government regulation. Instead, the suits challenge regulations which the industry feels exceed the scope of the FDA's statutory authority. Kelly, *Three Years Later*, 21 *Food Drug Cosm. L.J.* 21, 23-24 (1966).

¹¹³ Worley, *Problems of Compliance With the Drug Amendments of 1962*, 19 *Bus. Law.* 218-19 (1963).

¹¹⁴ S. Rep. No. 448 at 105, 231-44 (1961).

¹¹⁵ *Business Week*, Sept. 14, 1963, at 60.

¹¹⁶ Buatti, *An Appraisal of Progress in Drug Marketing*, 21 *Food Drug Cosm. L.J.* 33, 36-37 (1966).

language and on the tortured¹¹⁷ legislative history of the 1962 Amendments. Section 502(n) requires that all advertisements include "a true statement of . . . the established name . . . printed prominently and in type at least half as large as that used for any trade or brand name thereof . . ."¹¹⁸ The language of section 502(e),¹¹⁹ which applies to labels and labeling, is similar. Use of the word "any," however, makes the provision ambiguous. Plaintiffs urged that if the proprietary name is mentioned four times on a piece of promotional material, the type size of the established name "must be half as large as that used for 'any' mention of the proprietary name."¹²⁰ In this event, the type size would have to be half as large as the largest type used in mentioning the proprietary name. Even if "any" were read as "all," the statute would demand only that "the established name's type size must be half as large as that used for all four mentions of the proprietary name."¹²¹ "Any" would also "cover the case where two or more different proprietary names appear in a single promotional piece."¹²²

Furthermore, plaintiffs suggested that if Congress had intended the every-time requirement, the "prominently" requirement in the statute is superfluous.¹²³ To the FDA's argument that "prominently" would still have content by preventing the established name from being printed in type "as small as 4 point,"¹²⁴ the drug companies responded that the statutory command that the established name appear in type half as large as the trade name "effectively eliminates this possibility, for no manufacturer will out of self-interest underplay the brand name of his product."¹²⁵

The Food and Drug Administration stressed two items in the legislative history of section 502(e). The Senate Judiciary Committee Report on S. 1552¹²⁶ states that section 502(e) "would . . . require that on labels and on any labeling, wherever a trade or brand name is used, the established name . . . must be shown in type at least one-half as large as that used for the trade or brand name."¹²⁷ Plaintiffs

¹¹⁷ "Those in the future who attempt to study the legislative history of this measure as it passed through its various stages may be forgiven if they become somewhat confused." 108 Cong. Rec. 22037 (1962) (remarks of Senator Kefauver).

¹¹⁸ Food and Drug Act, 21 U.S.C. § 352(n) (1964).

¹¹⁹ Food and Drug Act, 21 U.S.C. § 352(e) (1964).

¹²⁰ Brief for Appellees, *supra* note 110, at 30.

¹²¹ Brief for Plaintiffs at 16, *Abbott Labs. v. Celebrezze*, 228 F. Supp. 855, 856.

¹²² Brief for Appellees, *supra* note 110, at 30.

¹²³ Brief for Appellees, *supra* note 110, at 30-31. This argument was successful in the district court. *Abbott Labs. v. Celebrezze*, 228 F. Supp. 855, 864 (D. Del. 1964).

¹²⁴ Brief for Appellants at 45, *Abbott Labs. v. Celebrezze*, 352 F.2d 286 (3d Cir. 1965).

¹²⁵ Brief for Appellees, *supra* note 110, at 31 n.30.

¹²⁶ S. Rep. No. 1744, pt. 2, 87th Cong., 2d Sess. (1962).

¹²⁷ *Id.* at 8.

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countered that "wherever" does not mean "every time;" rather, it means "if."¹²⁸ They said that this reading finds support in a statement made by Senator Eastland, Chairman of the Senate Subcommittee: "On the label, and on any labeling on which the drug . . . is named, if a trade name is used for the drug . . . , the established name of the drug . . . must be shown in type at least half the size of the type used for the trade name."¹²⁹ The interpretation of the word "wherever" was important because that word was admittedly the only indication in the Senate report that Congress intended an every-time requirement.¹³⁰

Second, the FDA pointed to the rejection of the "O'Brien Amendment." During debate on the Harris bill,¹⁸¹ the House unanimously adopted an amendment offered by Representative O'Brien, providing that in the case of labeling, the established name must be printed prominently and in half-size type "at the first place, and at the most conspicuous place if other than the first place, at which such proprietary name for such drug . . . is used. . . ."¹⁸² A House conference eliminated this provision,¹⁸³ which Senator Kefauver viewed as a limitation upon the frequency with which the established name should appear.

This limitation was not accepted by the conferees. Thus the established name of a prescription drug must appear in type at least half as large as the trade name wherever the latter is used in drug promotional matter, including package inserts, and so forth.¹⁸⁴

Disregarding Senator Kefauver's statement as self-serving, the plaintiffs argued that the rejection of the O'Brien Amendment did not make the every-time requirement imperative. Rather, the rejection "could mean, at most, that the one or two mentions of the established name specified in the O'Brien Amendment were not necessarily sufficient. . . ."¹⁸⁵

In oral argument, drug industry counsel suggested that the O'Brien Amendment strengthened the previous (and final) statutory provision. Counsel conceded that defining "prominence" was within

¹²⁸ Brief for Appellees, *supra* note 110, at 34-35.

¹²⁹ 108 Cong. Rec. 17366-7367 (1962) (remarks of Senator Eastland).

¹³⁰ The following colloquy occurred during oral argument before the district court:

"The Court: Is there anything in the report where it says, 'we intend that every time the brand name is used the generic or established name shall follow'?"

"Mr. Goodrich, counsel for defendants: Only the word 'wherever'."

Joint Appendix at 25a, *Abbott Labs. v. Celebrezze*, 352 F.2d 286 (3d Cir. 1965).

¹⁸¹ H.R. 11581, 87th Cong., 2d Sess. (1962).

¹⁸² 108 Cong. Rec. 21081 (1962).

¹⁸³ H.R. Rep. No. 2526, 87th Cong., 2d Sess. 23-24 (1962).

¹⁸⁴ 108 Cong. Rec. 22039 (1962) (remarks of Senator Kefauver).

¹⁸⁵ Brief for Appellees, *supra* note 110, at 36-37.

the FDA's authority,¹³⁶ and that the generic name should perhaps appear once per page on multi-page matter, and at the title of a publication if the trade name were used there.¹³⁷ But constant repetition of the generic name, besides detracting from the individuality of drug products, would be unnecessary and confusing, and would tend to discourage doctors from reading advertisements.¹³⁸ Finally, plaintiffs convinced the district court judge that their interpretation of the elimination of the O'Brien Amendment was correct.¹³⁹ Invalidating the regulations, the court said:

First, it is not clear that Kefauver's characterization of the O'Brien amendment as a limitation is accurate. Second Kefauver's term "wherever" is not free from ambiguity. It could mean that the generic name must appear each time the trade name is mentioned. On the other hand, it could mean that the generic name must appear on a label or brochure or medicine box wherever the trade name is used. Apparently Kefauver favored the every time requirement. But nowhere in the legislative history is there evidence to show that other members of the Congress favored the every-time requirement or that they were aware that "prominently" should have a special meaning.

The views of Senator Kefauver, in this instance, cannot override what the court believes is the general Congressional intent. This is especially true since the expression of those views are circumscribed and open to doubt.

If Congress had meant that the generic name should appear with every mention of the trade name, it could have said so. It has not. It has said only that the generic name must appear prominently. The statute will not bear the interpretation which the defendants have put upon it.¹⁴⁰

The Court of Appeals for the Third Circuit reversed on procedural grounds, holding that there was no "actual case or controversy" as

¹³⁶ See Joint Appendix, *supra* note 130, at 31a.

¹³⁷ *Id.* at 41a. The drug industry has also suggested twice per page (at the top and bottom). Note, Drug Amendments of 1962: How Much Regulation?, 18 Rutgers L. Rev. 101, 126 (1963).

¹³⁸ Counsel for plaintiffs compared the constant repetition of generic names in advertising to listing all of the parties whenever the terms "plaintiffs" or "defendants" are used in a brief, "so you (the court) are sure you know what I am talking about."

"The Court: I might not have read your brief."

"Mr. Gesell (counsel for plaintiffs): I think you might not. And I think the doctor may not read that (advertising)."

Joint Appendix, *supra* note 130, at 32a.

¹³⁹ See Joint Appendix, *supra* note 130, at 34a.

¹⁴⁰ *Abbott Labs. v. Celebrezze*, 228 F. Supp. 855, 864 (D. Del. 1964).

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required for justiciability under the Declaratory Judgment Act because no real threat of immediate prosecution had been presented.¹⁴¹ The Supreme Court reversed the decision of the court of appeals finding that "the impact of the regulations . . . is sufficiently direct and immediate so as to render the issue appropriate for judicial review at this stage,"¹⁴² and remanded the case to the court of appeals for a decision on the substantive issues.

On the day set for further argument in the Third Circuit, the FDA and the drug manufacturers announced settlement of the litigation. The FDA agreed to replace the contested every-time rules with new regulations. On any page of advertising or labeling which "features" a drug's trade name, the generic name must appear "in direct conjunction with" and in type half as large as the brand name each time the latter is featured, but need not appear again in promotional copy on the same page. If a trade name is used but not "featured," the generic name must appear at least once with the most prominent display of the trade name. In addition, each column of text providing detailed information on effectiveness or side effects must include the generic name at least once "in association with" the trade name, if used, in the same size type as that used for the text. If the trade name appears in a type size larger than that used for the column text, the generic name must again be half as large as the trade name.¹⁴³

In light of recent congressional hearings regarding prescription by generic name,¹⁴⁴ however, the FDA need not insist vigorously on educating doctors to use generic name drugs, so long as the generic name is prominently disclosed in drug advertising. In fact, a survey of ads in the journals shows that, contrary to FDA regulations, the generic name type face does not always appear half as bold or half as wide as that used for the trade name. In many cases, the generic name is not preceded by a phrase such as "brand of" nor surrounded by brackets or parenthesis. While the new rules may lead to new controversies over their exact interpretation, they appear to be a reasonable compromise. Commentators have split on the question of whether the now withdrawn every-time regulations were consonant with the Congressional purpose.¹⁴⁵ Ambiguity in the statutory provision on generic names and in its legislative history probably indicate that Congress had no intent on the question of frequency. The AMA, which generally supports the industry against the FDA, urges doctors to prescribe by

¹⁴¹ *Abbott Labs. v. Celebrezze*, 352 F.2d 286 (3rd Cir. 1965).

¹⁴² *Abbott Labs. v. Gardner*, 387 U.S. 136, 152 (1967).

¹⁴³ 21 C.F.R. § 1.105 (1969). See also 33 Fed. Reg. 3217-218 (1968).

¹⁴⁴ Hearings on Competitive Problems in the Drug Industry Before the Monopoly Subcomm. of the Senate Select Comm. on Small Business, 90th Cong., 1st Sess. (1967).

¹⁴⁵ Sweeney, *The Generic Every Time Case: Prescription Drug Industry in Extremis*, 21 Food Drug Cosm. L.J. 226 (1966).

trade name,¹⁴⁶ but to use generic names in teaching or communicating with other physicians; or where prescribing by generic name, to provide the name of a reliable manufacturer whose product could fill the prescription. Since the stated purpose of this practice is to insure the quality and potency of the prescribed drug, the AMA evidently does not think that the 1962 Amendments are fully effective. In light of this opposition, should the FDA insist on attempting to educate doctors to use generic name drugs and to think of drugs with the same generic name as equivalent, or should the FDA merely insure that the established name is prominently disclosed, leaving the medical schools to carry the burden of teaching doctors to use generic names? Contrary to industry contentions, advertisements which now comply with the every-time requirement are readable and attractive. In fact, if these companies have not noted any dilution of their trademarks, perhaps the scales should tip in favor of the FDA.

6. *Additional Requirements*

Since the regulations do not require that the established names of the ingredients of a drug lacking a generic name be printed in type half as large as that used for the drug's trade name, the names of ingredients often appear in small type. Since an ingredient (such as the ingredient estrogen in birth control pills) may have considerable side effects and contraindications, the FDA should enforce its regulations requiring that the prominence of the quantitative ingredient information or the generic names of active ingredients bear "a reasonable relationship to the prominence of the proprietary name."¹⁴⁷

If no established name exists for an active ingredient of a new drug, the New Drug Application must propose a nonproprietary name¹⁴⁸ so that one may be adopted before the drug becomes available commercially. The FDA requires that the name not conflict with other nonproprietary names or trademarks;¹⁴⁹ that it be simple and useful, and not misleading or confusing; and that it show the relationship between the drug and chemically and pharmacologically related drugs. The AMA, FDA, United States Pharmacopeia, and the National Formulary assist manufacturers in selecting a nonproprietary name,¹⁵⁰ which becomes the drug's established name when accepted by an official compendium, under FDA order, or by common usage.¹⁵¹ These four

¹⁴⁶ See generally Council on Drugs of the American Medical Association Conference, 207 J.A.M.A. 1335 (1969) [hereinafter cited as Council on Drugs].

¹⁴⁷ 21 C.F.R. § 1.105(c), (d)(1) (1969).

¹⁴⁸ 21 C.F.R. § 130.4(c), Form FD-356 § 6(d) (1969).

¹⁴⁹ CCH F. D. Cosm. L. Rep. ¶ 80,020 (1963).

¹⁵⁰ Id. at ¶ 80,011.

¹⁵¹ Id. at ¶ 80,020; see Food and Drug Act, 21 U.S.C. § 352 (1964).

organizations submit names for new antibiotics to the World Health Organization, the British Pharmacopeia Commission, the French Codex Commission, and the Nordic Pharmacopoeia Council.¹⁵² The FDA has stated that it hopes to issue only a minimum number of regulations establishing generic names.¹⁵³

If a drug or ingredient is a common substance the limitations of which would be readily recognized under the drug's established name, prescription drug advertisements may not employ a "fanciful" trade name for the drug or ingredient in a manner that implies some unique effectiveness.¹⁵⁴ Nor may an advertisement designate a drug or ingredient by a trade name which, because of similarity in spelling or pronunciation, may be confused with the trade or established name of a different drug or ingredient.¹⁵⁵

7. *Current Proposals*

FDA supervision of drug safety and consumer deception has become so comprehensive that there remain very few areas where it can be increased without completely subjecting the industry to administrative fiat. However, an example of a proposal which would give them even more power was adverted to by the Task Force on Prescription Drugs in its Second Interim Report. The Task Force recommended, among other things, that the Secretary of Health, Education and Welfare call one or more conferences to consider "development of a registration and licensing system under which no drug product would be permitted in interstate commerce unless produced under quality control standards set by the Secretary of Health, Education and Welfare."¹⁵⁶

Former Secretary Cohen, in testifying at the FTC's hearings on consumer protection in November, 1968, advocated that producers of over-the-counter drugs be required to submit records and reports of product performance to the Department of Health, Education and Welfare. He also supported requirements that drugs in tablet or capsule form bear numbers identifying the drug and its manufacturer, and that the label of a prescription drug bear the generic name of the drug and the name of the manufacturer. Whether the FTC or Secretary Richardson will support the proposal is in doubt. Mr. Cohen's proposal, in regard to prescription drug labels, went a bit further than

¹⁵² Council on Drugs, *supra* note 146, at 1352.

¹⁵³ CCH F. D. Cosm. L. Rep. ¶ 80,020 at 80,092.

¹⁵⁴ 21 C.F.R. § 1.105(a)(3) (1969).

¹⁵⁵ 21 C.F.R. § 1.105(a)(5) (1969).

¹⁵⁶ Task Force on Prescription Drugs, Report and Recommendations, Subcomm. on Monopoly, Senate Select Small Bus. Comm., 90th Cong., 2d Sess. 19-20 (1968).

that of the Task Force on Prescription Drugs which had recommended that:

The Congress should enact legislation requiring that the containers of all dispensed prescription drugs be labeled with the identity, strength and quantity of the product, except where this is waived upon specific orders of the prescriber.¹⁵⁷

Indeed, in a recent session of Congress a bill to this effect was introduced.¹⁵⁸ In commenting on the Task Force Report, the P. M. A. endorsed this proposal and suggested that it be broadened to require the label of dispensed prescription drugs to bear not only the name by which the drug was prescribed, but also the name of the manufacturer or distributor and the lot and control numbers.¹⁵⁹ The argument in favor of identifying a prescription drug on the label is based on safety: a user of prescription drugs, should he require medical treatment from a physician other than the prescriber, should be able to inform him accurately and without delay of the nature of the medication he is taking.

It is in the area of drug economics, however, that most of the legislative fireworks will occur in future sessions of Congress. Senator Kefauver, almost 12 years ago, called for an assault on what he termed the high price of drugs. For example, according to the United States Bureau of Labor Statistics, the cost of prescription drugs for the last five years has risen approximately 15 percent. Today, the political appeal of attacking the high prices paid for drugs by the consumer is enhanced by the ever-increasing involvement of government, at all levels, in progressively more expensive medical programs.

Drug patents and trademarks were the target of several witnesses before Senator Nelson's Monopoly Sub-Committee in 1969.¹⁶⁰ These witnesses contended that the restriction or even elimination of these industrial properties would encourage price competition. However, no legislation in this area is likely until completion of the study called for by the Task Force on Prescription Drugs. Whether the study will include presentations by non-governmental organizations is not clear. However, it is indeed ominous that the Task Force recommended conferences with representatives of the drug industry, pharmacy, clinical medicine and consumer groups to consider the proposal of federally

¹⁵⁷ *Id.* at 42.

¹⁵⁸ S. 3290, 90th Cong., 2d Sess. (1968).

¹⁵⁹ Critique of the Report and Recommendations of the Task Force on Prescription Drugs 57.

¹⁶⁰ For example, Testimony of Dr. Leonard G. Schefflin, Hearings Before the Subcomm. on Monopoly, Senate Select Comm. on Small Bus., 90th Cong., 1st & 2nd Sess., pt. 5, at 1862 et seq; Testimony of Dr. Henry Steele, *Id.* at 1901 et seq.

mandated quality control standards, but called only for a study by federal agencies of the revision of patent and trademark law.

In the First Session of the 90th Congress, a Senate-House conference deleted from the Social Security amendment a bill which would have established a United States formulary of generically identified drugs,¹⁶¹ together with price ranges for such drugs. The price ranges set out would determine federal payments for drugs dispensed under Medicare and state Medicaid programs. The conference did adopt a substitute clause calling for a study by the Secretary of Health, Education and Welfare of the quality and cost standards of drugs for which payments are made under the Social Security Act.¹⁶² Shortly before the conference's action, a proposal to add prescription drugs to the benefits available under the voluntary coverage provisions of Medicare Plan B had been defeated in committee.¹⁶³ That bill also contained provisions for a drug formulary with price information. Senator Nelson, still embroiled in his hearings, introduced a bill to amend the Food, Drug and Cosmetic Act to provide for a federal drug compendium of prescription drugs by their generic names.¹⁶⁴ This compendium would include price information.

C. Quantitative Ingredient Information

Every prescription drug advertisement must contain "a true statement of . . . the formula showing quantitatively each ingredient of such drug to the extent required for labels under Sec. 502(e). . . ."¹⁶⁵ The regulations likewise require that "the information presented in the advertisement concerning the quantity of each such ingredient shall be the same as the corresponding information on the label of the product."¹⁶⁶ The term "ingredient" applies to any substance in the drug, whether added to the formulation as a single substance or in a mixture with other substances.¹⁶⁷ Although section 502(n)¹⁶⁸ refers to "each ingredient," the cross-references to 502(e)¹⁶⁹ evidently indicate that the quantity must be given for each active ingredient, and the quantity or proportion of certain named ingredients (whether active or not), but not for other ingredients. But the advertisement may not feature inert or inactive ingredients "in a manner that creates an

¹⁶¹ H.R. 12080, 90th Cong., 1st Sess. (1967).

¹⁶² S. Amend. 142, 90th Cong., 1st Sess. (1967).

¹⁶³ S. Rep. 17, 90th Cong., 1st Sess. (1967).

¹⁶⁴ S. Rep. 2944, 90th Cong., 2d Sess. (1968). The Senator has reintroduced this legislation, S. 950, 91st Cong., 1st Sess. (1969).

¹⁶⁵ Food and Drug Act, 21 U.S.C. § 352(n) (1964).

¹⁶⁶ 21 C.F.R. § 1.105(a)(2) (1969).

¹⁶⁷ 21 C.F.R. § 1.104(b) (1969).

¹⁶⁸ Food and Drug Act, 21 U.S.C. § 352(n) (1964).

¹⁶⁹ Food and Drug Act, 21 U.S.C. § 352(e) (1964).

impression of value greater than their true functional role in the formulation."¹⁷⁰

The required statement of quantity should be given per dosage unit if the drug is in tablet, capsule, or other dosage form. If not, the amount of the ingredient must be expressed in a specified unit of weight or measure of the drug, or the percentage of such ingredient in the drug.¹⁷¹ In both cases, the statement of quantity must be made in terms informative to doctors.¹⁷² The order of listing or the relative prominence otherwise given the ingredient names in the ad may not be misleading.¹⁷³ All of the required ingredient information must appear together, without any intervening printed matter, except for the proprietary names of ingredients, which may be included with the listing of established names.¹⁷⁴ In addition, the quantitative ingredient information must appear "in direct conjunction" with the display of the name of at least one specific dosage form, which in turn must appear "prominently."¹⁷⁵ If other dosage forms are listed, the quantitative ingredient information for such dosage forms "shall appear in direct conjunction and in equal prominence with the most prominent listing of the names of such dosage forms."¹⁷⁶

PART II. PRESCRIPTION DRUG LABELING

Regulations governing prescription drug labeling are scattered among the several subsections of Section 501 of the Food and Drug Act.¹⁷⁷ They range from a broad ban against false and misleading labeling¹⁷⁸ to the rule that decimal fractions expressing the quantity of a drug shall not be carried out to more than three places.¹⁷⁹ The most comprehensive list of labeling regulations issued to date exempts¹⁸⁰ prescription drugs from the requirement that labeling include adequate directions for use.¹⁸¹ In effect, however, the "exemption" defines either directly or by cross-reference much of the information that must be disclosed for all prescription drugs, except those for which adequate use directions are commonly known.¹⁸² These "full disclosure" regula-

¹⁷⁰ 21 C.F.R. § 1.105(a)(4) (1969).

¹⁷¹ 21 C.F.R. § 1.104(d) (1969). The required percentage is specified in the regulations.

¹⁷² *Id.*

¹⁷³ 21 C.F.R. §§ 1.105(a)(2), 1.104(c)(1) (1969).

¹⁷⁴ 21 C.F.R. § 1.105(a)(1) (1969).

¹⁷⁵ 21 C.F.R. § 1.105(d)(2) (1969).

¹⁷⁶ *Id.*

¹⁷⁷ 52 Stat. 1050 (1938), as amended 76 Stat. 790-92 (1962), 21 U.S.C. § 352 (1964).

¹⁷⁸ Food and Drug Act, 21 U.S.C. § 352(a) (1964).

¹⁷⁹ 21 C.F.R. § 1.102(g) (1969).

¹⁸⁰ 21 C.F.R. § 1.106(b) (1969).

¹⁸¹ Food and Drug Act, 21 U.S.C. § 352(f) (1964).

¹⁸² 21 C.F.R. § 1.106(b)(3)(ii), (h) (1969).

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tions require that certain information appear on the label, which is defined as any written matter carried on the drug's immediate container, or on other labeling.¹⁸³ Furthermore, labeling on or within the drug's package must recite all of the information, including side effects and contraindications, which appears in all promotional labeling. Any information required to appear on the label must also appear on the outside container or wrapper of the retail package or be easily legible through it.¹⁸⁴

A. Regulation of Names

The FDA exercises control over drug names used in labeling much the same as it does over those used in advertising. Any labeling on which a trade name appears must include the corresponding established name for the drug.¹⁸⁵ The established name must be placed in direct conjunction with the proprietary name, either surrounded by brackets or preceded by a phrase such as "brand of."¹⁸⁶ It must be printed in letters at least half as large as those used for the brand name, and must have a prominence commensurate with the prominence of the trade name, "taking into account all pertinent factors, including typography, layout, contrast, and other printing features."¹⁸⁷ The every-time requirement for labeling¹⁸⁸ was suspended during the previously mentioned litigation. If an established name does not reveal that an ingredient is a derivative of certain parent substances specifically named in the Act, the labeling must do so.¹⁸⁹ Where a combination drug lacks an established name, the required quantitative ingredient information must "be placed in direct conjunction with the most prominent display of the proprietary name," and its prominence "shall bear a reasonable relationship to the prominence of the proprietary name."¹⁹⁰

B. Quantitative Ingredient Information

The labels of prescription drugs must bear a statement of the quantity of all active ingredients and certain listed ingredients whether active or not.¹⁹¹ This information must be expressed per dosage unit if the drug is sold in dosage-unit form or, if not, per specified unit of

¹⁸³ Food and Drug Act, 21 U.S.C. § 321(k) (1964).

¹⁸⁴ Food and Drug Act, 21 U.S.C. § 321(1) (1964).

¹⁸⁵ Food and Drug Act, 21 U.S.C. § 352(e) (1964).

¹⁸⁶ 21 C.F.R. § 1.104(g)(1) (1969).

¹⁸⁷ 21 C.F.R. § 1.104(g)(2) (1969).

¹⁸⁸ 21 C.F.R. § 1.104(g)(1) (1969).

¹⁸⁹ 21 C.F.R. § 1.104(f) (1969). A derivative of a substance named in Food and Drug Act, 21 U.S.C. § 352(e), is an article derived or prepared from such substance by any method, including actual or theoretical chemical action. 21 C.F.R. § 1.104(e) (1969).

¹⁹⁰ 21 C.F.R. § 1.104(h)(1) (1969).

¹⁹¹ Food and Drug Act, 21 U.S.C. § 352(e) (1964).

weight or measure, or in terms of the percentage of such ingredient in the drug.¹⁹² If the drug is not for oral use, its labeling must list the names of all inactive ingredients,¹⁹³ with certain exceptions. If the drug is for human consumption and contains any quantity of named habit-forming substances or their derivatives designated as habit-forming, its labeling must bear the name and quantity of such substances, "and in juxtaposition," the statement: "Warning—May be habit forming."¹⁹⁴ Under the Act, a drug's labeling is considered misleading if it fails to reveal the true proportion of an ingredient or some other fact regarding it, when such failure is material in light of the naming of the ingredient.¹⁹⁵ For example, labeling need not prominently list a powerful ingredient present in the drug in an amount so small as to have little effect, unless it states its quantity.¹⁹⁶

C. Placement of Information

All required ingredient information must appear "together" on the label without any intervening printed matter except (1) ingredient trade names, which may accompany the listing of established names, and (2) cautions such as "Warning—May be habit forming," as required by the Act.¹⁹⁷ If the drug's container is too small to bear the quantitative ingredient information on the main display panel, it may appear elsewhere on the label, so long as its size and prominence are "reasonably related" to the size and prominence of the front-panel display.¹⁹⁸ If the drug's container is too small to bear anywhere the nonproprietary names and quantities of ingredients, the label must state only the proprietary name of the drug, its established name, if any, an identifying lot or control number, and the name of the manufacturer, packer, or distributor. In addition, all other information required must appear on the carton or other outer container, or in the package insert.¹⁹⁹

D. Misleading Labeling

Under the general ban against false and misleading labeling, and under section 502(e), certain practices, including artful "word-smith-

¹⁹² 21 C.F.R. § 1.104(d) (1969).

¹⁹³ 21 C.F.R. § 1.106(b)(2)(v) (1969).

¹⁹⁴ Food and Drug Act, 21 U.S.C. § 352(d) (1964).

¹⁹⁵ 21 C.F.R. § 1.104(c)(2) (1969). See also Food and Drug Act, 21 U.S.C. § 201(n) (1964). In addition, labeling is misleading if it features inert or inactive ingredients in a manner that creates an impression of value greater than their true functional role in the formulation. 21 C.F.R. § 1.104(c)(4) (1969).

¹⁹⁶ Willig, *Some Present Responsibilities in Labeling and Advertising*, 24 Food Drug Cosm. L.J. 578, 582 (1969).

¹⁹⁷ 21 C.F.R. § 1.104(a) (1969).

¹⁹⁸ 21 C.F.R. § 1.104(h)(2) (1969).

¹⁹⁹ 21 C.F.R. § 1.104(i) (1969).

ing,"²⁰⁰ have been forbidden. Thus, labeling may be misleading (1) if the drug's name includes or suggests the name of one or more, but not all of its ingredients, even though the names of all such ingredients are listed elsewhere in the labeling;²⁰¹ (2) if it employs a "fanciful" brand name for the drug or its ingredients implying some unique effectiveness or composition, when the drug or ingredient is merely a common substance, the limitations of which are readily recognized under the established name or names;²⁰² (3) if the trade name of the drug or an ingredient may be confused with the trade or established name of a different drug or ingredient, because of similarity in spelling or pronunciation;²⁰³ or (4) by reason of the order of listing or prominence otherwise given the ingredient names in the labeling.²⁰⁴

E. Other Required Information

The "full disclosure" regulations also require that the label carry an identifying lot or control number,²⁰⁵ the recommended or usual dosage,²⁰⁶ the route of administration if the drug is not for oral use,²⁰⁷ and the statement, "Caution: Federal law prohibits dispensing without prescription."²⁰⁸ However, the drug's container may be too small or otherwise unable to accommodate a label with sufficient space to bear this information in addition to the required name and quantitative ingredient information. In that case, the lot number may appear on the crimp of the drug's dispensing tube; the caution may appear on the drug's outer container only; and the dosage, administration route, and names of all inactive ingredients of drugs not for oral use may be contained in other labeling such as the package insert.²⁰⁹

The label of a drug in package form must also contain the name and place of business of the manufacturer, packer, or distributor, and an accurate statement of the quantity of the contents in terms of weight, measure, or numerical count, as these terms are defined in regulations.²¹⁰ However, a drug is exempt from the latter requirement²¹¹ if the statement of quantity—together with all other information required to appear on the label by the Act—cannot be so placed on the label

²⁰⁰ CCH F. D. Cosm. L. Rep. ¶ 40,015.

²⁰¹ 21 C.F.R. § 1.101(b) (1969).

²⁰² 21 C.F.R. § 1.104(c)(3) (1969).

²⁰³ 21 C.F.R. § 1.104(c)(5) (1969).

²⁰⁴ 21 C.F.R. § 1.104(c)(1) (1969).

²⁰⁵ 21 C.F.R. § 1.106(b)(vi) (1969).

²⁰⁶ 21 C.F.R. § 1.106(b)(2)(ii) (1969).

²⁰⁷ 21 C.F.R. § 1.106(b)(2)(iii) (1969).

²⁰⁸ 21 C.F.R. § 1.106(b)(2)(i) (1969).

²⁰⁹ 21 C.F.R. § 1.106(b)(2) (1969).

²¹⁰ 21 C.F.R. § 1.102(c) (1969).

²¹¹ 21 C.F.R. § 1.102(m) (1969).

as to comply with the prominence standards of Section 502(c).²¹² Certain other small packages are also exempt. Section 502(c) provides that any required word, statement, or other information must appear on the label or labeling prominently and "with such conspicuousness (as compared with other words, statements, designs, or devices in the labeling) and in such terms as to render it likely to be read and understood by the ordinary individual under customary conditions of purchase and use."²¹³

F. *Package Inserts and Promotional Labeling*

In general, full disclosure labeling in the form of a package insert must accompany the marketed or dispensing package of all prescription drugs.²¹⁴ The insert supplies full information—not a summary—for the use of the drug by doctors. This information includes indications, side effects, dosages, routes of administration, frequency and duration of administration, contraindications, and other relevant warning information. Side effects must be given for all uses for which the drug is advertised or represented. For drugs subject to the new drug or certification requirements of the Act, the package insert must bear the labeling approved by the FDA.²¹⁵ This is the only case where the insert is subject to government pre-clearance. No package insert is necessary if the drug's hazards, warning, and use information are commonly known to physicians.²¹⁶

Promotional labeling other than strict reminder-pieces must contain similar information, including full disclosure of side effects.²¹⁷ If the labeling describes a new drug or antibiotic subject to certification, it must be "substantially the same" as that approved in the New Drug Application or certification.²¹⁸ Manufacturers are given a "satisfactory degree of latitude" in choosing phraseology and the format for labeling which functions as advertising, but otherwise mailing pieces must convey essentially the same information as appears in the package insert.²¹⁹ In response to criticism that physicians see promotional labeling and advertising, but not the drug's package insert, an official of the FDA has pointed out that the insert "at the present time . . .

²¹² Food and Drug Act, 21 U.S.C. § 352(c) (1964).

²¹³ *Id.*

²¹⁴ 21 C.F.R. § 1.106(b)(3) (1969).

²¹⁵ 21 C.F.R. § 1.106(b)(3)(ii) (1969).

²¹⁶ 21 C.F.R. § 1.106(b)(3) (1969).

²¹⁷ 21 C.F.R. § 1.106(b)(4) (1969). All labeling except labels and cartons which carry information concerning the uses of the drug must also bear the date of issuance or the date of the latest revision of such labeling. 21 C.F.R. § 1.106(b)(5) (1969).

²¹⁸ 21 C.F.R. § 1.106(b)(4)(i) (1969).

²¹⁹ Oser, *Regulatory Requirements for Misleading Labeling*, 24 Food Drug Cosm. L.J. 141, 145 (1969).

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is the one form of distribution of information which can be enforced."²²⁰ In addition, the package insert is contained in samples sent or given to doctors and may be obtained at drug stores. The full disclosure regulations thus enable doctors to prescribe medicines, especially powerful new drugs which may produce serious adverse reactions, with reasonable safety.²²¹

Compliance with these regulations is initially tested when a New Drug Application is submitted to the FDA. After determining that the drug is safe and effective under the conditions of use specified in its labeling,²²² the FDA approves the drug and notifies the manufacturer what warnings and contraindications must appear. New data indicating that the drug is no longer safe and effective under conditions expressed in the labeling provide a basis for withdrawing the New Drug Application.²²³ Moreover, the FDA may withhold or withdraw approval of the New Drug Application if the labeling is "false or misleading in any particular;"²²⁴ and a drug which does not conform to the Act's labeling or advertising provisions is misbranded.²²⁵

The manufacturer must file a supplemental New Drug Application if any mailing or promotional piece to be used after a new drug is marketed "deviates in any significant respect from the approved labeling."²²⁶ If a "material change" is made in advertising or labeling, and the drug is marketed before a supplement is approved for it, its New Drug Application may be withdrawn or suspended.²²⁷ However, a recent amendment to the regulations allows a manufacturer to make necessary additions of warning information, and deletions of "false, misleading, or unsupported indications for use or claims for effectiveness."²²⁸ The supplemental New Drug Application then filed must explain the changes, and the manufacturer must submit copies of revised labeling.²²⁹ If the supplemental New Drug Application is disapproved, labeling and advertising for the drug must be revised. In this way, therefore, the FDA can exercise a check on even those changes which appear urgent.

PART III. THE STANDARD OF CARE IN DRUG REACTION CASES

At a 1969 conference on drug usage, one speaker estimated that there were at least 1,500,000 hospital admissions annually due to drug

²²⁰ Pisani, *Drug Safety and F.D.A.*, 21 *Food Drug Cosm. L.J.* 68, 72 (1966).

²²¹ *Id.*

²²² Food and Drug Act, 21 U.S.C. § 355(d) (1964).

²²³ Food and Drug Act, 21 U.S.C. § 355(e) (1964).

²²⁴ 21 U.S.C. § 355(d), (e) (1964).

²²⁵ Food and Drug Act, 21 U.S.C. § 352 (1964).

²²⁶ 21 C.F.R. § 130.9(a) (1969).

²²⁷ 21 C.F.R. § 130.9(c) (1969).

²²⁸ 21 C.F.R. § 130.9(d)-(g) (1969).

²²⁹ 21 C.F.R. § 130.9(e) (1969).

reactions.²³⁰ Thus, concern for those patients who are exposed to combination antibiotics has a firm base indeed. An adverse reaction produced by a drug is any effect which is neither preventive, diagnostic, nor therapeutic. Such adverse effects may often occur even when a drug is administered according to the manufacturer's directions. Undesirable effects—such as sensitivity, allergic reactions, exaggerated responses, or effect on an organ other than the one at which the drug was directed—result from the qualitative variation in a patient's reaction to treatment. Information on a drug's recurrent side effects, or rarer but serious adverse reactions, is obviously important to a doctor weighing alternative medications, especially since many side effects are neither allergic nor unusual genetic reactions peculiar to the patient, but rather pharmacological effects of the drug. Similarly, the doctor must know what pathological conditions contraindicate use of the drug.

The above statistics are taken from hospital records in studies designed to measure the incidence of drug reactions. No such measurement has been attempted in the case of the general public, but it is a reasonable estimate that in the years ahead hundreds of thousands of people will be injured or killed through the use of alleged life preserving medications. Anaphylactic reactions to penicillin alone reportedly occur in one to five out of every 1,000 patients, with about 90,000 such anaphylactic reactions occurring annually.²³¹

Most of the adverse drug reactions might have been prevented if information regarding all of the side effects known to the manufacturer were freely released. In fact, doctors polled by an AMA study on misleading advertising termed such failure to cite side effects "the most heinous crime a pharmaceutical company can commit."²³² Drug industry spokesmen counter by contending that physicians can obtain full side-effect information elsewhere, particularly on the package insert which must accompany each prescription drug, and by means of the information appearing on all promotional labeling. They contend that advertisements aimed solely at doctors serve merely as "product reminders" and thus should not be treated as labeling. However, this argument begs the question of the importance of journal advertising in presenting drug news, and overstates the adequacy of alternative sources of information on side effects. Doctors often ignore the vast quantities of promotional labeling sent to their offices. They are most

²³⁰ Speech by Herbert Ley at a meeting of the New York Pharmaceutical Advertising Club, Feb. 13, 1969, CCH F.D. Cosm. L. Rep. ¶ 80,215, at 80,519.

²³¹ Shafer, *Penicillin Reactions*, 3 L. Med. J. 387 (1968). Indeed, this figure is deemed conservative because of the incidence of unreported cases.

²³² Council on Drugs of the American Medical Association Conference, Notes on the Package Insert, 207 J.A.M.A. 1335, 1337 (1969).

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apt to study ads appearing next to scientific articles in prestigious medical publications. Furthermore, the package insert goes not to the doctor who needs the "full disclosure" labeling but instead to pharmacists.

When a patient suffers the harmful effects of a prescription drug, the issue is often phrased in terms of whether the drug company or the physician should be legally responsible. It is conceivable, however, that a third entity, the FDA, should assume a share of this responsibility since it deemed the drug safe and its advertisements adequate. This section will discuss the allocation of liability among these three entities.

A. *Liability of the Government for Drug Reactions*

At the heart of the Food and Drug Act is the requirement that before a drug can be introduced into interstate commerce an application must be filed with the FDA,²³³ and approval for the drug's distribution secured from the Secretary of Health, Education and Welfare.²³⁴ The New Drug Application must contain full reports as to all tests made on the drug, a description of its components and the facilities for manufacturing it, and samples of the drug and of proposed labeling.²³⁵ The Secretary may refuse to accept the application if he finds there is insufficient information for a sound determination of the drug's safety and effectiveness, or if he determines that the proposed labeling is false or misleading.²³⁶ The FDA also has the power to suspend approval of an application and withdraw the drug from the market if new tests and clinical experience show that the drug is not safe for use under the conditions for which it was approved, or if the application or labeling are found to contain false statements.²³⁷ Before the Secretary can refuse to approve a new drug application or remove a drug from the market, however, he must give the manufacturer a hearing in order to inform him of the contemplated actions.²³⁸

Under the regulations, the FDA may intervene directly in the preliminary stages of investigation and testing.²³⁹ The Secretary can require the manufacturer to submit a report indicating all proposed pre-clinical testing, the names of those persons conducting the investigation, reports on the results of any tests and investigations, and any other information which the Secretary deems necessary to evaluate the drug

²³³ 21 U.S.C. § 355(a) (1964).

²³⁴ 21 U.S.C. § 355(c) (1964).

²³⁵ 21 U.S.C. § 355(b) (1964).

²³⁶ 21 U.S.C. § 355(d) (1964).

²³⁷ 21 U.S.C. § 355(e) (1964).

²³⁸ *Id.* The Secretary's ruling is subject to review in the federal courts. 21 U.S.C. § 355(h) (1964).

²³⁹ 21 U.S.C. § 355(i) (1964).

prior to its certification for use on humans.²⁴⁰ The FDA can halt further testing if it becomes harmful or unnecessary, and prescribe certain methods and procedures for more thorough investigations and tests.

Thus the FDA and the federal government have an important duty to protect the public against the threat of unsafe and ineffective drugs. The fact that perhaps millions of persons suffer from adverse drug reactions each year, however, is evidence that the duty remains unfulfilled. The law of products liability has grown steadily in this country since the decisions in *Thomas v. Winchester*,²⁴¹ *MacPherson v. Buick Motor Co.*,²⁴² and *Henningsen v. Bloomfield Motors, Inc.*²⁴³ At present, a remedy is available to one injured by the negligence of the drug manufacturer or the local pharmacist.²⁴⁴ This has opened to the public the possibility of recovery for harm resulting from adverse reactions to drugs. Not all of the responsibility, however, can be placed on the drug and pharmaceutical industries. The FDA, as the agent of the government entrusted with the duty to regulate the promotion and sale of drugs, is itself responsible for part of the problem. The 1962 amendments to the Food and Drug Act and the subsequent regulations have enormous potential to reduce the suffering and waste caused by useless and ineffective drugs. Yet, as one critic has warned: "No matter what the potential of the law and the regulations . . . what counts in the final analysis is their implementation—how FDA enforces them."²⁴⁵

Besides having a remedy against the private manufacturer, the victim of an adverse drug reaction arguably should also have a cause of action against the FDA. The liability of the federal government is controlled by the Federal Tort Claims Act,²⁴⁶ which provides for exceptions to the sovereign immunity doctrine.²⁴⁷ Any attempt to hold the FDA responsible for the manner in which it enforces the regulations

²⁴⁰ 21 U.S.C. § 355(i) (1964).

²⁴¹ 6 N.Y. 397 (1852). A consumer recovered damages for personal injuries caused by a falsely labeled bottle of poison. A duty was imposed on the seller because the harm was foreseeable.

²⁴² 217 N.Y. 382, 111 N.E. 1050 (1916). Plaintiff recovered in negligence for injuries caused by the careless manufacture of an automobile.

²⁴³ 32 N.J. 358, 161 A.2d 69 (1960). Plaintiff sued for personal injuries caused by failure of the steering mechanism on her new car. The court allowed recovery for breach of an implied warranty of merchantability. See also, *Larsen v. General Motors Corp.*, 391 F.2d 495 (8th Cir. 1968), holding that if there exists and "undisclosed defect in design," known to the manufacturer as a latent defect, "the duty of reasonable care should command a warning of this latent defect that could under certain circumstances accentuate the possibility of severe injury." *Id.* at 505, 506.

²⁴⁴ See Keeton, *Products Liability—Current Developments*, 40 *Texas L. Rev.* 193 (1961); Rheingold, *Products Liability—the Ethical Drug Manufacturer's Liability*, 18 *Rutgers L. Rev.* 947 (1964).

²⁴⁵ M. Mintz, *The Therapeutic Nightmare* 108 (1965).

²⁴⁶ 28 U.S.C. §§ 1346, 2671 et. seq. (1964).

²⁴⁷ *Id.*

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and carries out the duties delegated to it must arise from the provisions of this Act.²⁴⁸ A successful action against the FDA or its employees may mark a new era in the search for relief from the drug menace, and assure that the powers of the FDA will be fully exercised and administered.

The Federal Tort Claims Act grants to the district courts of the United States exclusive jurisdiction over civil actions for damages resulting from the negligent or wrongful act or omission of an employee of the government while acting within the scope of his employment.²⁴⁹ Under this Act, the government is liable in the same manner and to the same extent that a private person would be under similar circumstances.²⁵⁰ The surrender of sovereign immunity under the Act includes all federal agencies in the executive department, independent establishments of the government, and the employees of any federal agency.²⁵¹ There are several exceptions in the Act which limit its coverage, however, and not all federal agencies and employees can be made to answer in court. The most perplexing of the exceptions and the only one of importance to this discussion is found in subsection (a) of section 2680 and includes:

Any claim based upon an act or omission of any employee of the Government, exercising due care, in the execution of a statute or regulation, whether or not such statute or regulation be valid, or based upon the exercise or performance or the failure to exercise or perform a discretionary function or duty on the part of a federal agency or an employee of the Government, whether or not the discretion involved be abused.²⁵²

Several district court decisions have construed these exceptions narrowly; that is, against the allowance of claims and in favor of the government.²⁵³ Although the Supreme Court has neither specifically affirmed nor denied this narrow construction, its pronouncements tend toward a more liberal application of the exceptions.²⁵⁴ With the excep-

²⁴⁸ 3 K. Davis, *Administrative Law Treatise* § 25.03, at 444 (1958).

²⁴⁹ 28 U.S.C. § 1346(b) (1964).

²⁵⁰ 28 U.S.C. § 2674 (1964).

²⁵¹ 28 U.S.C. § 2671 (1964).

²⁵² 28 U.S.C. § 2680(a) (1964).

²⁵³ *McNamara v. United States*, 199 F. Supp. 879 (D.D.C. 1961); *Kearney v. A'Hearn*, 210 F. Supp. 10 (S.D.N.Y. 1962).

²⁵⁴ Compare *Dalehite v. United States*, 346 U.S. 15 (1953) with *Indian Towing Co. v. United States*, 350 U.S. 61 (1955) and *Hatahley v. United States*, 351 U.S. 173 (1956). *Indian Towing* points out that the distinction made as to tort liability of municipal corporations between governmental and non-governmental functions is not applicable to the liability of the government under the Federal Tort Claims Act.

tion of a few district courts, most courts have handled subsection (a) as a problem of application rather than a problem of construction.²⁵⁵

The first of the exceptions contained in subsection (a) requires that a federal agency exercise due care in the execution of a federal statute or regulation for its acts to be immune. When something less than due care is exercised by an agency or employee entrusted with the execution of a statute or regulation, liability may attach for the resulting harm.²⁵⁶ The second exception contained in subsection (a) acts to broaden the first by exempting federal agencies and employees from liability based upon the performance or omission of a discretionary function or duty, whether or not the discretion is abused. What Congress intended to include in "discretionary function or duty" is unclear from a reading of the Act, and as a result, the courts have applied the section in several different ways.

In *Dalehite v. United States*,²⁵⁷ the Supreme Court distinguished between an operational function of an agency and one that is discretionary or planning in nature. The Court in that case pointed out that this exception "was intended to cover more than the administration of a statute or regulation because it appears disjunctively in the second phrase of the section."²⁵⁸ As to the meaning of a discretionary or planning function that is given immunity by subsection (a), the Court said: "It is the discretion of the executive or the administrator to act according to one's judgment of the best course, a concept of substantial historical ancestry in American Law."²⁵⁹ The *Dalehite* ruling is also cited for the proposition that acts of subordinates in carrying out programs in accordance with discretionary decisions cannot be actionable under the Federal Tort Claims Act.²⁶⁰ Justice Jackson's dissent, however, pointed out that the adoption of such a view would "inaugurate an unfortunate trend toward relaxation of private as well as official responsibility in making, vending or transporting inherently dangerous products."²⁶¹ He argued that there are many governmental activities

²⁵⁵ Most courts have preferred to refrain from making policy judgments that would construe the exceptions contained in subsection (a).

²⁵⁶ *Hatahley v. United States*, 351 U.S. 173, 181 (1956).

²⁵⁷ 346 U.S. 15 (1953). *Dalehite* was an action against the United States under the Federal Tort Claims Act to recover damages for a death resulting from an explosion of ammonium nitrate fertilizer that had been produced according to government specifications. The Supreme Court held that the suit should be dismissed as a matter of law because the district courts do not have jurisdiction of a claim based upon a discretionary act or duty of a federal agency within the meaning of 28 U.S.C. § 2680(a) (1964).

²⁵⁸ *Id.* at 34.

²⁵⁹ *Id.* The Court cited *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803); *Spalding v. Vilas*, 161 U.S. 483 (1896); *Alzua v. Johnson*, 231 U.S. 106 (1913); *Louisiana v. McAdoo*, 234 U.S. 627 (1914), as authority for the historical ancestry of its concept.

²⁶⁰ 346 U.S. 15, 36 (1953).

²⁶¹ *Id.* at 50.

that are indistinguishable from those performed by private individuals, and in this area there is no reason to impose immunity or relieve the government or its officials from responsibility for acts performed without due care for the safety and protection of others.²⁶²

In 1955, the Supreme Court again faced the problem of applying the exceptions of subsection (a). In *Indian Towing Co. v. United States*,²⁶³ the Court avoided the non-governmental—governmental (proprietary vs. governmental) question that the Court in *Dalehite* used to reach a favorable result for the government, and imposed liability for damages resulting from negligence in the care of a lighthouse. The Court rejected the government's contention that there can be no recovery based on the negligent performance of an activity which is itself the end-purpose of the particular governmental function, by pointing out that there was no basis for the distinction of governmental activity from private activity on the operational level.²⁶⁴ The Court held that the Coast Guard need not have undertaken the operation of the lighthouse, but that once its discretion had been exercised and public reliance engendered, it was obligated to use due care to make certain that the light was kept in working order.²⁶⁵ As a result, the Coast Guard was held liable for failure to perform the duty. *Dalehite* was not expressly overruled but was greatly limited in application.

Application of the decision in *Indian Towing* has resulted in the government's liability for negligently conducting a Civil Aeronautics Administration survey,²⁶⁶ and for failure of Forest Service employees to prevent the spread of a fire.²⁶⁷ There are also many decisions holding that once a government employee or agent acts after having exercised his discretion at the planning level, the government will be liable for any subsequent negligence.²⁶⁸ Furthermore, there is authority for the statement that the discretionary function exception furnishes no immunity to the government if a statute or regulation imposes a mandatory duty to perform the function.²⁶⁹

Before suit may be instituted against the United States, the claimant must have first presented his claim to the appropriate federal agency, and the claim must have been denied.²⁷⁰ The statute itself

²⁶² Id. at 60.

²⁶³ 350 U.S. 61 (1955).

²⁶⁴ Id. at 68.

²⁶⁵ Id. at 69.

²⁶⁶ *Dahlstrom v. United States*, 228 F.2d 819 (8th Cir. 1956).

²⁶⁷ *Rayonier, Inc. v. United States*, 352 U.S. 315 (1957).

²⁶⁸ See, e.g., *United States v. Gray*, 199 F.2d 239 (10th Cir. 1952); *Costely v. United States*, 181 F.2d 723 (5th Cir. 1950); *Bullock v. United States*, 133 F. Supp. 885 (D. Utah 1955); *Rufino v. United States*, 126 F. Supp. 132 (S.D.N.Y. 1954); *Fair v. United States*, 234 F.2d 288 (5th Cir. 1956).

²⁶⁹ *Somerset Seafood Co. v. United States*, 193 F.2d 631, 635 (4th Cir. 1951).

²⁷⁰ 28 U.S.C. § 2675 (1964).

designates neither who may maintain a suit nor those individuals who must be sued. The courts, however, refuse to permit a plaintiff to join the United States and one of its employees as co-defendants.²⁷¹ But it is not necessary to sue the United States; if a plaintiff so chooses, he may sue only the individual employee.²⁷² An exception is the statutory immunity from personal liability recently granted to medical and paramedical employees of the Veteran's Administration unless the claim is first submitted to and denied by the V.A.²⁷³ Claims alleging malpractice or negligence in furnishing medical care and treatment by physicians, dentists, pharmacists, and paramedical and other personnel in the V.A.'s Department of Medicine and Surgery are covered by the new law.²⁷⁴ Should the plaintiff elect to sue the United States rather than the negligent employee, and be successful in recovering a judgment, he cannot thereafter bring an action to recover damages from the employee whose negligence gave rise to the claim.²⁷⁵ Moreover, the Supreme Court has held that the government cannot recover indemnity from the employee for whose negligence it has been required to pay damages under the Federal Tort Claims Act.²⁷⁶ It is also noteworthy that an employee of the government who voluntarily testifies for the plaintiff in an action against the government may subject himself to criminal prosecution under 18 U.S.C. § 283, which prohibits government employees from assisting in the prosecution of claims against the United States.²⁷⁷

The above exceptions must be considered when attempting to impose responsibility on the FDA under the Federal Tort Claims Act. As noted previously,²⁷⁸ the Federal Food, Drug and Cosmetic Act and the regulations of the FDA prescribe strict standards for the approval of New Drug Applications and for the removal of drugs from the market

²⁷¹ *Precht v. United States*, 84 F. Supp. 889 (W.D.N.Y. 1949); *Uarte v. United States*, 7 F.R.D. 705 (S.D. Cal. 1948).

²⁷² The rule in *Feres v. United States*, 340 U.S. 135 (1950), that a suit cannot be maintained against the government under the Federal Tort Claims Act for death or injury of a soldier on active duty, was followed in *Buckingham v. United States*, 394 F.2d 483 (4th Cir. 1968). Nor can a soldier sue an army physician for negligent acts performed in the line of duty. Permitting a soldier to litigate civilly with others in the Army would weaken discipline. *Baily v. De Quevedo*, 375 F.2d 72 (3rd Cir.), cert. denied, 389 U.S. 923 (1967).

²⁷³ 38 U.S.C.A. § 4116 (Supp. 1969).

²⁷⁴ V.A. Reg. 6(E) §§ 5514.1, 5611-13.

²⁷⁵ 28 U.S.C.A. § 2672 (Supp. 1969).

²⁷⁶ *United States v. Gilman*, 347 U.S. 507 (1954).

²⁷⁷ See *United States v. 679.19 Acres of Land*, 113 F. Supp. 590 (D.N.D. 1953); *United States v. Adams*, 115 F. Supp. 731 (D.N.D. 1953). In the former case a government employee was ordered by the court to testify against the government. The government then brought a criminal prosecution against the employee in the latter case under 18 U.S.C. § 283. The court dismissed the indictment holding that the section is not applicable to proceedings before a court.

²⁷⁸ M. Mintz, *supra* note 245, at 2.

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at the discretion of the Secretary.²⁷⁰ The Act specifies several grounds for the refusal of a New Drug Application or for the subsequent withdrawal of the drug from the market, but it is phrased so as to give the Secretary broad discretion in exercising his judgment at the planning level to decide how the public can best be protected. Before making a final determination, the Secretary must give the applicant due notice and an opportunity for a hearing.²⁸⁰ There is no duty imposed upon the Secretary to follow any specified course of action; within certain guidelines, approval and withdrawal of new drugs are left to officials at the planning level of the FDA.²⁸¹ Since the Secretary and the FDA are free to determine what tests shall be reasonable and adequate, and to establish the requirements for labeling, courts would probably be quick to bring this function of the FDA under the discretionary exception of the Federal Tort Claims Act.²⁸² Thus, the victims of drug-induced injury must look to Congress and the executive branch of the government for help in motivating the FDA to carry out the authority delegated to it to screen out harmful or ineffective new drugs already on the market. Only through the continued pressure of congressional investigation and presidential policy-making can the FDA's record in this area be improved.

Other functions of the FDA are either mandatory or at least arguably operational in character so as to come within the purview of *Dalehite*. As mentioned previously, the Federal Food, Drug and Cosmetic Act requires that the Secretary promulgate regulations regarding the certification of antibiotics and insulin.²⁸³ Within statutory guidelines, the content of these regulations is left to the discretion of the Secretary so as not to disturb the policy-making discretion of the agency. Once the regulations are prescribed, however, the situation becomes much like that in *Indian Towing*. That is, when this discretion is exercised, and the procedures and standards are promulgated, their enforcement is an operational function and the agency is bound to exercise due care.²⁸⁴ The Federal Food, Drug and Cosmetic Act states that the purpose of the regulations concerning the certification of each batch of insulin or of an antibiotic is to "adequately insure safety and efficacy of use."²⁸⁵ If a drug which is certified as having met the established standards of safety and quality causes harm, it would seem that

²⁷⁰ 21 U.S.C. § 355 (1964); 21 C.F.R. § 1.100 (1969).

²⁸⁰ 21 U.S.C. §§ 355(e), (h) (1964).

²⁸¹ 21 U.S.C. § 355(h) (1964).

²⁸² See *Meyer v. G. D. Searle & Co.*, 41 F.R.D. 290 (E.D.N.Y. 1966).

²⁸³ 21 U.S.C. §§ 356, 357 (1964); 21 C.F.R. §§ 141-46 (1969).

²⁸⁴ See *Indian Towing Co. v. United States*, 350 U.S. 61 (1955); *Bullock v. United States*, 145 F. Supp. 824 (D. Utah 1956); *Swanson v. United States*, 229 F. Supp. 217 (N.D. Cal. 1964).

²⁸⁵ 21 U.S.C. §§ 356(a), 357(a) (1964).

part of the responsibility must be borne by the FDA. To establish the agency's responsibility, the litigant might argue that the regulations pertaining to the certification of each batch of insulin or of an antibiotic set out the standards to be followed at the operational level of activity, thus avoiding the exceptions of subsection (a) of the Federal Tort Claims Act. The litigant must also prove that his damages were the result of the negligence of the FDA in allowing the marketing of a substandard, unsafe batch of insulin or antibiotics. Imposing such responsibility on the FDA, and requiring the government to respond in damages in a civil suit, might furnish the necessary incentive to the FDA to improve its past record of laxity and carelessness.

The only decision in a tort action involving the FDA was a claim for negligence in government sampling and inspection brought by a wholesaler of imported tomato paste. The government claimed the paste was adulterated and refused to accept it in fulfillment of a government contract. The wholesaler's claim was rejected by the court on the ground that the duty imposed on the government was to the ultimate consumer and not to an intermediate dealer.²⁸⁶ However, the sampling activity under the statute involved in this case required the testing only of such samples as the government deemed advisable. On the other hand, under the drug amendments of 1962, the FDA's new drug approval duty is absolute and induces reliance on the consumer's part that every new drug will be carefully examined for safety and efficacy before marketing is permitted.

The fact that the law now specifies that the FDA approve New Drug Applications on the basis of submitted evidence of both safety and effectiveness, and that the law gives the FDA new and increased powers and authority over every phase of drug manufacturing, may lead the courts to hold that the FDA is in the position of warranting the safety and efficacy of these drugs.²⁸⁷ If the Federal Tort Claims Act were held a bar to government liability, an anomalous situation would exist: the government has undertaken a duty, and yet has successfully absolved itself of any liability failing careful performance of that duty.²⁸⁸

No judicial decision has yet involved a product liability action for injury caused by a drug in its investigational stage, nor has there been a reported malpractice decision involving such a drug.²⁸⁹ The only case

²⁸⁶ *Anglo-American & Overseas Corp. v. United States*, 144 F. Supp. 635 (S.D.N.Y. 1956), *aff'd*, 242 F.2d 236 (2d Cir. 1957).

²⁸⁷ Note, *Federal Food and Drug Administration Practice and Procedure for New Drug Approval*, 37 Temp. L.Q. 191, 193-94 (1964).

²⁸⁸ Note, *The Drug Amendments of 1962: How Much Regulation?*, 18 Rutgers L. Rev. 101, 160 (1963).

²⁸⁹ *Stetler, Responsibility of the Food and Drug Administration Under Federal Tort Claims Act*, 72 Dick. L. Rev. 580, 586 (1968).

involving the government and an investigational drug was *Meyer v. G. D. Searle & Co.*²⁰⁰ The complaint was based on the allegation that use of an oral contraceptive damaged the heart. Causes of action against Searle were for negligence, breach of warranty, and misrepresentation. The complaint alleged a separate cause of action against the FDA for negligence in permitting the marketing of the product, notwithstanding its notice and knowledge of the potential danger of the drug. Also cited as indicia of FDA negligence was the failure to order withdrawal of the drug from the market on the basis that the drug was unsafe for clinical use, or at least to order that warnings of potential danger accompany the product. The government moved to dismiss on the ground its action involved the exercise of discretion. Plaintiff found the government's brief "persuasive" and discontinued its action.

If liability for negligence is imposed on the FDA by the courts, it should be comprehensive. For example, it would be inadequate to allow a claim against the government or against individual FDA officials only for the negligent approval of a New Drug Application. Were this the extent of the liability, the general bureaucratic preference for negative rather than positive action would be aggravated. To overcome inertia and the resulting increased reluctance to approve a new drug for marketing until an excessive amount of clinical data is accumulated, liability should be imposed for negative action as well. A member of the public would then have a claim if he were denied the benefit he might otherwise have obtained from a new drug except for the FDA's negligently withheld and unnecessarily delayed approval. "The public interest demands that the risks of inaction, as well as the risks of action, must be taken into consideration in decision-making regarding the clinical testing of drugs."²⁰¹

A complete solution to the problem of drug reactions and the abuses that accompany ineffective drugs may never be found, but means to control the problem are available. If effectively used, these partial solutions can reduce the hazards facing the drug consumers. The general public must become well informed of the dangers that drugs present and the harm they can cause if used improperly. The medical profession must use every available resource to insure the proper use of drugs to combat disease without bringing on adverse reactions. Drug companies must put the safety of the public before profit-seeking motives in determining when drugs are safe for marketing. The most effective means of controlling the drug menace, however, is through the FDA. Having assumed the leadership in regulating and

²⁰⁰ 41 F.R.D. 290 (E.D.N.Y. 1966).

²⁰¹ Herrell, Clinical Investigation: Why Make it More Difficult?, 2 Int. Med. Dig. 7 (1967).

controlling the drug industry, the federal government must also be deemed to have assumed liability for failure to carry out its tasks with due care and diligence.

B. Liability of the Physician for Adverse Drug Reactions

Whether in the form of pure food and drug statutes imposing liability on a negligence per se basis, or under a theory of warranty, all jurisdictions, in one way or another, hold the dispenser of adulterated drugs liable to the victimized consumer. Normally, the physician neither sells nor dispenses drugs, but merely prescribes them or orders them on a hospital chart. However, many physicians dispense free samples of various drugs to their patients as an accommodation, or dispense them for a fee from a stock which they maintain. In either situation, the physician is no longer acting merely as a prescriber, but becomes a dispenser of drugs as well, and as such it would seem that no court would find serious difficulty in holding him liable if the drugs were in fact adulterated or otherwise unwholesome. It is quite unlikely that one would find a case in which a physician dispensed to a patient an adulterated or unwholesome drug which could be proved the proximate cause of some condition of illness, disability or death. If such a case did arise, however, since liability is generally imposed upon hospitals where the preparation, storage or dispensation of a drug can be proven to be the proximate cause of harm to the patient,²⁰² then these same functions performed by a doctor should cause him to be similarly liable.

The more frequently recurring, and the more difficult problem is the adverse reaction of a recipient of a drug or medicine prescribed by a physician or ordered by him on the hospital order sheet. This type of case appears to be similar to that of any other malpractice situation. The duty incumbent upon a physician to warn his patient of any risks involved in the use of a prescribed drug is not coextensive with his duty to warn of some reasonable and recognized risks inherent in a particular medical or surgical procedure. The duty to warn is less encompassing when a drug is involved. The doctor is obligated only to explain any possible adverse reactions of the drug, not its composition or even necessarily its intended effect.²⁰³

If a particular drug is known to have side effects which may prove injurious to the patient, the physician should make a reasonably full disclosure of the risks involved before obtaining consent to administer the drug.²⁰⁴ A patient who developed exfoliative dermatitis after a

²⁰² See generally 9 ALR3d 567 (1966).

²⁰³ See Morse, *Law and Medicine: Drug Reactions*, 197 J.A.M.A. 221 (1966).

²⁰⁴ See *Your Professional Liability: 131 Questions and Answers*, 185 J.A.M.A. 789, 793 (1963). Before prescribing a dangerous drug for administration to an infant, a physician should inform the parents of possible dangers "unlikely to be suspected" by them,

series of gold salt injections for rheumatoid arthritis was entitled to recover damages in a suit against her physician. The evidence showed that no emergency existed in treating her condition, and that the medical profession recognized the possibility of undesirable reactions in the use of gold therapy. Under the circumstances, the physician had the duty of making a reasonable disclosure of the known dangers incidental to or possible in the proposed use of gold. The appellate court said, therefore, that the trial court did not err in instructing the jury that the physician could be found guilty of professional negligence if he failed to inform the patient properly.²⁹⁵ In another case, the patient was given phenobarbital with directions to take "one when necessary for pain" without warning as to the possible effects on his mental and physical faculties. Liability for negligence was imposed upon his physician when the patient took several capsules and then drove off the road.²⁹⁶

In a third case,²⁹⁷ a bus passenger injured in an accident sued the driver's physician alleging that the crash was attributable to a side effect of a prescribed antihistamine. The driver testified that the doctor gave him no warning of any possible side effects of the particular drug involved. He took the first pill the morning of the accident, felt groggy and drowsy a few miles before the accident, then fell asleep or blacked out shortly before the bus left the road. Several physicians testified that since about 20 percent of those persons taking the drug experience these reactions, the community standard required a doctor to alert a patient for whom he prescribed the drug of the potential consequences. Judgment by the trial court in favor of the physician was reversed by the state supreme court, which held there was sufficient evidence to raise the jury question: Did the physician fail to warn the driver of any possible side effects of the drug? If the jury determined the physician gave no such warning, it could find negligence, and this raised a second jury question: Did this negligence constitute the proximate cause of the passenger's injuries?

A doctor may be liable for a resulting harm if he fails to give adequate instruction as to the care required when a patient's condition is such that he must exercise more than ordinary care in order to avoid injury after medical treatment. He may also be liable if he was negligent in failing to make responsible efforts to determine whether the

thus giving them "the opportunity of an informed election," particularly since such a warning "would in no way induce nervousness in the patient so as to decrease likelihood of successful treatment." *Koury v. Follow*, 272 N.C. 366, 375, 158 S.E.2d 548, 555-56 (1968). Alleged failure of physicians to warn the parents of an infant of the dangers involved in administering chloramphenicol has been held actionable. *Sharpe v. Pugh*, 270 N.C. 598, 155 S.E.2d 108 (1967).

²⁹⁵ *DeRosse v. Wein*, 24 App. Div. 2d 510, 261 N.Y.S.2d 623 (1965).

²⁹⁶ *Whitfield v. Daniel Constr. Co.*, 226 S.C. 37, 40, 83 S.E.2d 460, 462 (1954).

²⁹⁷ *Kaiser v. Suburban Trans. System*, 398 P.2d 14 (1965).

patient was allergic to the drug, or if he administered the drug for a disease for which it was not an approved therapeutic.²⁹⁸

When prescribing medication, a physician must clearly specify the dosage to be given, as well as the mode and route of administration.²⁹⁹ Careful instructions should be given on possible side effects and any dangers inherent in the use of the drug, especially if taken in combination with another drug or with alcohol. Admitted faults of most physicians include their generally illegible handwriting, which is a common source of prescription error, and their failure to write complete prescriptions, a practice which leaves the nurse to decide which of several dosage forms to use.

Physicians must also know and follow local law and practice concerning drugs or liability may unexpectedly result. For example, the Attorney General of Iowa ruled that a physician may not authorize his nurse or an intern to prescribe or dispense prescription drugs.³⁰⁰ The statutes provide that a nurse or intern may administer such drugs, but they may do so only when acting under the direction and supervision of the medical practitioner who prescribed them.

As the number and potency of drugs increase, errors in medication become more common and more serious. The untoward consequences of prescribing and administering drugs may stem from a variety of circumstances, including prescription or administration of the wrong drug or dosage, or failure to administer the proper medication at the specified time or in the manner prescribed or normally considered acceptable. Untoward effects may also result from failure to diagnose and treat properly adverse drug reactions. Apparently the vast majority of medication errors go undetected. A recently reported method of detecting and counting medication errors in a non-university hospital disclosed the startling statistic that nearly one out of seven medications given or prescribed was an erroneous medication.³⁰¹ Therefore, it would seem that a physician must be held responsible for knowing that which is known or reasonably discoverable about the drugs he prescribes. A physician should be duty-bound to be familiar with the manufacturer's flyer accompanying all prescription drugs. He should certainly be responsible for knowing the commentary on any drug he prescribes as contained in the "Physician's Desk Reference." Further,

²⁹⁸ *Rotan v. Greenbaum*, 273 F.2d 830 (D.C. Cir. 1959).

²⁹⁹ *Campbell v. Preston*, 379 S.W.2d 557 (1964).

³⁰⁰ Opinion of the Iowa Attorney General, No. 68-4-1 (Iowa, April 1, 1968) as cited in 17 *The Citation* 121 (1968).

³⁰¹ Barker, Kembrough, & Heller, *The Medication Error Problem in Hospitals*, 1 *Hosp. Formulary Mgmt.* 29 (1966); *Hospital Medication Errors*, 195 *J.A.M.A.* 31 (1966); Fogg, *Errors of Medication in Hospital*, 2 *Lancet* 31 (1965).

the physician should be required to conduct a physical examination and study the medical history of an individual to ascertain whether there is any contraindication in the particular patient for the drug prescribed.

It would, of course, be elementary on the part of the physician to prescribe not only the right drug for the given patient's condition, but in the right quantity as well. Liability in a given case might be predicated upon an excess or possibly even an insufficient dosage. The doctor who exceeds the dosage specified on the package insert accompanying a drug, or who chooses to ignore a statement of adverse side effects or contraindications, may have assumed the burden of proving that he was correct in his judgment. In a New Jersey malpractice case, the insert in a package of epinephrine with lidocaine (Eylacaine) became the plaintiff's chief weapon against a dentist who had administered the drug to a hypertensive woman.⁸⁰² The burden of proof for the physician can be extremely difficult when one puts the vague language of a journal article concerning the drug against the definite and authoritative language of a package insert. Indeed, the burden will be impossible to overcome if the insert is treated as the exclusive authority on dosage and contraindication.⁸⁰³

In summary, it would seem clear that it is the duty of the physician to conduct follow up observations of the patient to detect early signs of adverse drug reactions. Physicians have been known to dismiss as crank calls the complaints of patients alleging peculiar reactions to a prescribed drug when early follow up might have prevented injury to the patient. It would likewise seem self-evident that the physician is obliged not only to be able to recognize an adverse drug reaction, but to treat it as well.

Questions which determine the liability of a physician in a case involving an adverse drug reaction should include whether the reaction was within the known scope of medical knowledge for the use of the drug; whether the reaction was discoverable in the particular patient; whether after the reaction proper treatment was instituted and continued; whether the patient was properly informed of the hazards and

⁸⁰² *Sanzari v. Rosenfeld*, 34 N.J. 128, 167 A.2d 625 (1961).

⁸⁰³ Legal counsel for the FDA has suggested that publishers, authors, and editors of medical journals who have approved and published drug dosages deviating from those on package inserts recommended by the FDA are liable for damages to the patient and to the pharmaceutical manufacturer (for injury to its good will). Such a statement is of questionable legal validity, however, and impairs free expression among the editors, publishers, and researchers who provide needed data on drug effects and dosage. Indeed, expert authors have withdrawn important articles on drugs because of the fear engendered by FDA pronouncements. Modell, Editorial: F.D.A. Censorship, 8 J. Clin. Pharmacol. & Therap. 359 (1967).

risks inherent in the use of the particular drug for his given condition; whether more benign or established drugs could and should have been used first; and whether the drug itself was contraindicated medically in the particular case.

It must be remembered that the choice of a particular drug or medicine as well as the dosage to be taken by the patient go to the very heart of the somewhat trite but nevertheless true saying that medicine is an art rather than a science. Rarely will the physician be held liable for a mistake in judgment which seemed reasonable at the time of prescription, but proved disastrous in result. There are many hypersensitive, toxic and allergic reactions which cannot be prevented even with reasonable diligence and foresight, or which involve an infinitesimally small risk in relation to the high probability of beneficial results to the patient. As in most cases of malpractice liability, expert testimony in this area will usually be required and will be exceptionally hard to obtain. These suggested guidelines, however, might aid in determining potential areas of liability for the physician, and in making a finding of negligence or due care.

C. Liability of the Drug Manufacturer for Adverse Drug Reactions

Who should bear the loss suffered by the victims of unavoidable injuries from "idiosyncratic" reactions (whether allergic or otherwise) to prescription drugs? Can we justify making the innocent victim of an "idiosyncratic" reaction bear the total burden of his physical impairment and the costs of his medical care? The terms "unreasonably dangerous" and "defective" are merely legal labels for value judgments as to who should bear the loss in drug reaction cases. These terms have meaning only to the extent we choose to give them meaning. Looking at a particular drug from a plaintiff's point of view, one may ask whether it was not unreasonably dangerous and defective as to him? Courts have denied recovery because a particular plaintiff cannot amass a history of similar unfortunate cases, but it seems perverse indeed to require that a great many persons be injured before we compensate any. Moreover, it seems improper to require specific proof of a defect when the current state of medical knowledge has turned the term "idiosyncratic" into a verbal wastebasket, a receptacle for all kinds of defects for which there is yet no explanation. These facts are apparently ignored when drug analysis is extended no further than the conclusory labels "defect" and "unreasonably dangerous." The following discussion will attempt to explain some of the meanings of those labels, along with the probable methods of obtaining more equitable results in cases of idiosyncratic reactions.

REGULATION OF PRESCRIPTION DRUG PROMOTION

1. *Duty to Warn Physicians of Adverse Drug Reactions*

When a manufacturer markets prescription drugs, it is under a duty to warn physicians of the possible side effects of the drug for the protection of patients.⁸⁰⁴ Failure to warn may be considered a failure to exercise a reasonable standard of care, and may expose the manufacturer to liability for negligence.⁸⁰⁵

The ultimate concern of any regulation or requirement should be for the patient who is injured as a result of a non-defective drug, adequately tested and properly manufactured, which carried with it adequate warnings of harmful side effects of which the manufacturer knew or had reason to know. To date, however, the majority of the extant decisions involve a negligence question, so that the problem of non-negligence resulting in injury has not been conclusively decided.

In discussing negligence, it is important to note that the courts, in their efforts to assist plaintiffs within the framework of existing law, are stringent in the requirements of due care which they impose upon drug manufacturers. In recent years, the duty to warn has become an increasingly significant obligation in the area of product liability.⁸⁰⁶ Just as a manufacturer's liability for injury resulting from its product's defects has been extended beyond the original purchaser to all who could reasonably be expected to use the product or be injured in the course of its use, its duty to warn of dangers or defects in its products has likewise been expanded.

Perhaps the most stringent application of this duty to warn can be seen in two opinions of the Eighth Circuit. Both involved the drug chloroquine phosphate, marketed under the trade name "Aralen" by Sterling Drug, Inc. The first case, *Sterling Products, Inc. v. Cornish*,⁸⁰⁷ affirmed an award of \$80,000 for an arthritis victim who developed chloroquine retinopathy as a result of using Aralen. The evidence indicated that chloroquine retinopathy is a relatively recent medical discovery. The first article to describe the condition was published in a British medical journal in October, 1959. The defendant manufacturer, however, made revisions in some of its literature concerning Aralen as early as June, 1960. The plaintiff took the drug daily from November, 1959, to December, 1962, with a resulting extensive and permanent impairment of her vision. In June, 1963, after the plain-

⁸⁰⁴ A.M.A. News, April 22, 1968, at 13. See also *Tinnerholm v. Parke Davis & Co.*, 411 F.2d 48 (2d Cir. 1969); *Parke Davis & Co. v. Stromsod*, 411 F.2d 1390 (8th Cir. 1969); Note, *The Manufacturer's Duty to Warn of Dangers Involved in Use of a Product*, 1967 Wash. U. L.Q. 206 (1967).

⁸⁰⁵ *Bine v. Sterling Drug Inc.*, 422 S.W.2d 623 (1969).

⁸⁰⁶ See 2 L. Frumer & M. Friedman, *Products Liability* § 16 (1968); 1 R. Hirsch, *American Law of Products Liability* §§ 2.28-2.29 (1961).

⁸⁰⁷ 370 F.2d 82 (8th Cir. 1966).

tiff's injury, the manufacturer sent a letter to all physicians calling their attention to the retinal side effect of Aralen.⁸⁰⁸ The trial judge instructed the jury that if the manufacturer knew or should have known that a group of persons would suffer this side effect, then it had a duty to warn the medical profession of the susceptibility of the hypersensitive or idiosyncratic group. The manufacturer objected to this instruction on the ground that its duty to warn did not extend to those few individuals who might be injured because of their unusual hypersensitivity to its product. In rejecting the manufacturer's position, the court drew a distinction between the duty to warn hypersensitive or idiosyncratic persons with respect to over-the-counter retail drugs and a drug sold on a physician's prescription. The denial of relief in the retail sales situation, the court said, seemed to be based upon the unforeseeability of the injury and the futility of the warning. However, the court stated:

In the instant case there was sufficient evidence for the jury to find that the drug manufacturer did in fact know, and thus could have foreseen, that some persons would be injured by the drug's side effect. Moreover, in this case we are dealing with a prescription drug rather than a normal consumer item. In such a case the purchaser's doctor is a learned intermediary between the purchaser and the manufacturer.⁸⁰⁹

The court found the evidence sufficient to sustain the finding that since medical literature on the subject was available, the manufacturer knew or should have known that the product was causing retinal damage to some users. While the question of the timeliness and effectiveness of the manufacturer's warning was properly left to the jury, the court did conclude that the warning must reasonably be expected to apprise the prescribing doctor of the dangerous side effects connected with a drug:

If the doctor is properly warned of the possibility of a side effect in some patients, and is advised of the symptoms normally accompanying the side effect, there is an excellent chance that injury to the patient can be avoided.⁸¹⁰

In the second case, *Yarrow v. Sterling Drug, Inc.*,⁸¹¹ a federal court in South Dakota found the drug company negligent for failure to warn, and awarded the plaintiff \$180,000 for blindness attributed to

⁸⁰⁸ See *Products Liability—Prescription Drug—Duty of Manufacturer to Warn Physician*, 19 Defense 49 (1970).

⁸⁰⁹ 370 F.2d at 85.

⁸¹⁰ *Id.*

⁸¹¹ 263 F. Supp. 159 (D.S.D. 1967), *aff'd*, 408 F.2d 978 (8th Cir. 1969).

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the side effects of Aralen. In this case, the plaintiff complained to her physician of increased discomfort from an arthritic condition that had been bothering her since 1950. Her doctor, unaware of any irreversible side effects which might result from its prolonged use, prescribed daily doses of chloroquine phosphate. He had been introduced to the drug by a detail man employed by Sterling Drug, Inc. When the detail man acquainted the physician with the drug, he did not inform the doctor of Aralen's dangerous side effects, nor, on any of his subsequent visits, did he disclose the possible connection between Aralen and chloroquine retinopathy.

Although Sterling disseminated information concerning the side effects of Aralen as these became known,⁸¹² the company never instructed its detail men to discuss the newly discovered dangers with the physicians they contacted. Thus, none of Sterling's warnings gained the attention of Mrs. Yarrow's physician. The Aralen treatment continued until October, 1964, when her doctor learned of the connection between Aralen and irreversible chloroquine retinopathy from an ophthalmologist who examined Mrs. Yarrow and found substantial deterioration of her vision. Although the use of chloroquine phosphate was discontinued, her eyesight continued to deteriorate. In early 1965, an eye specialist determined that Aralen had deprived Mrs. Yarrow of 80 percent of her vision.

Mrs. Yarrow filed suit against Sterling in the United States District Court for the District of South Dakota to recover for the damage to her eyes. The district court held that Sterling was negligent in failing to warn the physician of known dangers involved in the use of Aralen. On appeal, the United States Court of Appeals for the Eighth Circuit affirmed, and held that a drug manufacturer's duty to warn includes instructing its detail men to warn physicians on whom they regularly call of all dangerous side effects involved in the use of the manufacturer's drugs when the manufacturer knows, or in the exercise of reasonable care should know of the existence of such side effects. The importance of the *Yarrow* case lies in its expansion of the drug industry's responsibility to warn physicians of the dangerous side effects of drugs.

Drug manufacturers usually adhere to standard, industry-wide methods of communicating the necessary warnings to practitioners. These methods include use of the Physician's Desk Reference, and

⁸¹² Information concerning the relationship between Aralen and chloroquine retinopathy began appearing in 1957. By 1963 the connection was well established. The condition was found to develop in a small percentage of those treated with Aralen on a daily basis for a significant length of time. *Sterling Drug, Inc. v. Yarrow*, 408 F.2d 978, 985-87 (8th Cir. 1969).

"product cards" distributed to physicians. The use of standard industry-wide practices to discharge the manufacturer's obligation to warn, however, has not always satisfied the courts. In *Blohm v. Cardwell Manufacturing Co.*,⁸¹³ the Tenth Circuit Court of Appeals pointed out that although accepted industry-wide practices would be admissible as evidence to show that the manufacturer's warning had been reasonable, they were in no way conclusive.⁸¹⁴ In the words of one writer: "[i]t should be remembered . . . that occasionally an entire industry has been found lacking in ordinary care."⁸¹⁵

Similarly, although drug manufacturers are required by the FDA to relay specific warnings regarding certain drugs, those warnings have also been considered minimal guidelines rather than conclusive evidence that the manufacturer exercised reasonable care in warning physicians about its products. In *Love v. Wolf*,⁸¹⁶ for example, where defendant Parke-Davis issued a specific warning authorized by the FDA for the drug in question, the California appellate court held the warning inadequate since it did not properly convey the serious nature of the drug's hazards. Parke-Davis had advertised and promoted the drug on a large scale after the dangers had been discovered, thus undermining the effect of the warnings that had been given. Hence, although the warnings had been widely distributed, they were inadequate because the gravity of the danger had been de-emphasized. Further indication that mere compliance with the FDA's warning requirement will not provide a complete defense can be found in *Stromsodt v. Parke-Davis & Co.*⁸¹⁷ In approving a \$500,000 recovery in favor of a brain-damaged infant, the court held:

Although all of the Government regulations and requirements had been satisfactorily met in the production and marketing of quadrigen, the standards promulgated were minimal. The Defendant still owes a duty to warn of dangers of which it knew or should have known in the exercise of reasonable care.⁸¹⁸

In the *Yarrow* case, the Eighth Circuit re-examined the sufficiency of the industry's warning practices in determining whether Sterling had made a reasonable effort to alert Mrs. Yarrow's doctor to Aralen's

⁸¹³ 380 F.2d 341 (10th Cir. 1967).

⁸¹⁴ *Id.* at 343. See *Colorado Milling & Elevator Co. v. Terminal R.R. Ass'n*, 350 F.2d 273, 278 (8th Cir. 1965).

⁸¹⁵ Noel, Recent Trends in Manufacturers' Negligence as to Design, Instructions or Warnings, 19 Sw. L.J. 43, 52 (1965).

⁸¹⁶ 226 Cal. App. 2d 378, 38 Cal. Rptr. 183 (1964).

⁸¹⁷ 257 F. Supp. 991 (D.N.D. 1966), *aff'd*, 411 F.2d 1390 (8th Cir. 1969).

⁸¹⁸ *Id.* at 997. See *Gonzalez v. Virginia-Carolina Chem.*, 239 F. Supp. 567 (E.D.S.C. 1965).

dangerous side effects. Sterling had issued its warnings in three different ways: through the Physician's Desk Reference,⁸¹⁹ through product cards,⁸²⁰ and by use of a "Dear Doctor" letter, which it mailed to every physician in the United States.⁸²¹ These methods had been approved, either expressly or impliedly, in earlier suits against Sterling for injuries caused by Aralen. In *Cornish*,⁸²² although the Eighth Circuit held that Sterling's use of the Physician's Desk Reference and product cards was inadequate, the court did imply that the "Dear Doctor" letter may have constituted a sufficient warning had it been issued earlier.⁸²³ In *Yarrow*, Sterling argued strenuously that the "Dear Doctor" letter was evidence that it had made a reasonable effort to warn, but neither the district court nor the court of appeals was persuaded. The district court stated:

Where the doctor is inundated with the literature and product cards of the various drug manufacturers, as shown here by the facts, a change in the literature or an additional letter intended to present new information on drugs to the doctor is insufficient. The most effective method employed by the drug company in the promotion of new drugs is shown to be the use of detail men; thus, the Court feels that this would also present the most effective method of warning the doctor about recent developments in drugs already employed by the doctor, at no great additional expense.⁸²⁴

The decision suggests that the information provided by drug warnings in the mail is not adequate. The type of duty to warn imposed upon the drug company would seem to require its detail men to ring the bell of every physician personally, and give adequate and timely warn-

⁸¹⁹ The warnings published in the Physician's Desk Reference from 1958 until 1961 concerning the side effects of Aralen referred to "visual disturbances." There was no listing of Aralen in the Physician's Desk Reference in 1962. In 1963, the warning included possible blurring of vision, corneal changes, and retinal changes that were unusual and irreversible. In 1964, the warning was substantially the same, although it contained more specific information regarding retinal change, which was still regarded as rare and irreversible. *Yarrow v. Sterling Drug, Inc.*, 263 F. Supp. 159, 163 (D.S.D. 1967).

⁸²⁰ *Id.* The product card on Aralen in 1957 warned of blurring of vision as a side effect of Aralen. In 1959, the card warned of temporary blurring of vision and corneal changes, advising periodic eye examinations. In 1960, it warned of temporary blurring of vision, retinal vascular response, macular lesions, and again advised periodic eye examinations. The same warning was given in 1961, and in 1962 the card suggested tri-monthly examinations.

⁸²¹ Letter from E. J. Foley to American Physicians, undated, reprinted in *Sterling Drug, Inc. v. Yarrow*, 408 F.2d 978, 988 (8th Cir. 1969).

⁸²² *Sterling Prods., Inc. v. Cornish*, 370 F.2d 82 (8th Cir. 1966).

⁸²³ *Id.* at 84. The injury to *Cornish* was sustained before the letter was circulated.

⁸²⁴ *Yarrow v. Sterling Drug, Inc.*, 263 F. Supp. 159, 163, *aff'd*, 408 F.2d 978 (8th Cir. 1969).

ing of the dangers of a drug as promptly as such dangers become known. Such a requirement is not unreasonable in light of the fact that detail men make such personal visits when promoting the drug.

Although affirming on appeal, the court of appeals undertook a somewhat different approach to the problem, ignoring the proposition that the manufacturer was required to warn by the "most effective method":

Under the circumstances of this case, when the dangers of the prolonged use of this drug, mass produced and sold in large quantities, became reasonably apparent, it was not unreasonable to find that appellant should have employed all its usual means of communication, including detail men, to warn the prescribing physician of these dangers. In this connection, it is noted that no extraordinary means of giving a warning of high intensity was employed.³²⁵

Although it attempted to do so, the reviewing court never quite reconciled its holding with that of the trial court. Rather than being concerned with the most effective method of warning, the Eighth Circuit held that detail men must be used to relay to the physicians on whom they regularly call information on a drug's potentially hazardous side effects.³²⁶ Because the court refused to say that the lower court had erred, and nevertheless proceeded to make a different statement of the applicable law, there remains confusion as to what standard of care the courts will demand in the future.

In requiring that Sterling make use of its detail men in discharging its duty to warn, the court appeared to be interested in protecting the public from the sometimes unconcerned drug industry. If so, this would not be the first time that the drug industry's seeming lack of concern for its consumers had vexed the judiciary.

In essence, *Yarrow* demands that detail men be used as advisors to the physicians with whom they regularly meet, rather than merely as fast-talking salesmen. The question therefore arises as to how far the courts can go in trying to achieve this type of arrangement; how far can courts go to require a manufacturer to discourage the use of his product? By requiring that a manufacturer's detail men inform physicians of a drug's risks as well as its benefits, *Yarrow* has enabled the physician to make a more informed decision, and thus has taken a step in the direction of greater protection for patients who use prescription drugs.

³²⁵ *Sterling Drug, Inc. v. Yarrow*, 408 F.2d 978, 992 (8th Cir. 1969).

³²⁶ *Id.*

2. *Strict Liability in Tort for Adverse Drug Reactions*

The principal argument advanced for the extension of strict liability where the manufacturer could not reasonably have known of the risks of a particular defect, is the benefit to be achieved by the distribution of loss through the use of insurance.⁸²⁷ The cost of insurance then becomes a cost of production, passed on to the consumer through the price, and is thus absorbed by the beneficiaries of the enterprise.⁸²⁸

There has been steady progress throughout the last half-century in providing safer products and in shifting the risks of enterprise through insurance and price controls back to the consumers. In this way the group carries most of the load and no one is excessively burdened. The imposition of the risks of enterprise upon the victim alone has now, in varying degrees, been rejected everywhere.⁸²⁹

Proponents argue that strict liability is preferable to a system of liability based on fault where an enterprise or activity, beneficial to many, takes a more or less inevitable accidental toll of human life or limb. All limitations imposed by the doctrine of privity would be dispensed with, and strict liability would be imposed upon the manufacturer on an implied warranty against unreasonable dangers lurking in any kind of product. Liability would extend to anyone hurt by a foreseeable use of the product.

About one-third of all American courts now impose strict liability for injuries resulting from the consumption of food.⁸³⁰ Manufacturers are liable not because of fault, nor because they could have prevented the risks, but because they can best distribute this unavoidable cost to all persons who benefit from the enterprise.⁸³¹ For example, in a lengthy concurring opinion, containing a number of arguments for strict liability, Chief Justice Traynor of the California Supreme Court stated:

Those who suffer injury from defective products are unprepared to meet its consequences. The cost of an injury and the loss of time or health may be an overwhelming misfortune to the person injured, and a needless one, for the risk of injury

⁸²⁷ See, e.g., Comment, *Cigarettes and Vaccine: Unforeseeable Risks in Manufacturers' Liability under Implied Warranty*, 63 Colum. L. Rev. 515 (1963).

⁸²⁸ Calabresi, *Some Thoughts on Risk Distribution and the Law of Torts*, 70 Yale L.J. 499 (1961).

⁸²⁹ Green, *Should the Manufacturer of General Products Be Liable Without Negligence?*, 24 Tenn. L. Rev. 928, 937 (1957).

⁸³⁰ Noel, *Manufacturers of Products—The Drift Toward Strict Liability*, 24 Tenn. L. Rev. 963 (1967).

⁸³¹ Note, *The Cutter Polio Vaccine Incident: A Case Study of Manufacturers' Liability Without Fault in Tort and Warranty*, 65 Yale L. J. 262 (1955).

can be insured by the manufacturer and distributed among the public as a cost of doing business. . . .⁸³²

No other justices concurred in his opinion, and since no opinion of the Supreme Court of California has agreed, Traynor's view is not yet the law of California.

Professor Prosser proposes that the "risk-spreading" argument be accorded more respect. The manufacturers, as a group and an industry in a complex civilization, should absorb the inevitable losses resulting from the use of their products, "because they are in a better position to do so, and through their prices to pass such losses on to the community at large."⁸³³ This has led to the view that such entities are capable, if held legally responsible, of passing on to users generally those losses suffered by the few. Thus there has resulted a wider acceptance of the view that when the benefits of the many come at a high cost to a few, the many should pay for these losses. While the courts have generally based liability on a so-called warranty theory, that is, an obligation arising out of contract, the liability is more in the nature of tort liability than it is contractual.⁸³⁴

Prosser further delineates the nature of the liability:

What all of this adds up to is that "warranty," as a device for the justification of strict liability to the consumer, carries far too much luggage in the way of undesirable complications, and is leading us down a very thorny path. . . .

. . . Why talk of warranty? If there is to be strict liability in tort, let there be strict liability in tort, declared outright, without an illusory contract mask. . . . There are not lacking indications that some of the courts are about ready to throw away the crutch, and to admit what they are really doing, when they say that the warranty is not the one made on the original sale, and does not run with the goods, but is a new and independent one made directly to the consumer; and that it does not arise out of or depend upon any contract, but is imposed by the law, in tort, as a matter of policy.⁸³⁵

Chief Justice Traynor, admittedly an apostle of strict liability, still believes that "[t]he manufacturer's strict liability depends on what is meant by defective. . . . When the injury is in no way attributable to a defect, there is no basis for strict liability."⁸³⁶ Proof of a "defect" in

⁸³² *Escola v. Coca-Cola Bottling Co.*, 24 Cal. 2d 453, 462, 150 P.2d 436, 441 (1944).

⁸³³ Prosser, *The Assault Upon the Citadel (Strict Liability to the Consumer)*, 69 *Yale L.J.* 1099, 1120 (1960).

⁸³⁴ *Id.* at 1126-27.

⁸³⁵ *Id.* at 1133-34.

⁸³⁶ Traynor, *The Ways and Meanings of Defective Products and Strict Liability*, 32 *Tenn. L. Rev.* 363, 366-67 (1965).

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a product should require the plaintiff to show that the manufacturer sold an "unreasonably dangerous product," one which involved "unexpected dangers," or was sold without adequate warning, or which produced an allergic response not adequately warned against, or contained a harmful substance not "natural to the product."

Rules of product liability ordinarily applicable to consumer products are not generally appropriate to prescription or ethical drugs, which are *sui generis*: they are neither a consumer product, nor are they intended to be sold over the counter. They are a physician's product. Drug advertisements are found only in professional journals, not consumer magazines, and are regulated by the FDA. Representations made by the manufacturer in labeling or in medical literature are directed solely to the medical profession. The manufacturer does not actually, or even by implication, make known to a patient the purposes for which a prescription drug is to be used. No product warranty is, therefore, intended to run from the manufacturer to the patient. The patient does not select a prescription drug for his own use; rather it is prescribed by his physician. The only common ingredient of the lawsuit against the product manufacturer of either the consumer product or the prescription or ethical drug, whether the action sounds in tort or in breach of warranty, is proof of a specific defect in the product. Special rules on warranty and the failure to warn, and strict liability in tort of the prescription drug product are needed.⁸³⁷ A properly prepared and marketed product with a proper warning to physicians should satisfy the legal obligation of the drug manufacturer.⁸³⁸

The conclusion that "if the drug is safe in theory, but toxic in fact, the responsibility rests on the pharmaceutical house which takes the commercial risks of introducing the product, and has done inadequate testing," and that liability should follow,⁸³⁹ is too rigid. As Prosser appreciates:

The whole pharmacopoeia is filled with drugs that are not safe, even when they are properly made and properly used. A striking example is rabies vaccine. . . . Is the maker who has done what can be done to make these things safe to be held liable when they go wrong? No doubt he must give what warning he can when the dangers are not likely to be known; no doubt a product sold without such a warning is to be regarded as defective and will subject him to strict liability; but if he gives such warning is he to be held strictly liable

⁸³⁷ Freedman, Prescription or Ethical Drugs: Fallacies as to Warranties, Failure to Warn, and Strict Liability in Tort, 21 Food Drug Cosm. L.J. 599 (1966).

⁸³⁸ *Id.* at 615.

⁸³⁹ Spangenberg, Aspects of Warranties Relating to Defective Prescription Drugs, 37 Colo. L. Rev. 194, 204 (1965).

for selling the product at all?⁸⁴⁰ [N]o breach of the warranty is found when the buyer is given what he asks for and expects to get, even though the whole product is not free from qualities that cause him loss or damage.⁸⁴¹

[T]he rule which has emerged is that, if the product is safe for the normal user, there is no liability when it injures the rare abnormal one. When the manufacturer knows or should know that there is danger to a substantial number of persons, even though they constitute only a small percentage of the population, he is under a duty to give warning; but if he gives it, he does not become liable merely because he has sold the product.⁸⁴²

All this leads rather irresistibly to the conclusion that there is no strict liability when the product is fit to be sold and reasonably safe for use, but it has inherent dangers that no human skill or knowledge has yet been able to eliminate.⁸⁴³

Just as no surgeon can guarantee the success of an operation, no assurance can ever be given that pharmaceuticals will not produce side effects from time to time. The guiding rule is that the greatest benefit for the largest number of patients should be produced. The risk of harm from allergies or other predisposition to injury from the use of a good drug that is not unreasonably dangerous should be allocated to the user so long as the drug is accompanied by appropriate warnings and instructions. FDA approval of a drug should preclude recovery on strict liability grounds.⁸⁴⁴ Simple negligence is the most appropriate of all of the doctrines that may be employed in this special area because it has been developed to balance the social desirability of rights and conduct on both sides of the dispute.⁸⁴⁵

Strict liability should be imposed only if a drug is unreasonably dangerous. No drug should be considered unreasonably dangerous unless, considering all the knowledge existing at the time, no reasonable manufacturer would market the drug, and no reasonable physician would administer it. No inference should be made that a drug was unreasonably dangerous simply because later information prompts withdrawal of the drug from the market.

Section 402A of the Restatement of Torts was adopted by the

⁸⁴⁰ Prosser, *The Fall of the Citadel (Strict Liability to the Consumer)*, 50 Minn. L. Rev. 791, 808 (1966).

⁸⁴¹ *Id.* at 810.

⁸⁴² *Id.* at 811.

⁸⁴³ *Id.* at 812.

⁸⁴⁴ Keeton, *Some Observations About the Strict Liability of the Maker of Prescription Drugs: The Aftermath of MER/29*, 56 Calif. L. Rev. 149, 159 (1968).

⁸⁴⁵ Peterson, *Products Liability of Drug Manufacturers*, 16 *Defense* 277, 296-97 (1967).

American Law Institute three times.⁸⁴⁶ Tentative Draft Number 6, adopted in 1961, limited product liability to "food for human consumption." Tentative Draft Number 7, adopted in 1962, included other products "for intimate bodily use." The final draft, adopted in 1964, applies "to any product" and provides:

- (1) One who sells any product in a defective condition unreasonably dangerous to the user or consumer or to his property is subject to liability for physical harm thereby caused to the ultimate user or consumer, or to his property, if
 - (a) the seller is engaged in the business of selling such a product, and
 - (b) it is expected to and does reach the user or consumer without substantial change in the condition in which it is sold.
- (2) The rules stated in Subsection (1) applies although
 - (a) the seller has exercised all possible care in preparation and sale of his product, and
 - (b) the user or consumer has not bought the product from or entered into any contractual relation with the seller.⁸⁴⁷

Allergic reactions of susceptible patients do not make a product "defective." Comment h explicitly states that a "product is not in a defective condition when it is safe for normal . . . consumption." Comment i examines the question of "defect" in the product by defining "unreasonably dangerous" as "dangerous to an extent beyond that which would be contemplated by the ordinary consumer who purchases, with the ordinary knowledge common to the community as to its characteristics." This comment also emphasizes that "many products cannot possibly be made entirely safe for all consumption," citing the fact that any product necessarily involves some risks of harm, that is, a food or drug "from over-consumption," or even sugar which is a "deadly poison to diabetics." These products are not "unreasonably dangerous," and hence not defective. No case had then been reported in which a prescription drug had actually been termed "unreasonably dangerous."

Comment j states that a product is not "in a defective condition" if proper or adequate warning is given. The seller may reasonably assume that the warning will be read and heeded; indeed, "a product bearing such a warning which is safe for use if it is followed, is not in a defective condition, nor is it unreasonably dangerous." Obvious or patent dangers do not require warnings, and, if the risks are unknown, warnings obviously cannot be expected; hence, the absence of warnings

⁸⁴⁶ Prosser, *supra* note 340, at 793.

⁸⁴⁷ Restatement (Second) of Torts § 402A (1964).

in such instances does not make the product defective. Comment j also points out that "the seller may reasonably assume that those with common allergies . . . will be aware of them, and he is not required to warn against them." Illustrations under comment j recommend that the seller warn if the product contains an ingredient to which a substantial or appreciable number of the population is allergic, if the ingredient is one whose danger is not generally known, and, if the ingredient is one whose danger is known, yet it is one which the user would not reasonably expect to find in the product. Foreseeability is properly an element in the law of strict liability. Where the pure and unadulterated drug allegedly caused a reaction, and the state of medical knowledge was such that, at the time of injury, the manufacturer in the exercise of ordinary care could not have anticipated such a reaction, the manufacturer should not be liable to the patient.

Comment k is specifically applicable to drugs:

There are some products which, in the present state of human knowledge, are quite incapable of being made safe for their intended and ordinary use. These are especially common in the field of drugs. An outstanding example is the vaccine for the Pasteur treatment of rabies, which not uncommonly leads to very serious and damaging consequences when it is injected. Since the disease itself invariably leads to a dreadful death, both the marketing and the use of the vaccine are fully justified, notwithstanding the unavoidable high degree of risk which they involve. Such a product, properly prepared, and accompanied by proper directions and warning, is not defective, nor is it *unreasonably* dangerous.

The same is true of many other drugs, vaccines, and the like, many of which for this very reason cannot legally be sold except to physicians, or under the prescription of a physician. It is also true in particular of many new or experimental drugs as to which, because of lack of time and opportunity for sufficient medical experience, there can be no assurance of safety, or perhaps even of purity of ingredients, but such experience as there is justifies the marketing and use of the drug notwithstanding a medically recognizable risk. The seller of such products, again with the qualification that they are properly prepared and marketed, and proper warning is given, where the situation calls for it, is not to be held to strict liability for unfortunate consequences attending their use, merely because he has undertaken to supply the public with an apparently useful and desirable product, attended with a known but apparently reasonable risk.

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No distinction is made between investigational drugs and those whose hazards are definitely known. Medically and practically there may be a vast difference, and this should be a significantly distinguishing legal fact. For example, the comment cites the Pasteur treatment. Once developed, rabies in man is invariably fatal; one out of seven dies solely from the Pasteur treatment. A patient thus has a choice of assuming a specific and definitely known calculated risk. This is a far cry from taking an investigational drug presumably safe but whose dangers may be entirely unknown. However, if adequate animal studies are performed, an investigational drug presumably safe, properly prepared and administered, and properly noting all warnings about ignorance of side effects, is given to the investigators as adverse effects become known, the application of comment k should preclude the imposition of liability for investigational drugs. Irrespective of any possible implied warranty in a marketed drug, no implied warranty of safety or efficacy should be imposed for an investigational drug.

While section 402A has not yet been uniformly accepted, the fact that many courts do rely on the Restatement for other purposes will in itself probably bring about more widespread adoption of this section. By the admissions of those who drafted it, the section is not the present law, but at most the future law, in this important area of product liability.⁸⁴⁸ Nevertheless, it is considered to be one of the most radical and spectacular developments in tort law during this century.⁸⁴⁹ According to Prosser, the date of the fall of the citadel of privity can be fixed with some certainty in the field of product liability as May 9, 1960, when the Supreme Court of New Jersey announced its decision in *Henningsen v. Bloomfield Motors*.⁸⁵⁰ Within the last few years the courts of twenty-two states had accepted strict liability as to all products, and five more states had adopted it by statute. In three others, federal courts, forecasting that a change in state law was imminent, concluded that the rule would be accepted. Two states had not extended the doctrine beyond products for intimate bodily use, and six restricted it to foods.⁸⁵¹

In a leading case, a California court of appeals dispensed with privity and the requirement of a sale to the ultimate consumer and found breach of implied warranties of fitness, merchantability, and general wholesomeness in the Cutter polio vaccine.⁸⁵² In a later case,

⁸⁴⁸ Miller, Significant New Concepts of Tort Liability—Strict Liability, 17 Syracuse L. Rev. 25, 36 (1965).

⁸⁴⁹ American Law Institute Meeting, 32 U.S.L.W. 2623, 2627 (1964).

⁸⁵⁰ 32 N.J. 358, 161 A.2d 69 (1960).

⁸⁵¹ Prosser, Strict Liability to the Consumer in California, 18 Hastings L.J. 9 (1966).

⁸⁵² *Gottsdanker v. Cutter Labs.*, 182 Cal. App. 2d 602, 6 Cal. Rptr. 320 (1960). Few jurisdictions have adopted this holding.

another California court of appeal quoted Prosser as suggesting certain limitations upon the scope of the warranty:

In the ordinary case the maker may also assume a normal user; and he is not liable where the injury is due to some allergy or other personal idiosyncrasy of the consumer, found only in an insignificant percentage of the population. . . .⁸⁵³

The court concluded that the manufacturer's duty is to guard against probabilities, not possibilities.⁸⁵⁴

Speaking for the California Supreme Court, however, Justice Traynor said:

The liability is not one governed by the law of contract warranties but by the law of strict liability in tort. Accordingly, rules defining and governing warranties that were developed to meet the need of commercial transactions cannot properly be invoked to govern the manufacturer's liability to those injured by its defective products unless those rules also serve the purposes for which such liability is imposed.⁸⁵⁵

Although a more recent case⁸⁵⁶ seems to indicate that a plaintiff may go to the jury on a mere showing of injury following the use of defendant's product,⁸⁵⁷ California has held that strict liability does not apply to a claim for failure to warn the ultimate consumer of the dangerous side effects of a drug. It has spelled out the duty of a product manufacturer "to warn the doctor who prescribes the drug. This would be the only effective means by which a warning could help the patient," and specifically held that failure to adequately warn the patient of the known side effects of the drug did not make the product defective.⁸⁵⁸

Promotion of an ethical drug product does not involve any direct advertising to the public. This factor, a New Jersey appellate court concluded, "casts doubt on the very existence of an implied warranty of merchantability running from the defendant to the plaintiff."⁸⁵⁹ In fact, the patient is seldom aware of the identity of a particular drug administered by his physician. An overwhelming majority of courts have steadfastly refused to consider the treating physician as the agent of the patient in receiving such warranties or representations concerning the

⁸⁵³ W. Prosser, *Torts* 503 (2nd ed. 1955), quoted in *Magee v. Wyeth Labs., Inc.*, 214 Cal. App. 2d 340, 352, 29 Cal. Rptr. 322, 329 (1963).

⁸⁵⁴ 214 Cal. App. 2d at 352, 29 Cal. Rptr. at 329.

⁸⁵⁵ *Greenman v. Yuba Power Prods., Inc.*, 59 Cal. 2d 57, 63, 377 P.2d 897, 901 (1963).

⁸⁵⁶ *Thomsen v. Rexall Drug & Chem. Co.*, 235 Cal. App. 2d 775, 45 Cal. Rptr. 642 (1965).

⁸⁵⁷ See *Condon*, *Product Liability-1965*, 21 *Food Drug Cosm. L.J.* 154 (1966).

⁸⁵⁸ *Love v. Wolf*, 226 Cal. App. 2d 378, 394, 38 Cal. Rptr. 183, 192 (1964).

⁸⁵⁹ *Kaspirowitz v. Schering Corp.*, 70 N.J. Super. 397, 403, 175 A.2d 658, 661 (1961).

REGULATION OF PRESCRIPTION DRUG PROMOTION

product.⁸⁰⁰ Obviously, in the doctor-patient relationship, there is no opportunity for a manufacturer to affirm any fact to a patient tending to induce sale of the product. Accordingly, no logical legal basis exists for warranty, whether express or implied, to run from the manufacturer in favor of the patient.

Another essential element of a cause of action for breach of warranty of fitness for particular purpose is reliance by the person seeking recovery. Since the patient has no voluntary part in the selection or use of the drug and seldom knows its identity, there is no opportunity for reliance. An Ohio court of appeals case affirming judgment in favor of a manufacturer of a prescription drug which allegedly caused a skin disorder, found no breach of warranty, either express or implied, as to the plaintiff, because "the record fails to disclose any reliance by the plaintiff upon anything published or said by the defendant. . . . The record is completely silent as to any reliance upon the part of the plaintiff"⁸⁰¹ The court also emphasized that there was no "affirmation of fact by the seller as to a product or commodity to induce the purchase thereof"⁸⁰² Interestingly, the court also found "nothing to indicate that the doctor relied upon any information furnished by the defendant in prescribing Aralen for his patient. . . . [So] it can hardly be said that he relied upon anything produced by the defendant or found in the general literature."⁸⁰³ Accordingly, without the opportunity to rely upon the warranty, no reliance can, in fact, exist.

The "unavoidably unsafe product" doctrine is illustrated by the blood transfusion, following which homologous serum hepatitis may develop. Despite the most careful screening and selection of blood donors, the disease is impossible to detect or prevent and is accepted as a risk inherent in all blood transfusions. Transfusion of blood by a hospital is averred to be a service, and since there is no sale, there can be no implied warranty of fitness or merchantability; however, several courts have very recently rejected this argument.⁸⁰⁴

Chloramphenicol ("Chloromycetin") should properly be classified as an "unavoidably unsafe product." It is an excellent broad spectrum antibiotic but also a power antimetabolite. Unfortunately, despite the cautionary statements in the advertising literature, in the medication packet, in medical journals, and in the lay press, physicians continue

⁸⁰⁰ See, e.g., *Moehlenbrock v. Parke Davis & Co.*, 141 Minn. 154, 169 N.W. 541 (1918); *Krom v. Sharpe & Dohme, Inc.*, 7 App. Div. 2d 761, 180 N.Y.S.2d 99 (1958); *Marcus v. Specific Pharmaceuticals, Inc.*, 191 Misc. 285, 77 N.Y.S.2d 508 (Sup. Ct. Spec. T. 1948).

⁸⁰¹ *Oppenheimer v. Sterling Drug Co.*, 7 Ohio App. 2d 103, 110, 219 N.E.2d 54, 59 (1964).

⁸⁰² *Id.*

⁸⁰³ *Id.* at 103-09, 219 N.E.2d at 58-59.

⁸⁰⁴ See Boland, *Strict Liability in Tort for Transfusing Contaminated Blood*, 23 Ark. L. Rev. 236 (1969).

to ignore the warnings. The drug has been prescribed for common colds and other common infections that are self-limited and in which either no treatment or relatively harmless drugs can be used.⁸⁶⁵ It is still the drug of choice for typhoid fever, may be life saving in other instances, and should remain available when needed. Since it may cause significant bone marrow depression in rare cases, each time it is prescribed for non-indicated use a patient is placed at needless risk. When so used, despite the precautionary data, and adverse effects occur, the physician is negligent, not the drug company.

There is no warranty, express or implied, as to the absolute effectiveness of a drug for a specific condition.⁸⁶⁶ Strict liability has been applied only to the manufacturer or distributor of defective drugs. A hospital is not answerable for the quality of the drugs it administers. Strict liability in tort or alleged breach of express and implied warranties for the intravenous injection of bacterially contaminated dextran is not applicable to the hospital.⁸⁶⁷ Breach of express warranty, however, may extend to a physician who warrants that a drug or device is safe for human use, and the warranty is breached.⁸⁶⁸

The variation among jurisdictions is particularly exemplified by the contradictory outcomes in cases involving "MER/29" which was marketed after known adverse reactions in animals were deliberately withheld. In some trial courts, plaintiffs have been awarded substantial damages. The largest award was \$350,000 in compensatory and \$850,000 in punitive damages. The Supreme Court of New York, on motion by Richardson-Merrell, Inc., the defendant, left standing the compensatory damages but reduced the punitive damages to \$100,000. Whether the punitive damages will be affirmed on appeal remains to be determined.⁸⁶⁹

On the other hand, the Court of Appeals for the Second Circuit in a New York case overturned an award of \$100,000 punitive damages against Richardson-Merrell, Inc., but affirmed \$17,500 compensation for alleged side effects of "MER/29."⁸⁷⁰ The opinion noted that punitive damages could have a "staggering" effect because of the hundreds of cases pending and could have a long range effect on the entire pharmaceutical industry. Damages could run to "tens of millions. . . . We have the gravest difficulty in perceiving how claims for punitive

⁸⁶⁵ Hosp. Trib., March 11, 1968, at 4, col. 3.

⁸⁶⁶ *Butler v. Travelers Ins. Co.*, 202 So. 2d 354 (La. Ct. App. 1967).

⁸⁶⁷ *Shivers v. Good Shepherd Hosp. Inc.*, 427 S.W.2d 104 (Tex. Civ. App. 1968).

⁸⁶⁸ *Godard v. Ridgway*, 445 P.2d 757 (Wy. 1968). The court failed to fully consider patient's cause of action against her physician for breach of warranty; but remanded the entire case for retrial, thereby leaving the issue open.

⁸⁶⁹ *Drug News Weekly*, January 9, 1967, at 8, col. 4. Some 99 percent of the MER/29 cases have been settled. *Drug News Weekly*, January 30, 1967, at 14, col. 1.

⁸⁷⁰ *Roginsky v. Richardson-Merrell, Inc.*, 378 F.2d 832 (2d Cir. 1967).

damages in such a multiplicity of actions throughout the nation can be so administered as to avoid overkill."³⁷¹ Of course, the judge's reasoning is illogical. If the law provides a remedy, difficulty in administration or unequal application does not justify its rejection.

A federal district court in Illinois held that a patient who developed cataracts from the use of "MER/29" had a good cause of action for breach of implied warranty against the manufacturer-distributor, notwithstanding lack of privity of contract.³⁷²

Other courts have reached a different result, although on the same reasoning. Texas denied recovery for breach of warranty to an individual who developed cataracts because of an unusual susceptibility to "MER/29" at a time when the manufacturer could not have foreseen such a reaction.³⁷³ A federal court, applying Maryland law, ruled that privity of contract is required between plaintiff and drug manufacturer in an action for breach of warranty.³⁷⁴ Florida, affirming the dismissal of a complaint for failure to state a cause of action in a case involving "MER/29", held that no action for breach of implied warranty will lie against the druggist for injury sustained as a result of the nature of the drug, as opposed to any foreign matter or impurities in it, which has been approved for sale by federal authorities acting pursuant to federal law, and which has been dispensed on the prescription of a physician.³⁷⁵ The Oregon Supreme Court in a case involving "MER/29" concluded that a drug properly tested, labeled with appropriate warnings, approved by the FDA and marketed properly under federal regulations, is, as a matter of law, a reasonably safe product, and the manufacturer is not liable in the breach of warranty to a user who suffered adverse effects, in the absence of evidence of defective manufacturing or impurities in the drug.³⁷⁶

In a landmark case, the Pennsylvania Supreme Court, with one dissent, specifically adopted section 402A as the law of Pennsylvania.³⁷⁷ The extent to which this will be applied to drugs remains to be seen. It is noteworthy that Pennsylvania has held that an action for breach

³⁷¹ *Id.* at 839.

³⁷² *Bennett v. Richardson-Merrell, Inc.*, 231 F. Supp. 150 (E.D. Ill. 1964).

³⁷³ *Cudmore v. Richardson-Merrell, Inc.*, 398 S.W.2d 640 (Tex. Civ. App. 1965), cert. denied, 385 U.S. 1003 (1967).

³⁷⁴ *Blum v. Richardson-Merrell, Inc.*, 268 F. Supp. 906 (D. Md. 1965).

³⁷⁵ *McLeod v. W. S. Merrell Co.*, 167 So. 2d 901 (Fla. Dist. Ct. App. 1964). This case was based on breach of implied warranty brought by purchasers; therefore no question of privity was raised.

³⁷⁶ *Lewis v. Baker*, 243 Ore. 317, 413 P.2d 400 (1966).

³⁷⁷ *Webb v. Zern*, 422 Pa. 424, 220 A.2d 853 (1966). The dissent by Chief Justice Bell refers to the holding as "revolutionary," "unfair," "unjustifiable," and "liability without fault." The rule requiring privity of contract to enable a purchaser to sue a manufacturer for breach of implied warranty was expressly abolished by *Kassab v. Central Sovia*, 432 Pa. 217, 246 A.2d 848 (1968).

of implied warranty, whether for personal injury or property damage, is governed by the four-year statute of limitations contained in the U.C.C.,⁸⁷⁸ rather than the two-year personal injury statute governing personal injury actions in Pennsylvania.⁸⁷⁹ Additional states continue to adopt the section⁸⁸⁰ as the frontal assault against the ancient citadel of privity progresses, and negligence and warranty become supplemented by the doctrine of "strict liability."

⁸⁷⁸ U.C.C. § 2-725.

⁸⁷⁹ *Gardiner v. Philadelphia Gas Works*, 413 Pa. 415, 197 A.2d 612 (1964).

⁸⁸⁰ *Heaton v. Ford Motor Co.*, 435 P.2d 806 (Ore. 1967); *Dippel v. Sciano*, 37 Wis. 2d 433, 155 N.W.2d 55 (1967); *O.S. Stapley Co. v. Miller*, 103 Ariz. 556, 447 P.2d 248 (1968).

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