

**Correspondence**

# Response to Open Peer Commentaries on “The Pitfalls of Deducing Ethics from Economics: Why the Association of American Medical Colleges is Wrong About Pharmaceutical Detailing”

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I am grateful for the thoughtful responses to my piece from both supporters and opponents of pharmaceutical detailing. Several commenters dispute my account of the AAMC’s Report, “Industry Funding of Medical Education,” (hereafter “the Report”) (Association of American Medical Colleges 2008). Bethany Spielman (2010) and Carson Strong (2010) contend that the Report does not ban detailing and that I overemphasize the Report’s reliance on behavioral economics. As to the former assertion, the medical community uses the phrase “pharmaceutical detailing” to refer to in-person drug rep-to-physician advertising, generally involving promotional items and food; it is this practice which the AAMC seeks to ban in academic medical centers. It is worth pointing out that while the medical literature on detailing generally frames the issue as physician receipt of “gifts,” this is inapt. Detailing involves not gifts but inducements for physicians to subject themselves to personal advertising, as is well understood by physicians who participate. It is beside the point to assert that atypical detailing visits not involving food or promotional items will still be permitted by the AAMC’s proposed rules. Physicians are not, in general, going to see drug reps during time taken away from patient care or other work rather than at times when they can combine a detailing visit with a break and/or a snack. Carrying out the AAMC’s recommendations leads more or less to the disappearance of drug reps from the academic medical center, as has happened at the medical center to which I belong. It is idle to maintain that this is not the result of a ban on detailing, or that such is not the intention of the AAMC.

As to the rationale proffered by the AAMC for its recommendations, it is quite true that the Report cites the empirical literature on detailing, which I suggested the Report’s authors relied upon less, as well as the behavioral economics

data, which I focused upon in my piece. I cannot, of course, read the minds of the Report’s authors and the language in my piece was too definite as to what they were relying upon as they wrote their Report. I continue to believe that the behavioral economics data loomed larger than the empirical detailing data in the Report’s genesis, but I could, of course, be mistaken. It is enough, perhaps, to note that there was membership in common between those who spoke at the AAMC Symposium (Association of American Medical Colleges 2007) and the authors of the Report; that one of the members-in-common, David Korn, explicitly expressed the hope that the insights from behavioral economics would “provide a firm scientific foundation” for the Report; and that the implications for pharmaceutical detailing drawn by the behavioral economists who presented their work at the Symposium, that “small gifts” be completely prohibited, were exactly the recommendations that appeared in the Report.

The question of interest is not, of course, just what weight two distinct bodies of data had on the Report’s authors, but whether either or both bodies of data warrant the conclusions drawn and the recommendations made in the Report. Do harms from detailing justify a ban; and should regulation of detailing be framed as a matter of professional ethics? Carson Strong (2010) and Howard Brody (2010) believe that the AAMC is correct to frame the issue of detailing in ethical rather than prudential terms, on the grounds that the promotional items and food involved with detailing constitute a conflict of interest for physicians, or at least the appearance thereof. That detailing presents physicians with a worrisome conflict of interest is implausible. Detailing passes generally accepted tests for worrisome conflicts of interest because a “reasonable person” would not conclude that well-paid physicians would deliberately betray

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75 patients for pens, notepads or sandwiches. Nor does detailing present the appearance of a conflict of interest, at least for most patients, so far as can be determined by what data we have. Surveys have repeatedly shown that large majorities of patients do not regard the promotional items and  
 80 food involved in typical detailing to be ethically problematic (Blake and Early 1995; Gibbons et al. 1998; Mainous et al. 1995). Presuming, as I do, that detailing is not in principle evil, the question to be asked is whether the benefit of useful information obtainable thereby is worth the effort of overcoming the bias it also contains. This is a prudential rather than an ethical question. Contra Strong and Steinman (Strong 2010; Steinman and Schillinger 2010), I do not maintain that regulation of detailing is appropriate only when conclusive evidence is available. I suggest that detailing presents a prudential rather than an ethical question to policy-makers; and, hence, demands a policy response framed prudentially rather than in the form of ethical imperatives (even if the response is prohibition).

As to the prudential question, opponents of detailing here invoke behavioral economics research as providing a plausible mechanism for the harms purportedly demonstrated by the empirical literature. The case developed here for harm is a fair representation of the case generally made: detailing is aimed at sales rather than education (Steinman and Schillinger 2010; Appelbaum 2010). Commercially biased information from detailing achieves influence over physician prescribing (Appelbaum 2010; Brody 2010; Steinman and Schillinger 2010; Strong 2010;). Such influence is malign, as physicians cannot overcome detailer “spin” (Steinman and Schillinger 2010) and the result is the prescription of unnecessary or unnecessarily expensive medications (Appelbaum 2010, referring to the Wazana studies). The difficulty with this case is not with its premises, as detailing is indeed aimed at sales and does achieve influence. The faulty inference is from influence to harm. As Rubin points out, the Wazana studies (Wazana 2000) do not show that the more expensive prescribing they detected was harmful; it may in many cases have been beneficial. The post-Wazana studies of prescribing behavior cited in the Report, which I did not mention (for which omission I am taken to task by Spielman) do not alter that conclusion. There is population level evidence (Lichtenberg’s work, cited by Rubin (Rubin 2010) that new drugs in the aggregate provide substantial benefits at an acceptable cost such that, insofar as detailing furthers the use of new drugs, it is likely beneficial. The case for harm has not only not been made; it is seriously challenged by a case for benefit (Rubin 2010). There is indeed “robust psychosocial evidence” that detailing affects physician decision-making—or as the AAMC would prefer to put it, that “gifts” affect physician decisions (Association of American Medical Colleges 2008, p.4). But the evidence for harm is quite weak, perhaps “almost entirely speculative” (to appropriate Appelbaum’s underestimation, as I believe, of the case for benefit from detailing).

130 I take the case for harm to be outweighed by the case for benefit, which comes in part from the economics literature,

much of which suggests that detailing conveys useful information to physicians. A notable example of such work is Azoulay’s (2002) paper, which Spielman (2010) erroneously accuses me of misrepresenting. Azoulay shows that marketing plays a more important role than science in new drug diffusion (when the two are considered separately); but also that marketing is in part driven by science and conveys scientific information. Another example is the Narayanan and colleagues article (2005) which Brody regards as unhelpful because among physician sources of information about drugs, it’s analysis is limited to detailing. Such a limitation is, of course, no bar to investigating whether detailing offers useful and true information about prescription drugs. And truth, for Narayanan, is not, per Brody, “what the drug industry says,” but is indeed truth: “update(d) beliefs. . . about the true quality of the new product. . .” (Narayanan et. al. 2005). Narayanan’s conclusion, that detailing usefully informed physicians in the early stages of new drug diffusion in the anti-histamine market, thus remains unaffected by Brody’s criticism.

The adverse conclusions drawn about physician processing of detailing by its opponents appear to follow not only from the empirical literature but from a deeply pessimistic view of physician cognition and agency, a view they believe to be confirmed by behavioral economics. Steinman takes the latter to suggest that “physicians—as humans—are unable to compensate for the influences on behavior that can arise from. . . conflicts (of interest)” (Steinman and Schillinger 2010). Brody offers a prudential argument against detailing that presumes physicians are incapable of critically assessing what they are told by drug reps; those who engage with detailing must either accept detailing information uncritically or spend time and effort cross-checking it (Brody 2010). Given detailer bias, the first alternative would be fool-hardy; but the second would involve physicians in needless labor; consulting unbiased sources of information after consulting a detailer is an imprudent use of time and so, unprofessional. Leaving aside the questionable equation of prudent time management with professionalism (if all poor time management is unprofessional, who is professional?), this argument would work if physicians were like computers, uncritically accepting inputs and generating outputs of a quality that directly varied with the inputs. Of course this is not what clinical knowledge (or error) is actually like. Physicians exercise judgement upon any information to which they give attention. Information from detailers, depending upon the specifics, may need cross-checking, may warrant immediate acceptance, or may warrant some caution in use or even immediate rejection. To suppose, as Brody does, that physicians are incapable of making these distinctions and must cross check everything a detailer says or succumb to error is not only implausible on its face—it is to give up on valid physician learning of any kind, as being able to judge the merits of new information, from whatever source, is essential to learning.

This defeatist view of physician cognition is belied not only by common sense, but by the economics literature,

190 which suggests that physician processing of detailing is not  
 pervasively irrational; it is a mixture of rational and irra-  
 tional thinking, as, perhaps, human thinking in the aggre-  
 gate must inevitably be. That being the case, it is perfectly  
 plausible to suppose that processing of detailing may be im-  
 195 proved by education (contra Steinman and Schillinger 2010,  
 Appelbaum 2010 and Schwab 2010).<sup>1</sup> The broader policy  
 question for bodies such as the AAMC then becomes which  
 of two errors it is most important to avoid: 1) unnecessary  
 restriction of action of those who are not in danger of mak-  
 200 ing particular errors (or who could be educated not to make  
 them) or 2) a failure to restrict irrational action that could  
 be prevented by more restrictive policies.<sup>2</sup> In the absence of  
 definitive evidence that rational or irrational responses to  
 detailing must decisively prevail, this choice will inevitably  
 be in part ideological. Detailing supporters do, of course,  
 205 bring normative preferences to the issue; I suspect that most  
 of us deplore the AAMC policy on several such grounds:  
 its singling out of commercial interests as uniquely corrupt-  
 ing among the innumerable extraneous interests with which  
 physicians must inevitably contend (the inevitability of such  
 210 interests, as highlighted by Stossel, suggesting that fiduciary  
 law is an inappropriate guide for physician behavior, as per  
 Stell and contra Morreim; Stossel 2010; Stell 2010; Morreim  
 2010); its unfortunate message that physicians are helpless  
 patsies in need of official direction in knowledge-gathering;  
 215 and its unjustified decree that engagement with pharma-  
 ceutical detailing is transgressive of professional ethics. For  
 these reasons among others, the AAMC recommendations  
 to academic medical centers concerning pharmaceutical de-  
 tailing are, to borrow from Steinman, the wrong policies for  
 220 the wrong reasons at the wrong time. ■

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1. As at least one study so far investigating this issue tends to con-  
 firm; see AF Shaughnessy et al., "Teaching information mastery:  
 evaluating information provided by pharmaceutical representa-  
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2. See the illuminating discussion in Gregory Mitchell, "Why Law  
 and Economics' Perfect Rationality Should Not Be Traded for Be-  
 havioral Law and Economics' Equal Incompetence" *Georgetown Law  
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