

Prescriber Profiling: Time to Call It Quits

Pharmaceutical marketing to physicians recently surpassed \$23 billion per year, and the pharmaceutical industry currently employs 1 sales representative for every 5 office-based physicians (1, 2). In this setting, policy-makers and patients are understandably concerned about commercial influences on physicians' prescribing decisions.

Real-time, physician-specific data on prescribing habits are a powerful tool that pharmaceutical sales representatives rely on when visiting a physician's office. A representative can quickly access a breakdown of pharmaceuticals prescribed by any physician on a handheld computer, enabling that representative to deliver a tailored marketing pitch to physicians selected for their current prescribing habits. Within weeks, the sales representative can monitor each physician's response to the pitch—as well as to inducements, such as meals, gifts, and drug samples—and can make repeated visits to achieve sales goals.

Given that prescriber profiling is so deeply embedded in pharmaceutical detailing, we have surprisingly little published research about its effect on sales. One recent market research report concluded that profiling improves profit margins by as much as 3 percentage points and the initial uptake of innovative drugs by 30%. Few details of the study are publicly available, and its quality is difficult to evaluate (3). However, other indirect indications of effectiveness exist—for example, the emphasis that pharmaceutical marketing consultants place on the value of prescribing profiles for enhancing sales force effectiveness (4–6).

How do pharmaceutical companies obtain such detailed prescribing data? Currently, retail pharmacies sell de-identified patient prescription records with limited physician identifiers to data intermediaries known as health information organizations (HIOs). By purchasing a comprehensive database of U.S. physicians from the American Medical Association (AMA), HIOs can link individual physicians to prescription records by using identifiers common to the pharmacy databases and the AMA database, such as a physician's U.S. Drug Enforcement Agency and medical license numbers. They also can track a physician's demographic and practice characteristics. The HIOs build prescribing profiles on the basis of these linked databases and sell them to pharmaceutical companies, which use the profiles to identify sales targets and plan detailing visits.

Prescriber profiling is a long-standing practice, not the recent phenomenon one might imagine it was from the attention being paid to it. In this issue, Greene (7) describes the historical origins of the collection and use of physician prescribing and practice profiles for commercial marketing. He finds that pharmaceutical firms were assembling prescriber profiles as early as the 1940s and 1950s. Early alliances between pharmaceutical companies and the AMA were instrumental in the development of the data collection industry, as such collections served the market-

ing interests of the companies and provided substantial revenue to the AMA. This business relationship between the profession and pharmaceutical manufacturers continues today. In 2005, it contributed to the AMA's \$44.5 million in revenue from the sale of database products—16% of the AMA's total revenue for that year (8).

Greene also finds that individual physicians—operating independently of organized medicine—have played a key role in pharmaceutical market research. Physicians have been enrolling in profiling studies conducted by pharmaceutical companies since the 1950s and continue to do so to this day. For 1 such trial, the National Disease and Therapeutic Index, participating physicians maintain detailed practice diaries that they provide to the sponsoring market research firm. Although this market research involves relatively small panels of physicians, the results help marketers to segment the physician market and optimize promotion strategies by providing an in-depth understanding of how physicians make prescribing decisions. Greene reports that two thirds of physicians have agreed to participate when asked and posits that the marketing firms sometimes encourage participation by emphasizing the secondary professional or public health benefits. What physicians believe about the principal purpose of these market research studies and why they participate remain unknown. Are they unaware of the commercial motivation for these profiling studies, do they see assisting in commercial marketing as a valid role for medical professionals, or are they simply attracted by an opportunity to increase revenue?

Many physicians believe that using prescribing profiles in commercial marketing crosses a line of acceptability. A Kaiser Family Foundation survey found that only 60% of physicians were aware that drug companies have access to physician-specific prescribing data. When they were told of the practice, 74% disapproved (9). A physician survey commissioned by the AMA found similar levels of awareness (77%) and disapproval (66%) (10). Anecdotes also confirm the survey findings, with one physician recently commenting, "It makes me feel like a rat in a maze when they put little nibblets in front of me to see if I'll prescribe their drug" (11).

With a substantial majority of physicians opposing the sale of prescribing data and the public and policymakers rightfully concerned about the influence of marketing on prescribing, the key question is what physicians can do to end this practice. In 2006, New Hampshire—with support from the physician community—enacted a ban on the sale of prescribing data. The law allowed use of the data for public health, health care administration, and research purposes (12). Two major HIOs immediately challenged the law on the grounds that it violated their right to commercial free speech (selling information); a ruling from the district court is expected by May 2007 (13). Health infor-

mation organizations also argue that prescribing data serve important public functions; however, Greene notes that public benefit uses are “more of a potential space than a true wellspring of benefit,” given the high cost of purchasing the data (7). The National Physicians Alliance, consumer groups, and several medical societies are working in other states to promote legislation similar to the New Hampshire law (14).

Physician discontent recently led the AMA to launch the Prescribing Data Restriction Program, which enables physicians to “opt out” of having their prescribing data made available to sales representatives (15). While pharmaceutical companies continue to purchase the prescribing data of physicians who opt out, they have agreed not to show the data to individual sales representatives. Providing an opportunity to opt out is a step in the right direction; however, participation in the program thus far is low (<1% of all physicians), as is awareness (25%), which raises concern that the AMA opt-out program is not an effective way to address the concerns of physicians and their patients (7). Moreover, the considerable revenue the AMA is earning from the current system is a conflict of interest—it’s not clear to what extent the AMA is willing to develop a remedy that would better serve the public. Physician members of the AMA could introduce a resolution calling for an end to the practice altogether or, at a minimum, to adopt an “opt-in” approach, in which the AMA could release a physician’s data only if the physician consented.

Individual-level prescribing data and in-depth physician market research primarily serve to augment the success of pharmaceutical marketing. However, combining pharmaceutical detailing with physician prescribing data allows marketers to influence prescribing in ways that threaten medical professionalism. The Charter on Medical Professionalism identified the primacy of patient welfare as a fundamental principle (16), and a large body of literature already demonstrates the subtle and unconscious influences of gifts on prescribing (17, 18). With profit as the central focus of commercial marketing and market research, professional responsibility requires that physicians make their treatment decisions free from undue influence by marketers.

If physicians want prescriber profiling to end, they must act by urging state legislatures to enact laws similar to those in New Hampshire, lobbying their professional organization to support such laws, and calling on the AMA to place further limits on selling physician data for use in prescriber profiling. Furthermore, physicians should refuse to participate in marketing research that generates prescribing patterns because the primary purpose of this practice is to enhance sales, not patient welfare. The time has come for physicians to roll back the influence of commercial marketing practices on clinical decisions. Ending physician participation in marketing research and the sale of physician prescribing data to marketing firms is the right place to start.

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