These drug reps come bearing facts, not freebies

Early results show that the 'unsales' approach is changing physician prescribing behavior

By Paula S. Katz

Sidebar:
- He opts for a lunch that's free—of distractions

When Daniel Haimowitz, FACP, a geriatrician in Levittown, Pa., knows he's having a lunch meeting with a drug representative, he sometimes invites Kristin Nocco, RPh, who works with a program sponsored by the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE), part of the state's department of aging. Not only does that save PACE the cost of a lunch, he explained, but the drug reps are interested in what she has to say, too.

That's because Ms. Nocco brings information gathered by a team at Harvard and geared toward quality care, not specific drug sales. And recent data show this "unsales" approach is changing physician prescribing behavior. High-volume prescribers who participated in the PACE program on cox-2 inhibitors spent $60 less per physician per month on coxibs six months later, said Tom Snedden, director of PACE and co-director of the pharmacy project in the Governor's Office of Health Care Reform.

'Unsales' rep Kristin Nocco, RPh, discusses hypertension with Neal Berkowitz, MD, of South Side Family Medicine in Allentown, Pa. A former drug rep, Ms. Nocco now works with the Independent Drug Information Service project, a $3 million, three-year initiative in Pennsylvania.

"That was better than I expected," he said. Preliminary evaluation of the program's educational module on proton-pump inhibitors is showing an even greater reduction in overuse of these drugs.

That's what Jerry Avorn, MD, professor of medicine at Harvard Medical School, had in mind when PACE asked him to find a way to get more complete information on certain drug classes to PACE's high volume physicians who saw at least 14 PACE patients. Dr. Avorn is a pioneer in the field of academic detailing—an approach that reviews drug information from an academic standpoint instead of a commercial one and then presents the findings to physicians interactively in their offices.

The result of the effort was the Independent Drug Information Service project (iDiS), a $3 million three-year initiative launched in the fall of 2005, funded by the state's Department of Aging, and run by an independent group of physicians and researchers from Brigham and Women's Hospital in Boston. Though outnumbered by more than 100,000 drug reps in a field that spends an estimated $30 billion on physician marketing nationally, the iDiS's 11 "unsales" reps cover 1,200 physicians in 28 counties. They make up for the pharmaceutical industry's free samples and other perks by providing evidence-based physician and patient information, clinically relevant materials on five subjects—the hypertension module was just launched in May—and continuing medical education credit from Harvard.

Others looking at the growing $274 billion prescription drug industry are taking note of PACE's success and Dr. Avorn's contentions that it can save $2 for every dollar spent on prescriptions while meeting the needs of today's time-pressured, evidence-oriented physicians, like Dr. Haimowitz.

Dr. Haimowitz likes knowing that he can take Ms. Nocco's presentation at face value. "She has no hidden agenda. She's not selling anything," he explained. "She's giving unbiased information about what's important to my patients."

No axe to grind

The idea behind iDiS is not just to refute drug company information, said Dr. Avorn, a former primary care physician. He bristles at the term "counter detailers" for his reps, who are officially known as independent drug consultants. In fact, sometimes the evidence supports the use of certain costly drugs, he emphasized. Those conclusions are left to the team of physicians and drug researchers at Harvard who synthesize journal articles and other data. Neither Dr. Avorn nor any members of his division accept any honoraria or consultancies from any pharmaceutical companies.

In addition to cox-2 inhibitors, iDiS has already addressed other drug classes PACE felt were problematic for its typical enrollee—a 78-year-old frail woman with multiple diseases and living alone—including proton pump inhibitors (PPIs), anti-platelet agents, antihypertensives and lipid-lowering agents. Preliminary evaluation of the program's educational module on proton-pump inhibitors is showing an even greater reduction in their use. Drugs for diabetes and Alzheimer's disease are being considered as possible upcoming topics.

While at times iDiS recommends a certain drug—for example, clopidogrel bisulfate (Plavix) over aspirin in certain situations—other times the message is to go back to basics. For example, iDiS recommends that physicians start treating acute and chronic pain with acetaminophen, a recommendation subsequently affirmed by the American Heart Association a year later. "The overwhelming evidence from clinical trials shows that selective cox-2 inhibitors do not have any stronger analgesic efficacy than conventional NSAIDs such as naproxen or ibuprofen," iDiS states.

iDiS recommendations often consider lifestyle changes, compliance and generics. Hypertension is a striking example of this, said Dr. Avorn, who is also chief of the Brigham's Division of Pharmacoepidemioogy and Pharmacoeconomics. If there are no other illnesses, a 3- to 4-cent per day thiazide works as well as or better than amlodipine besylate (Norvasc), he said.

It sounds good, said Mason Tenaglia, managing director at the Amundsen Group, a pharmaceutical strategy consulting firm, in Lexington, Mass. But is it really objective? "Everyone has a conflict of interest," he argued. "Managed care companies want to keep costs down. Doctors own stock in pharmaceutical companies. Pharmacies make more on generics. So who is the fair and honest broker?" Even physicians who are trying to help their patients cope within Medicare's new drug benefit limits are feeling the pressure, he said.

According to Dr. Avorn, that is where iDiS fits in. In the end, the group's recommendations may save money, but that's not the goal, he emphasized. "We have no particular axe to grind. We just want to get it right."

It's not a new idea. Dr. Avorn coined the term "academic detailing" in the early 1980s, and it's been used in Australia, Canada, the U.K and the Netherlands. What's unique is its use in a state initiative, its straightforward language, and its focus on taking a page from where drug companies excel—communication techniques that can change behavior.

"We work not only in mastering data but how to work with doctors so we're not coming off as confrontational, gotcha-ish, but as a colleague who's a drug information consultant," he said.

The program's independent drug consultants are nurses or pharmacists hired for a straight salary. They earn their title by spending days in Boston reviewing literature for each drug class they discuss. Dr. Avorn said doctors have become more skeptical of drug companies' messages, especially since Vioxx, and are increasingly willing to learn from such an "unsales" force.

"Physicians know when they have an informed expert teaching them about meds versus an attractive art history major with no clinical background," he said.

No cold calls

Still, some iDiS reps found it hard to get appointments with doctors when they started out a year and a half ago. Doors started to open only after they convinced the front office that they were not selling anything and wouldn't stop by without an appointment.

Initially, physicians can be very suspicious, said Leigh Bradshaw, RN, an iDiS independent drug consultant who has a list of 132 physicians and schedules one to two appointments per day. But she knows how to make physicians comfortable.

I'm an additional resource … to show the good, the bad and the ugly about a drug class regardless of who's authoring it." —Leigh Bradshaw, RN

"I'm a nurse, not a doctor. I'm an additional resource … to show the good, the bad and the ugly about a drug class regardless of who's authoring it." She emphasizes to doctors that they will get CME credit from Harvard Medical School for completing each drug class module, regardless of what they end up prescribing. That's struck a chord: Through April 2007, physicians completed 313 CME post-tests, according to the iDiS.

While the typical commercial drug rep visits may average around four to seven minutes, according to Michelle K. Spetman, MS, MPH, manager of the program, the consultants' visits average about 20 minutes—and sometimes longer.

Ms. Nocco, a former sales representative for Eli Lilly & Co., just finished a 40-minute visit with a South Philadelphia physician talking about how to increase compliance among his hypertension patients. "I was a sales rep for six years and unless I had a lunch I never even had 15 minutes with a doctor," she said. Now, many of the 60 physicians she sees ask her when she's coming back—she usually sees physicians three to four times a year to coincide with a new iDiS module—and why she's waiting so long.

Ms. Nocco likes her new vantage point. Some of the physicians walk her out to the front desk to be sure she's scheduled for the next appointment before she leaves. Any questions she can't answer are referred to the Harvard researchers for a response. As of April 2007, there were 165 inquiries from Pennsylvania physicians, according to the iDiS.

She even gets her share of attention from other drug reps who covet the time she spends with physicians and the kind of information she shares. "I get lots of their business cards," she said.

Best science

At the end of a visit, iDiS reps leave behind the iDiS "unadvertisement" materials, which include a four- to eight-page brochure with key points, a longer evidence document with copious

references, and patient education materials. (All of the materials are available at www.RxFacts.org)

While they may be able to give out sample generics in the future, for now the only perks are occasional subs they may pick from the office's favorite deli—although Ms. Bradshaw said many offices tell her not to bother. Then there's the other, more important reason for a visit—hand delivering a CME certificate.

That's a far cry from the lunches, dinners and other perks most physicians are familiar with, courtesy of drug companies. According to a recent survey reported in the April 26, 2007 *New England Journal of Medicine*, internists and family practitioners led all specialties in accepting gifts from industry in 2003-04, with internists reporting an average of 10 meetings per month with drug reps and family practitioners reporting 16. According to that article, 83% of all respondents accepted gifts, mostly food. Lesser numbers were reported for CME admission (26%), meeting expenses (15%), consulting (18%) or serving on a speaker's bureau (16%).

Although most physicians don't think they can be influenced by small gifts, the literature is "solid that gifts of small value give feelings of reciprocity and quid pro quo. It builds relationships and that's what influences doctors," said Eric G. Campbell, PhD, author of the *NEJM* article and assistant professor of Medicine, Harvard Medical School Institute for Health Policy.

He said he would just eliminate food and beverages entirely. "If the information they give you is important enough, you'll meet with them anyway. If the information's value is less than food, that food and beverage is payola. It's a bribe," he said. At this point, he said, professional societies need to step up.

Even the Pharmaceutical Research and Manufacturers of America's (PhRMA) 2002 code of ethics has put expensive meals, lavish gifts, gifts for the physician's personal benefit, such as golf balls, tickets to sporting events and other recreational activities, off limits.

Warming up to the results

PACE will look at PPI prescribing results next and is keeping its options open for continuing the program when the contract is up for renewal in July 2008. It already had planned to introduce the program into the retiree drug benefit this spring and was even considering recommending that it be carried over to the state's Medicare Part D and Medicaid programs, according to Mr. Snedden. The state does not plan to turn any of this prescribing information into a report card, or to share it with anyone else, he noted.

Can it play elsewhere? The improved patient outcomes and reduced drug expenditures more than cover the costs of the services, proponents say, and interest in the idea is growing in Maine, New Hampshire and Vermont. In May, the Maine legislature passed a law creating a statewide academic detailing program there.

"The success of the drug industries' marketing tactics disguised as education has been a wake-up call to medical educators. It's time for us to re-examine post-graduate medical education and to develop innovative programs like academic detailing that can deliver what the doctor ordered," said Rich Pinckney, MD, MPH, who is involved with Vermont's program.

Interest in educating doctors may rise in tandem with the rapid growth in U.S. prescription drug sales, which grew 8.3% to $274.9 billion in 2006 and are expected to continue to grow 6%-9% through 2010, according to IMS Health, which provides market intelligence to the pharmaceutical and health care industries.

Yet the drug industry has seen some of its big players reduce the size of their sales forces recently. This could be in response to having less to talk about, fewer blockbuster drugs or just a harder time getting in to see physicians, said Mr. Tenaglia of the Amundsen Group. "We may have hit the pivot point where sales forces start to decline. They're just not as effective," he said.

For now, Scott Lassman, PhRMA's senior assistant general counsel, said the drug industry is not too worried about academic detailers, believing that they can work hand-in-hand with the traditional reps as long as the information is "accurate and balanced … and meet the same high [FDA] standards that drug companies have to meet."

But Dr. Avorn said there may be more going on. "I hear that we're making the drug industry nervous," he said. "They would like us to go away but there's not much they can do about it."

Wearing his primary care hat, he feels a bond with time-pressured internists. "I view this as the best protection of the doctor-patient relationship, physician integrity and a way to stay current if you can't read 12 journals a day."

That works for Dr. Haimowitz of Levittown, Pa. He said he's already changing some prescriptions based on the iDiS information. "I'm always thinking, "Have I been biased by the rep? Is the information sound?' But this is the nonbiased drug rep. It gives me a better sense of security ... and I don't feel like I'm being bought. That's a really good feeling when I'm applying that information in practice."

Top

He opts for a lunch that's free—of distractions

From the window of his Sarasota, Fla. office, Frederick E. Turton, FACP, looked out on a familiar sight: doctors and other employees having lunch around a picnic table courtesy of a pharmaceutical company. The meals are so reliable, he said, that anyone interviewing for a job at the medical group is told they get lunch. Eating from a brown bag he brought from home, Dr. Turton reflected on his decision to opt out of the free lunches.

Even before he was elected ACP Governor for the Florida Chapter in 1998, Dr. Turton, a general internist at a multispecialty medical group, had limited the time he spent with pharmaceutical reps. His connection to ACP and its policies, he said, made him feel even more uncomfortable with those meetings, especially as he considered what others might think of the arrangement.

"The culture of reciprocity is an extremely powerful motivating force in the American culture. If you accept a gift you feel obligated to reciprocate," Dr. Turton explained. "I can't eat their lunch and say, 'No thank you, I don't want to talk to you.'"

That sentiment is reflected in the College's position that strongly discourages accepting industry gifts, hospitality, services and subsidies that might diminish the objectivity of professional judgment. The position continues that studies have documented that "the acceptance of even small gifts can affect clinical judgment and heighten the perception and/or reality of a conflict of interest."

The College released its update in the March 20, 2007 issue of *Annals of Internal Medicine*. For the update, visit here; for the full paper visit here.

While some physicians contend that the traditional relationship between doctors and industry can help busy physicians stay on top of the literature and new drugs, Dr. Turton, chair of the College's Ethics, Professionalism and Human Rights Committee, said those potential benefits have too many strings attached for him. "Studies point to the fact that gift-giving by pharmaceutical companies is effective," he said. "Why would they continue to spend money on this if it wasn't?"

He knows that other physicians don't necessarily see it his way. "We all feel that our judgment is sound. It's hard to argue with individual physicians," he acknowledged. And he knows that pharmaceutical companies will keep courting physicians as long as it works for them. "They understand what a lunch costs them and what it gets them," he said.

So, while he sometimes misses the social interaction afforded by pharmaceutical company-sponsored events, he doesn't regret the path he has chosen. It's led him to look more closely at generics and the benefits of older drugs and to question whether starting a patient on a free sample—he still has access to the shared sample closet used by the group's more than 50 physicians—could lead to higher costs down the road.

So how does he stay on top of the latest drug information? Continuing medical education helps, he said, and he looks things up as necessary. Plus, he's put the extra time he now spends alone during lunch hours to good use—that's when he catches up on his journal reading.