ON TRACK

Stimulus, Response, Interpretation

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In this On TRACK, I consider the *stimulus* provided by articles in the last issue of the *Annals* and the *response* of thoughtful readers commenting in the *Annals* online discussion (TRACK), and I provide my own *interpretation*. I encourage readers to write your own interpretation as an online comment to On TRACK or the original article.

PHARMACEUTICAL REP ADDICTION

The ethical analysis by Howard Brody[1] provided a powerful stimulus for thoughtful and deeply felt replies. Dr. Brody argues that physicians ought to refuse to see pharmaceutical representatives (reps) on the grounds of both professional integrity and sensible time management.

Responses range from agreement[2-4] to taking offense that "Dr. Brody must not practice in the real world."[5] Others suggest ways for physicians to manage, rather than avoid, the conflict,[4,6-8] while one writer calls for a new code of conduct for education and practice, organizations, and individuals.[9]

Picking up on an analogy in Dr. Brody's analysis, John Scott labels the phenomenon as "Pharmaceutical Rep Addiction,"[10] and prescribes a cure—abstinence.

One solo physician describes his own "recovery," saving 1 to 2 hours each day and an office room, both of which allow him to spend more time seeing patients. He also describes a dramatic reduction in telephone calls from pharmacies as he began to prescribe fewer nonformulary drugs.[11] A physician in group practice echoes the sentiment that eliminating free samples of the most expensive drugs "has not hurt our patients or our practice in the least. It gives us extra time to focus on patient care."[12]

Two physicians note the additional conflict of direct-to-consumer marketing.[12,13]

Discussants argue for the benefit of providing samples to needy patients, "If you do not see a rep you do not get samples,"[5] and learning from the reps, "I appreciate the opportunity to learn about the latest innovations that occur regarding medical care."[7]

Adam Goldstein decries the educational value of pharmaceutical reps, saying that the relationship "comes down to 1 of 2 things: either a plea for samples or a plea for food."[14] In an interview for *US News & World Report,*[15] Dr. Goldstein reflects that pharmaceutical-sponsored meals "are part of our culture."

My own analysis of the discussion is that Dr. Brody's appraisal hits hard because it not only documents the moral argument but makes the practical case as well. The practical case is hard for family physicians to ignore, because we think of ourselves as pragmatists focused on what is best for our patients.[16] Brody shows us that giving time and taking (skewed) information and (expensive) samples is neither practical nor in our patients' interest.

As family physicians, we prescribe abstinence for our addicted patients, but offer cutting back as an option for those who are not ready to abstain. The first step should be to recognize the ignoble nature of our dependency and the insidious way in which we became addicted—typically through professional socialization during training and having the best intentions for our patients as practicing clinicians. We should try the experiment of cutting back or abstaining and explore other options for meeting our patients' needs for affordable drugs, as well as our own needs to keep up with new knowledge. Brody's analysis gives us good reason to believe that the experience of Drs. Mitchell and Fior[11,12] will be our experience—that patients and our professionalism will benefit from the experiment. If we can break this addiction as individuals, we will gain the moral authority to ask our professional organizations to do the same.

DEPRESSION MANAGEMENT IN PRIMARY CARE

The cluster of 6 studies of depression[17-22] and the related editorial[23] provided a stimulus for responses addressing the following:

- Community participatory research as a fundamental approach to primary care inquiry[24-26]
- Integrated care management[27-32]
- Tailored, individualized, personalized care that empowers patients[32-36]

I interpret this discussion as a cry for reduction in the fragmentation of care. Those on the front lines see fragmentation as a major cause of increased costs. This fragmentation lowers the effectiveness of diagnosis and treatment of depression and reduces the effectiveness of health care in general. Both researchers and clinicians see the potential of integration of care as a powerful way of enabling people to get on with their lives to the best extent possible, given chronic somatic and mental illness.

OTHER STIMULUS AND RESPONSE

Studies from the last issue of the *Annals* stimulated readers and shaped their thinking and responses. These studies "undermine the notion that there is a perceived ethical conflict between commitment to the well-being of the individual patient, and a concern for distributive justice and the health care needs of the entire society."[37,38] They also "raise the intriguing question of how much lower the criteria will become for the diagnosis of 'diabetes' and how far ahead we should be thinking."[39,40]

Studies from the November/December 2004 issue of the *Annals* stimulated further responses that many are awaiting the results of the national demonstration project for the New Model of family medicine[41] proposed by the Future of Family Medicine Project and financially modeled in the recent supplement.[42,43] Writers also expressed frustration from both patients and physicians with overburdened access systems that result in no-shows.[44-49]

The revisiting of the biopsychosocial model continues to resonate. "[M]oving from objective detachment to reflective participant could serve as a galvanizing soundbite for what is required to move into high performance primary care. We all, patients and physicians alike, so desperately need a time and place where we can consult, 'mind-fully,' and we physicians need a workload and practice systems that will permit us to be prepared, available, attentive—indeed 'attending physicians.'"[50]

Please join these and other writers in adding your insights at http://www.AnnFamMed.org. Click on "discussion of articles" or follow the links for the comments or the article on which you wish to comment.

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