PHARMACY PRACTICE

Drug Detailing in the Hospital: Background for Policy Development

Julian Chan and Thomas Einarson

INTRODUCTION

The drug detailer, a common sight to all hospitals, has often been the subject of controversy. Many pharmacy managers are concerned about the potential negative effects of drug detailers on physicians' prescribing and the possible disruption of the workings of the pharmacy department. Thus, in order to deal with these issues, some hospitals have found it necessary to implement policies to guide the handling and the conduct of pharmaceutical service representatives. Some of these policies have been published in the literature and may prove to be useful in the development of policies in other hospitals. This article is intended to provide background reading on drug detailing by summarizing relevant literature and published policies. From this review, suggestions may then be offered toward the development of policies in individual hospitals.

DISCUSSION

Drug detailers, also known as detailmen, pharmaceutical sales representatives (PSR), and medical service respresentatives, are sales personnel employed by pharmaceutical manufacturers to promote their products to healthcare professionals. Traditionally their job has involved taking drug orders and product returns, speaking with physicians and pharmacists about their products (i.e., detailing, from which they get their name), setting up exhibits in hospitals, and sampling. Recently, however, there has been increasing emphasis on detailers as a potential source of new drug information or continuing education.[1-3] Crane et al.[2] outlined four main functions of PSRs which included: customer services, professional services, cost containment information, and research support.

Initially pharmacists were often recruited by pharmaceutical manufacturers to perform this role, however, this is no longer the case. Although the recruit is typically a graduate of a science-related field, actual training for the job often consists of two to four weeks of specific training, followed by field experience.[1,4] An accreditation course available from the Council for the Accreditation of Pharmaceutical Manufacturers Representatives of Canada also exists which, after a year of correspondence study, yields an accredited Pharmaceutical Manufacturers Representative (APMR).[5]

In 1983, about half of manufacturers' promotion budgets, an estimated $115 million, was spent on Canada's 2500 detailers, costing about $80 per visit.[5,6] Other estimates place the figure as high as 70% of all promotional expenditures.[7] In 1987, corresponding estimates approached $220 million, or approximately $100 per visit.[5,7] Added to that is the cost of samples estimated at over $18 million.[5,6] In addition to the financial attention received, some drug advertising magazines consider detailers important enough to be the standard index against which to compare newer modes of advertising.[9] It appears that the sales representative is the main tool for pharmaceuticals promotion in North America.[5,6,10]

Regardless of how important and professional PSRs are claimed to be by the pharmaceutical manufacturers, most of the literature regarding PSRs expresses strong concerns.[5-7, 11-15] Certainly, there would be skepticism towards the credibility of an article extolling the virtues of detailmen, no matter how sincere the underlying sentiment. In fact, there seems to be considerable controversy surrounding drug detailing, and it is important to examine the issue from both points of view more closely.

Industry's Position

First, one must consider the point of view of the pharmaceutical industry. The Pharmaceutical Manufacturers' Association of Canada (PMAC) claims that the pharmaceutical industry is the victim of a bad public

Julian Chan, B.Sc.Phm., Faculty of Pharmacy, University of Toronto, Toronto, Ontario.
Thomas R. Einarson, Ph.D., Faculty of Pharmacy, University of Toronto, 19 Russell St., Toronto, Ontario M5S 2S2
Address correspondence to: Dr. Einarson at the above address.

image and objects to the characterization of PSRs as being slick salesmen who trick physicians into prescribing medications without thinking of the best interests of the patients. While some companies may choose other options, the majority of drug companies are tending towards a professional role (along with its attendant professional conduct) for their representatives. Of primary interest is the PMAC Code of Marketing Practices, which was updated, formalized, and published recently.[16] Industry points to several pharmacy, medical, academic, and governmental (i.e., non-industry) bodies that assisted in this task of defining "how industry should operate in an ethical manner."[4] In its declarations about pharmaceutical sales representatives, PMAC directs its representatives to "display the highest professional and ethical standards at all times, as reflected by their conduct and appearance" and to "provide full and factual information on products, without misinterpretation or exaggerations."[16]

Companies in the Association (PMAC) are responsible for all of their representatives. Any inappropriate activities of a representative can be brought to the attention of PMAC to undergo a complaint review process. If a complaint is lodged against the company, it is investigated by a committee of marketing people that makes a decision. This decision may be appealed to a group of three referees (one referee is chosen by each side and one is mutually agreed upon) for a final decision. If the decision is against the company, it is ordered to desist. Persistent disregard of this order may result in expulsion from the association, although such action has not yet occurred in Canada.[4] In Britain, at least one firm has been suspended over actions of its representatives.[17]

Industry also points to their annual APMR course. Although not a requirement of most pharmaceutical firms, many encourage participation in the program. Essentially, the stated purpose of the course is to take steps towards establishing minimum standards for PSR. The curriculum includes health-related subjects such as anatomy, physiology, and pharmacology geared to help adequately prepare the respresentative to more intelligently converse with health-care professionals. Knowledge is assessed at the examination in May, which is held at a "university setting", and a grade of at least 75% is required to pass. Beyond this program there are nine smaller, more specialized courses that deal with upgrading the knowledge base in fields such as cardiovascular drugs, anti-infectives, and renal drugs.[4] Thus, the view of the pharmaceutical industry is that their representatives constitute a group of well educated and highly trained professionals who provide a valuable service to their clients.

The Critics' Position

Essentially, the main concerns that critics of the drug industry have regarding PSRs involve lack of qualifications to provide drug information, the accuracy of such information, the potentially strong bias and lack of controls on such information, and a perceived detrimental effect on prescribing. Despite the industry's position that their PSRs provide professional service, Hemminki and Pesonen[18] have produced evidence that pharmaceutical firms regard detailing as a sales activity. Eastman[19] has documented cases of extreme pressure by companies on their PSRs to sell drugs to physicians and pharmacists. Thus, there is a great potential for conflict between roles as information provider and salesperson.

It seems that despite their stated disapproval of reliance on manufacturer-provided drug information and believing themselves largely "untouched by the seductive ways of industry marketing men", health professionals do listen to detailers, whether it be for a relaxing break from a hectic routine or for actual drug information.[5,6,15] Actually PSRs appear to be an important source of awareness and interest in new drugs. They are also a major source of new drug information, and have a substantial impact on physician prescribing.[5-7,20]

Avorn et al.[21] showed that physicians relied heavily on PSRs and pharmaceutical advertisements for information, some of which was inaccurate or invalid. Hemminki[22] demonstrated that the information provided by detailers was very biased, always presenting their product as the drug of choice. Seldom were adverse drug reactions or reasonable alternatives discussed, resulting in a lack of balance in presentation. A review by Herman and Rodowskas[23] concluded that commercial sources of drug information for physicians outnumbered all other sources from 1.1:1 to 3:1. Haayer[24] conducted a study that demonstrated that the rationality of prescribing was negatively correlated with reliance on the industry for drug information.

Despite the heavy influence that detailing has on physicians prescribing habits, it would not be an issue if PSRs were seen as a benign, educational, unbiased source of information. Critics of the pharmaceutical industry, however, do not find this to be the case. In several articles[5,6] and in his book, *The Real Pushers*,[25] Lexchin recounts numerous accumulated instances of wilful deceit and misconduct on the part of pharmaceutical representatives, as well as in drug advertising in general. In fact, Lexchin goes as far as to conclude that doctors should not see

detailers at all. Avorn et al.[21] verified that facts were often distorted or presented in a biased fashion.

A great deal of effort is often expended to monitor representatives and to "counter-detail" to "undo the damage" done by the PSRs.[5,6,8,26] That approach has been taken not only by individual hospitals, but also by independent researchers who have implemented "academic detailing".[28,29] Such trials have resulted in substantial improvements in appropriateness of selected prescribed drug therapy.

Lumbard[26] pointed out that formularies were implemented in hospitals in order to eliminate duplication of products that were identical (i.e., generic copies) or therapeutically interchangeable. Consequently, the drug inventory could be reduced, resulting in lower costs and more efficient use of storage space. Dealing with requests for nonformulary drugs is time consuming and costly for the department.[26] In addition, a new drug may cost much more but offer the patient little real (therapeutic) advantage.[27] Many pharmaceutical firms have followed approved protocols for securing formulary status for their products. However, others have attempted to bypass the system. Many PSRs have attempted to have their products accepted into formularies or have promoted nonformulary drugs to selected influential physicians who would, in turn, demand those nonformulary drugs. Such action puts pressure on the pharmacy department and the Pharmacy and Therapeutics (P&T) committee.[26] Some United States (US) companies or their PSRs have resorted to other questionable practices. Liang[30] cited a case where a representative warned that a hospital could be found negligent if the (purportedly) superior product were not stocked by the hospital despite a lack of conclusive supporting evidence. Pharmacists have also become incensed towards the journal advertisements recommending physicians to indicate "dispense as written" on prescriptions.[31] Those authors urged pharmacists to inform PSRs of their strong opposition to these advertising practices that were considered an infringement on the pharmacist's role. Miller et al.[32] cited cases of direct pressure by PSRs for formulary status for their products in exchange for financial support for dubious clinical studies, provision of visiting speakers, or for publication of a journal.

Other authors have also concluded that industry is less than ethical, and one article lists as one of seven "principles of irrational drug therapy" to be relying on professional sales representatives as the "best source of information on side effects". The authors continue as they quote a former pharmaceutical company medical director saying that "detail men are either shrewd salesmen or shrewd businessmen, never philanthropists . . . they make investments, not gifts." They even charge that "it is a standard operating procedure for drug manufacturers to suppress reports on the toxicity of their products as long as they can get away with it."[33]

There have been surveys done in the US to determine the attitudes and opinions of pharmacists and hospital pharmacy directors towards PSRs. *Pharmacy Times* has been conducting a survey in the US for more than thirty years. The major findings appear to be that: 1. more chief pharmacists feel that PSRs take too much of their time; 2. more chief pharmacists report that PSRs often "tie up" their pharmacy staff; 3. more chief pharmacists state that PSRs use pressure in detailing them.[34-36] Santell et al.[37] conducted a national survey of US hospitals. A majority of directors (61%) indicated that PSRs met the hospital's needs less than 60% of the time.

Policy Development

Critics' objections notwithstanding, it seems doubtful that the pharmaceutical industry will abandon the practice of detailing hospitals. Yet, because of the perceived potential negative impact that could arise from drug detailing, the matter should be addressed. In that way, PSRs could function compatibly within the operations of the hospital rather than continue in an adversarial relationship. Thus, it would seem worthwhile to consider developing a PSRs policy, not only to control behaviour, but to also draw on the potential positive resource the PSRs can represent.[2] In that way, all parties could benefit from the relationship.

In 1985, Thomas[38] conducted a survey of American hospital policies on pharmaceutical sales representatives. Although two-thirds of the hospitals had formal, written policies, many of those policies had been adopted quite recently. Several hospitals without written policies indicated a desire to undertake their development in the next two years, thus continuing the trend. In the meanwhile, most hospitals were in the practice of oral orientation of PSRs possibly accompanied by written formal or informal guidelines.

According to Thomas's survey, in the majority of hospitals it is mostly the pharmacy director who is responsible for determining the scope of PSRs activities. The Pharmacy and Therapeutics committees, medical-staff committees, and purchasing directors sometimes assist. However, when it comes to handling PSRs violations, the pharmacy director is usually solely responsible, without participation of the committees and other staff.[38]

For the American hospital, there was only moderate satisfaction with

the developed policies. In the future, it is expected that there will be stricter regulations on persons, products, and areas of the hospital allowed to be detailed and sampled.[38,39] Published information on PSRs policies in Canadian hospitals is lacking.

There are some guidelines for handling PSRs provided in the literature. Referring to the American hospital survey,[38] the following summarizes what pharmacy directors regarded as the most useful and the most annoying PSRs activities, as well as new services that they would like to receive in the future. Useful activities performed by PSRs included: returning goods and issuing credits; product information, especially about new drugs, as wells as seminars, continuing education, and in-service education programs. In-service education programs and the sponsoring of guest speakers were the most requested new services for those hospitals not yet receiving them.[39] Among the activities directors wanted discontinued were: excessive sampling, pressure selling, overselling, biased information, and semi-truths and detailing nonformulary, unstocked drugs.

McGhan et al.[40] published results form a survey which indicated that while directors tended to receive monthly visits and staff pharmacists received weekly visits, all hospital pharmacists preferred monthly detailing visits. It also showed that disseminating drug information was the most important and most utilized function of a medical service representative. In fact, PSRs were the third ranked source of drug information, surpassing seminars and professional colleagues. Even with such support, most clinical pharmacists responded that PSRs left them insufficiently informed, and wanted more information from them.[40]

The most complete PSRs policy package was described by Willcox et al.[41] The package was developed by the pharmacy services staff of a large American teaching hospital. They established a three-part program to monitor the activities of hospital PSRs consisting of: written procedures regulating the activities within the hospital, a formalized orientation program for PSRs new to the hospital and quarterly PSRs committee meetings.

The written policies entailed many elements similar to those discussed above. Representatives were required to make appointments, check in at the appropriate reception desk in the pharmacy department, avoid patient care areas at all times, and upon leaving, to sign out, surrender the identification badge, and leave the hospital promptly. In addition, a mailbox was provided for representatives to facilitate sending messages. The allowable frequency of visits was set at once per week to twice monthly. Representatives were allowed access to various members of the pharmacy staff such as directors and drug information pharmacists on an appointment basis, but were prohibited from interacting with other pharmacists while they were on duty. Additionally, a request was made that all new and revised drug information, as well as research articles, be made available to the drug information centre by the representative.[41]

An orientation program was designed to acquaint the PSRs to the physical facilities and to the policies of both the pharmacy and medical department. The representatives were provided with an orientation package that included, among other things a welcoming letter, route map and guide to the hospital; a hospital fact sheet, a statement of the philosophy and objectives of the pharmacy department; a pharmacy department catalogue; an organizational chart of pharmacy services and personnel; a copy of the pharmacy newsletter; a copy of the PSRs visitation register; and a copy of PSRs rules, regulations, policies, and procedures.[41]

To achieve direct communication with all PSRs, quarterly meetings of all PSRs with the pharmacy director were arranged. This arrangement permitted direct communication of hospital policies to all PSRs in an open forum format. This practice met with a high degree of enthusiasm and appears to have helped to improve the success of the program.[41]

Also mentioned were projects to help increase the drug information role of the PSRs. An annual two-day drug fair sponsored by the departments of pharmacy and nursing was an example of such an educational endeavour. That fair gave the PSRs an opportunity to present product displays and to discuss these products with the healthcare staff. Also, PSRs-sponsored "medical information dialogues" were implemented as continuing education for medical staff. In that forum, the PSRs arranged several tables of specialty medical experts, with which the attending medical staff could interact and update their knowledge base. Both programs seemed to have been well-received, and the representatives' participation was well recognized and appreciated.[41]

Not all hospitals have found it necessary to adopt such a comprehensive policy. A British hospital reported a high level of success in the establishment of a simple six-point code in helping them analyze PSRs activities. Representatives were asked to register all visits in a visiting book at a reception desk where they could also obtain information such as staff lists, the hospital formulary, contact names for contract negotiations, and policy statements regarding the promotion of

new drugs. Prior appointments were preferred whenever a PSRs visited. It was stated that all drug supplies were to be arranged through pharmacy. The representatives were also asked to wear identification badges, to avoid entering clinical areas without written permission, and to respect the drug use policies of the hospital.[42]

CONCLUSION

Each hospital must first determine whether a drug detailing policy should be implemented in that institution. A survey of pharmacy and medical staff could be a valuable method of needs assessment. If a problem is identified or dissatisfaction exists between the hospital staff and the PSRs, it would be useful to first identify the reasons for dissatisfaction. Alternatively, the pharmacy department may simply want more service from the representative, such as more inservice training, medical dialogues, or even drug fairs. Thus, department needs should be balanced with demands made upon PSRs and the companies they represent. Regardless of which needs are addressed and incorporated into the policy, the policy's effectiveness must be evaluated. Followup and policy adjustment are strongly recommended.

Because Canada has considerably less information concerning PSRs policy than the US, a survey would be appropriate to provide such information. Further recommendations or specific details concerning the actual content of PSRs policies could perhaps be made following such a survey.

REFERENCES

1. Klein T. Detailing and other forms of promotion. In: Smith MC, ed. Principles of pharmaceutical marketing. Philadelphia: Lea and Febiger, 1983: 400-17.
2. Crane VS, Jefferson KK, Morgan R. Rethinking pharmaceutical industry relationships. *Am J Hosp Pharm* 1987; 44:1884-6.
3. Craig SA, Clark T. Professional development and continuing education programs for pharmacists in large hospitals. *Am J Hosp Pharm* 1988; 45:2503-6.
4. Brennan J, PMAC PGPA chairman. Personal communication, 1990 April 9.
5. Lexchin J. Doctors and detailers: therapeutic education or pharmaceutical promotion? *Int J Health Serv* 1989; 19:663-79.
6. Lexchin J. Pharmaceutical promotion in Canada: convince them or confuse them. *Int J Health Serv* 1987; 17:77-89.
7. Meadows RJ. Communicating new drug information — the medium is the message. *Drug Info J* 1981; 15:11-5.
8. Anon. The 1989 health care advertising review (pharmacy) — how much is too much detailing? *Med Market Media* 1990; 25(3):66-67.
9. Roseman E. Where the changing promotional mix is headed. *Med Market Media* 1989; 24(6):10-20.
10. Foster C. Sales pitch still crucial to pharmaceutical firms. Globe and Mail, Toronto; 1982 Sep 10:p.R2.
11. Rasmussen JE. Drug samples. A conflict of interest? *Arch Dermatol* 1988; 124:1283-5.
12. Musher DM, Young EJ, Hamill RJ. The ethics of pharmaceutical promotion [letter]. *N Engl J Med* 1986; 315:590.
13. Potter HP Jr. Costs of drug advertising [letter]. *N Engl J Med* 1988; 319:798.
14. Bricker EM. Industrial marketing and medical ethics [letter]. *N Engl J Med* 1989; 320:1690-2.
15. Solomon SD. We need ethical guidelines for promotion of prescription drugs to physicians. *N Engl J Med* 1989; 320:1700.
16. Pharmaceutical Manufacturers Association of Canada. Code of Marketing Practices. Ottawa, ON: PMAC, February 1988.
17. ABPI Code of Practice Committee. Bayer UK Ltd suspended over actions by representatives. *Pharm J* 1986; 237:821.
18. Hemminki E, Pesonen T. The function of drug company representatives. *Scand J Soc Med* 1977; 5:105-14.
19. Eastman M. The day the detailman talked. *Am Pharm* 1978; NS18:592.
20. Brodrick A, Preece G, Oakley R. An evaluation of the release of information on a new drug in a hospital without a drug information services. *J Clin Hosp Pharm* 1982; 7:293-7.
21. Avorn J, Chen M, Hartley R. Scientific versus commercial sources of influence on the prescribing behavior of physicians. *Am J Med* 1982; 73:4-8.
22. Hemminki E. Content analysis of drug detailing by pharmaceutical representatives. *Med Educ* 1977; 11:210-5.
23. Herman CM, Rodowskas CA. Communicating drug information to physicians. *J Med Educ* 1976; 51:189-96.
24. Haayer F. Rational drug prescribing and sources of information. *Soc Sci Med* 1982; 16:2017-23.
25. Lexchin J. The real pushers. Vancouver, BC: New Star Books, 1984.
26. Lumbard J. The foremost problems associated with formulary management: second response. *Hosp Pharm* 1983; 18:134.
27. Hoffman RP. The foremost dilemma in managing a hospital formulary. *Hosp Pharm* 1982; 17:245.
28. Avorn J, Soumerai SB. Improving drug therapy decisions through educational outreach. *N Engl J Med* 1983; 308:1457-63.
29. Somerai SB, Avorn J. Principles of educational outreach ('Academic detailing') to improve clinical decision making. *JAMA* 1990; 263:549-56.
30. Liang FZ. Hospital risk in selecting therapeutic alternates. *Am J Hosp Pharm* 1988; 45:1052.
31. Mitchell JF, Pawlicki KS. "Dispense as written" advertisements are demeaning to pharmacists. *Am J Hosp Pharm* 1988; 45:2073.
32. Miller K, Gouveia WA, Barza M, et al. Undesirable marketing practices in the pharmaceutical industry. *N Engl J Med* 1985; 313:54.
33. Vance MA, Millington WR. Principles of irrational drug therapy. *Int J Health Serv* 1986; 16:355-61.
34. Teplitsky B. A 25-year trend: what chief pharmacists think about detailmen. *Pharm Times* 1980; 46(12):55-64.
35. Teplitsky B. 1955 vs. 1985 part I: 30-year trend: what chief pharmacists think about detailers. *Pharm Times* 1985; 51(11):83-92.

36. Teplitsky B. 1955 vs. 1985 part II: 30-year trend; what chief pharmacists think about detailers. *Pharm Times* 1985; 51(12):55-6, 58.
37. Santell JP, Birdwell SW, Scheckehoff DJ. Perception of the role of medical-service representatives in hospitals. *Am J Hosp Pharm* 1990; 47:1354-9.
38. Thomas J III. National survey of hospital policies on pharmaceutical sales representatives' activities. *Am J Hosp Pharm* 1987; 44:1334-40.
39. Thomas J III. National survey of recent changes in hospital policies on pharmaceutical sales representatives' activities. *Am J Hosp Pharm* 1989; 46:565-9.
40. McGhan W, Serry S, Hill B, Koda R. Hospital pharmacists' attitudes towards medical service representatives: a comparison of directors, staff, and clinical pharmacists. *Hosp Formul* 1982; 17:957-61.
41. Willcox GS, Mahoney CD, Jeffrey LP. Monitoring the hospital activities of medical service representatives. *Am J Hosp Pharm* 1983; 40:989-91.
42. Hopley PJ, Rich AJ. Pharmaceutical company representatives — an activity analysis. *Pharm J* 1988; 24 (Nov 12 supplement):R21-2.