

## Many Sources for Conflict of Interest in Medicine

### *Definitions and Various Sources of Conflict of Interest.*

Jonathan H. Marks, MA, BCL (Oxon)

Jonathan H. Marks, MA, BCL (Oxon) -Special Presentation

It is important to remember that not every financial conflict of interest in medicine is industry related. For example, even fee-for-service medicine can put pressure on physicians to put aside the primary interest of the patient in favor of the secondary interest of financial gain.

“Conflict of interest” has many definitions. One helpful definition formulated by Dennis Thompson was recently used by the Institute of Medicine in a 2009 report on conflicts of interest. He defined a conflict of interest as a set of circumstances that creates a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest. To simplify this, think in the context of a patient’s care in which a primary interest would be the interest of the patient, the patient’s health, or even public health, but the secondary interest would be related to the pharmaceutical industry. For example, if a physician has interactions with the pharmaceutical industry, he or she may feel some obligations of reciprocity that might be at odds with the primary interest (to care for patient’s health). **Sources of Conflict of Interest:** There are several sources of conflict of interest. Some conflicts of interest are financial, while some are not. An example of a potential non-financial conflict is that of an academic or biomedical researcher who has invested a significant part of his or her career pursuing a research agenda. The primary interest of a researcher should be the integrity of science and the pursuit of knowledge, yet the reputational investment in the research project may generate a powerful secondary interest that is at odds with that primary interest. Tension may be created when scientific data are unfavorable to the research agenda. Scientific misconduct may occur as an egregious example of failure to resolve this inherent conflict. **Financial Conflicts of Interest:** Not every financial conflict of interest is necessarily industry-related. For example, fee-for-service for medical practitioners is an example of a financial conflict of interest that is not related to the pharmaceutical industry. One of the reasons why we become very concerned about industry-related conflicts of interest is because of their increasingly pervasive nature and their systemic effects. (Reviewer-).

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## Is Industry Funding of CME Events Truly Unavoidable?

*Avoidable and Unavoidable Conflicts of Interest in Medicine.*

Jonathan H. Marks, MA, BCL (Oxon)

Jonathan H. Marks, MA, BCL (Oxon) -Special Presentation

For academic medical centers in the United States, >50% of all continuing medical education (CME) events are underwritten by the pharmaceutical industry. However, in Canada, industry funds only 14% of CME events at academic medical centers.

In medicine, conflicts of interest are everywhere. Sometimes they are unavoidable. Even when they are avoidable, these conflicts of interest continue to be ubiquitous. As physicians, we may have a conflict of interest between our desires to spend more time with our families and our patients' needs and desires to have more time with us. The physician who is in the room with her patient but wants to rush home because it is her 5-year-old's birthday party is facing a conflict. This is a common and probably inevitable type of conflict of interest. When is a conflict of interest morally problematic--when do we and when don't we need to be concerned about a particular conflict of interest? Avoidability may be one useful distinction. **Avoidable Conflicts of Interest:** Some conflicts are avoidable, but we have come to accept them because they are so pervasive. We are challenged to identify these avoidable conflicts of interest and get rid of them. A good example of what seemed to be an unavoidable conflict of interest, until very recently, has been industry funding of continuing medical education (CME). For academic medical centers in the United States, >50% of all CME events are underwritten by the pharmaceutical industry. It is tempting to say that this conflict of interest is simply unavoidable--we need industry funding for CME events for health professionals. However, in Canada, only 14% of CME events at academic medical centers are funded by industry. If you look outside the profession of medicine to other professions, you will find many other examples of continuing professional education that do not rely on funding from a source that creates conflict of interest. **Unavoidable Conflicts of Interest:** Some conflicts of interest are unavoidable. Nonetheless, we need to identify them and do a better job of managing them. (Reviewer-).

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## Sense of Reciprocity Activated by Free Gifts

*Industry Influences May Be Subtle -- The Psychology of Reciprocity: Part 1.*

Jonathan H. Marks, MA, BCL (Oxon)

Jonathan H. Marks, MA, BCL (Oxon) -Special Presentation

An increasing body of social science data shows that subtle forms of industry interaction play against our sense of reciprocity. Receipt of small gifts with company logos subtly influences the clinical judgment of health professionals.

(Card 1 of 3) We have learned a lot in the last several decades about the nature of conflict-of-interest problems that arise when industry interacts with physicians. One concern is actually about how good people can be led astray, despite their best intentions. Cognitive and behavioral psychologists have told us that all sorts of subtle influences arise from our interactions with industry of which we may not necessarily be aware. These kinds of influences operate at a very subtle level and unwittingly exploit characteristics that we normally value in people. One influence involves reciprocity: For example, I sent you a draft paper of mine and asked for your comments. You commented in great detail, and sent it back to me within 24 hours. The following month, you asked me to look at one of your papers. Instead of sending this back to you quickly, I hold it for 3 months, and despite your repeated requests to provide comment, I never respond. In this case, there has been a failure of reciprocity. I have not reciprocated your excellent behavior as a scholarly colleague. **Psychology of Reciprocity:** Reciprocity is a positive trait that we look for in our colleagues in medical practice, in our partners, and in our friends. Reciprocity is something we value in terms of building relationships. However, reciprocity can create a serious problem if it impairs the judgment of a health professional in the conduct of medical practice or medical research. An increasing body of social science data shows that there are subtle forms of influence that play against our sense of reciprocity. Therefore, receipt of small gifts with company logos, such as mugs, pens, and pencils, start to subtly exercise their influence on the clinical judgment of health professionals. (Reviewer-).

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## Little Gifts Have Big Impacts on Physicians

*Industry Influences May Be Subtle -- The Psychology of Reciprocity: Part 2.*

Jonathan H. Marks, MA, BCL (Oxon)

Jonathan H. Marks, MA, BCL (Oxon) -Special Presentation

Even small gifts of very limited value can have a major impact on people's cognitive assessment. The emerging body of social science data says that small gifts have a major impact on physician's professional judgments.

(Card 2 of 3) Although professional conferences underwritten by a pharmaceutical company are not equivalent to the small gift of a pen with the company's logo or a pizza lunch, the hazards of subtle influence and reciprocity arise from each. As physicians, we may be most acutely aware of these obligations in relation to an all-expenses-paid junket to some exotic location, but we may not be aware of subtle forms of influence that arise from small gifts. Even little things like a pen with the company's logo or a pizza lunch actually affect people's clinical judgments. Empirical data from social science studies demonstrate that even these interactions have an effect on practitioners' decision making and professional judgment. **Subtle Influence of Free Lunches:** For example, 1 study looked at free lunches sponsored by drug companies. In many cases, these lunches affected physicians' prescribing habits, even though they could not remember attending the lunch. All these interactions create different varieties of the same problem -- the often subtle and undetected obligations of reciprocity and influence. When you ask physicians whether they are impacted by these small interactions, most say they are not. Then, they will go on to say that they worry that their colleagues are indeed influenced. **Self-Serving Bias:** Cognitive and behavioral psychologists tell us that these responses are an example of self-serving bias. Self-serving bias is something that all human beings have -- we all identify and process information in a way that serves our own interests. This is why these interactions are particularly problematic. **Subtle Influence of "Having":** There are some wonderful experiments in which the people on 1 side of a room receive free mugs, and those on the other side receive free pens. Next, the people are asked who would be willing to swap their mugs or their pens. Remember, neither group had either of these items for longer than 10 minutes. However, the process of possessing these items for 5 or 10 minutes causes people to endow them with special values that they would not have anticipated otherwise. Therefore, even tiny items of very limited value can have a major impact on people's cognitive assessment. We should take into account this emerging body of social science data that says small gifts really have a major impact. (Reviewer-).

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## Industry Interactions Alter Prescribing Habits of Docs

*Industry Influences May Be Subtle -- The Psychology of Reciprocity: Part 3.*

Jonathan H. Marks, MA, BCL (Oxon)

Jonathan H. Marks, MA, BCL (Oxon) -Special Presentation

The data from a number of empirical studies clearly demonstrate that interactions with industry representatives (including receiving free samples, etc) drastically alter prescribing habits of physicians, even when they do not recall the interaction.

(Card 3 of 3) **Subtle Influence of Industry Logos:** A group of experimental subjects were told that a fictitious company was sponsoring a study in which they would be participating. Subjects were then asked to rate works of art from -5 (dislike) to +5 (like very much). They rated a number of images of famous paintings that were flashed before them. Randomly, the logo of the fictitious corporation said to be sponsoring this experiment was flashed alongside these pictures as experimental subjects evaluated them. What happened? The valuations accorded to pictures with randomly assigned logos were higher than those without the logo. In other words, just being told that the experiment was being funded by a company caused people to alter their esthetic judgment. Now, obviously, that was not intentional on the part of any experimental subjects, but nonetheless, the effect was real. **Effects of Industry Interactions on Physicians:** Looking at medical practice and medical care directly, the data from a number of empirical studies clearly demonstrate that interactions with industry representatives (including receiving free samples, etc) drastically alter prescribing habits of physicians, even when they do not recall the interaction. As a result of industry interactions, physicians tend to prescribe newer and more expensive patented drugs. The reality with many of these drugs is that the side effect profile is not as well known, so the drugs are not only expensive but they also impose increased hazards on the patient. Recently, the Food and Drug Administration reviewed all of its new drug approvals over a course of 7 to 10 years. They determined that about 83% of these drugs offered no significant improvement over existing therapies. As a result, the trend revealed by several studies is that physicians are often being led to prescribe more expensive patented drugs with less well-known side effect profiles and that do not necessarily offer an enhanced benefit over existing cheaper therapies provided by generic drugs. If this is true, then physicians have reasons to worry about those interactions with industry. (Reviewer-).

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## Study Design Can Be Tweaked to Improve Outcomes

*Outcomes More Favorable for Industry-Sponsored Research.*

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Jonathan H. Marks, MA, BCL (Oxon) -Special Presentation

So that funding will continue, researchers may desire to provide outcomes that are favorable to their sponsors. They do not falsify or fabricate results, but they may look carefully at the study's design and presentation of results.

Empirical studies show that industry-funded research tends to produce outcomes that are many, many times more favorable than those produced by non–industry-funded research. The mechanism behind this finding is very fascinating, and further empirical studies are needed to fully define it. However, there are a number of potential explanations for why industry-funded studies may provide more favorable outcomes for industry sponsors. **Methodology:** One explanation is that the methodology leads to these kinds of favorable results. For example, if you are looking to demonstrate the comparative efficacy of a new drug, then you might overdose the new drug just a touch, and underdose the competitor drug. On the other hand, if you are looking at side effects, you might underdose the new drug so that the side effects are not so drastic. Therefore, research to explore methodological reasons for favorable outcomes in industry-sponsored research is needed. **Funding Needs:** Another possible explanation for these favorable outcomes is that the researcher has had a long-term relationship with a pharmaceutical company. Therefore, the researcher may desire to provide an end result that is favorable to the sponsor so that funding will continue. This does not mean that researchers necessarily take the treacherous route of falsification or fabrication, but there are gray areas and complicated decisions to be taken in relation to both the design of the study and the presentation of the results. For cases in which the results are “close calls,” it may be that, as a result of these subtle obligations, researchers are making choices that are favorable to industry sponsors. (Reviewer-).

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## Evidence Makes the Case -- Time to Limit Industry Interactions

*Evidence Overwhelming for Need to Regulate Physician-Industry Interactions.*

Jonathan H. Marks, MA, BCL (Oxon)

Jonathan H. Marks, MA, BCL (Oxon) -Special Presentation

There is a huge body of empirical data regarding the negative impact of industry interactions with physicians in medical care. Although not everyone agrees, we now need to limit the physician's interactions with industry.

Conflict of interest is a very important topic in medicine. Studies have shown that even small gifts from industry influence professional decisions made by physicians. When do we decide that we have enough information regarding these negative effects that we should proceed with regulating the physician's interaction with industry? In my opinion, there is a huge body of empirical data at a number of levels regarding the impact of industry interactions with physicians in medical care. These data come from studies looking directly at the behavior of physicians in medical practice coupled with other laboratory studies abstracted from medical practice. I think these studies overwhelmingly make the case for the need to regulate the physician's interactions with industry. Not everyone endorses this position; some dispute the extent of this evidence. In my view, we are at the stage where we need to start addressing the problem. Indeed, bodies like the American Association of Medical Colleges and the Institute of Medicine have reached the same conclusion. **Possible Regulatory Measures:** In many cases, institutions and academic medical centers have adopted conflict-of-interest policies, even if to a limited degree. For example, institutions may recognize problems that gifts from industry may cause and restrict or prohibit such gifts. There are other potential conflict areas where there is still much debate, such as continuing medical education. When an Institute of Medicine committee met last year to discuss its report on conflicts of interest, they recognized that the funding of continuing medical education in the United States was a problem. They recognized that it should not continue being so vastly underwritten by industry, because, when industry funds medical education, their primary purpose is marketing. So the Institute of Medicine has rightly said that something needs to be done to change the practice, but they could not agree on precisely what should be done. Therefore, they suggested that a deliberative process be initiated and that another committee take up this issue and reach a conclusion within 24 months of the publication of their report last year. **Changes in Ethical Standards:** I see that ethical standards are evolving. I believe it is pretty clear that some behaviors, which would have been considered ethical 10 or 20 years ago, are now no longer considered ethical, such as the receipt of out-and-out gifts. Other behaviors are in a state of flux, but I think we are going to see new ethical norms evolving over time. An example of this is the problem of industry funding of continuing medical education. (Reviewer-).

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## Positive Incentives May Reduce Industry Sponsorships

### *The Carrot and the Stick -- Limiting Physician-Industry Interactions: Part 1.*

Jonathan H. Marks, MA, BCL (Oxon)

Jonathan H. Marks, MA, BCL (Oxon) -Special Presentation

Industry funding of continuing medical education (CME) might decrease if active participation in providing CME is an additional factor assessed during promotion and tenure considerations at academic medical centers.

(Card 1 of 2) Conflict of interest is a very big topic in the medical world. For academic medical centers in the United States, >50% of all continuing medical education (CME) events are underwritten by the pharmaceutical industry. Once thought to be an unavoidable conflict of interest, the problem of managing continuing education without the intervention of industry is now being widely discussed. This is a concern for academic medical centers and for private practitioners. This problem is especially acute for physicians who are in small private practices in rural areas where their options for CME are rather limited. **Alternate Sources:** I would submit that, despite appearances, it is not hard to come up with alternate sources of CME without an industry sponsor. For example, lawyers find alternate ways of meeting their continuing legal education requirements. As a lawyer, points are awarded for providing educational segments for colleagues and for attending lectures by colleagues, all of which have been accredited for continuing professional education. In the legal world, the notion that continuing education is a professional responsibility is widely accepted. If your employer will not cover the expenses of continuing education, then it is part of your professional obligation to meet the cost of your own continuing education. This behavioral norm is still not uniformly accepted in the medical profession for historical and cultural reasons. **Incentives:** One way of creating policies to address conflict-of-interest issues is with a “carrot” and another way is with a “stick.” Many of the institutional policies with which I am familiar take the stick approach, which is to basically say, “Doctors you cannot do this (do not take gifts, do not do this, do not do that).” I suspect that this approach has the intended effect of disengaging physicians from industry. This is an area where there is lots of room for more work and improvement, because there are a number of carrots that one can use. **CME Alternatives:** I think that academic medical centers should take a “carrot” approach and encourage their people to actively provide CME programs without the support of industry. For example, positive assessments could be given for promotion and tenure requirements when an individual has dedicated some time and effort to delivering CME-accredited educational segments. In other words, promotion and tenure requirements should explicitly state that providing CME to your colleagues is an additional factor to be taken into account for promotion and tenure. If this was the case, then I believe people would be more willing to provide CME to their colleagues, and industry funding would become less necessary. (Reviewer-).

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## Bye, Bye Industry -- Welcome Public Interest Medicine

### *The Carrot and the Stick -- Limiting Physician-Industry Interactions: Part 2.*

Jonathan H. Marks, MA, BCL (Oxon)

Jonathan H. Marks, MA, BCL (Oxon) -Special Presentation

In medicine, to avoid conflicts of interest caused by industry sponsorships, we need to find ways of signaling and rewarding the practice of medicine and the conduct of medical research in the public interest.

(Card 2 of 2) **Continuing Education Alternatives:** I believe that free lunches sponsored by industry are something that we tend to overvalue as part of our continuing medical education (CME) experience. I believe that physicians lack the time rather than the money to buy lunch, in most cases. Therefore, why not have an internal CME event presented by a faculty member at an academic medical center. The lunch could be provided by the department either out of its internal budget or via reimbursement of the attendees, rather than relying on industry to provide it. **Public Interest Medicine/Research:** A larger and slightly more financially demanding topic is that of finding ways to change our professional norms. These days, we think that truly successful researchers are the ones who bring in tons of industry money. However, what if, borrowing from a legal model, we started right at the beginning and funded some of the brightest and best young people through medical school with public interest medicine fellowships -- the idea being that people who take this money to fund their way through the university would deliver at the other end by being public interest medicine practitioners. This would mean that they would be committed to not taking money from industry sources when they did medical research and that they would be committed, as practitioners, to providing greater amounts of care to people in their community who do not have access. In other words, we need to find ways of signaling and rewarding the practice of medicine and the conduct of medical research in the public interest. **Special Accreditation:** There is a whole host of creative possibilities for developing "carrots" to help change our professional norms. For example, institutions and health professionals could earn accreditation for their lack of dependence on industry funding, sort of like the accreditation system used to designate foods as being organic. Although accreditation schemes raise some very complicated questions about their design and operation, the idea of some third party accreditation might be a way of creating some incentives rather than just battering people with sticks. (Reviewer-).

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Keywords: Bioethics, Conflicts of Interest, Regulating, Incentives

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## Disclosure May Not Counteract Conflicts of Interest

*The Dirt on Coming Clean: Perverse Effects of Disclosing Conflicts of Interest.*

Cain DM, Loewenstein G, Moore DA:

J Legal Studies 2005; 34 (January): 1-25

Research shows that people tend to be trusting of their doctors. Therefore, if a physician discloses some conflict of interest, the patient may assign more credibility, rather than less, to the doctor's advice.

**Background:** Conflicts of interest are a concern for many professions. Many different solutions have been proposed and implemented to reduce problems associated with conflicts of interest, especially that of biased information and advice. Disclosure of conflicts of interest appears to be the common element in most of these proposed solutions. **Research on Bias:** When a researcher or physician discloses that he or she has a conflict of interest, this information should lead us to be less confident or trusting of data or information provided. However, this assumes that we know what to do with the disclosure information. Research shows that people tend to be trusting of their doctors. Therefore, if a physician discloses some conflict of interest, the patient may assign more credibility, rather than less, to the doctor's advice. Even if we realize that we need to adjust for the disclosed conflict of interest, most of our adjustments are insufficient. Research has also shown that disclosing a conflict of interest reduces feelings of guilt, giving doctors or researchers moral license to bias their advice even more than they would have done without the disclosure. **The Study:** A laboratory study was performed by the authors. In this study, a person was assigned the task of estimating an unknown quantity of money in a jar (the "estimator") and was paid for all accurate estimates. An advisor, who had more information than did the estimator, was assigned to the case. Three scenarios were set up: (1) the advisor was paid when the estimator made an accurate estimate, (2) the advisor was paid when the estimator guessed too high of a value, but this was not disclosed, and (3) the advisor was paid when the estimator guessed too high of a value, and this conflict of interest was disclosed. When the study was over, estimators earned less money and advisors made more money when conflicts of interest were disclosed. Therefore, disclosure benefitted providers of advice/information but not its recipients.

**Conclusions:** Although disclosure may not always benefit providers of biased information and it may not always hurt recipients, the results of this report challenge the belief that disclosure is an effective remedy for conflicts of interest. Disclosing a conflict of interest to a patient does not necessarily protect that patient from the dangers posed by biased advice. The best way to counteract a conflict of interest is to eliminate it in the first place.

**Reviewer's Comments:** Conflicts of interest in medicine are both inevitable and ubiquitous. The challenge for doctors is to: (1) know when they have a conflict of interest; (2) recognize whether the conflict is avoidable or not; and (3) avoid the conflict if possible and manage it if not possible to avoid. Disclosure has long been considered a primary way to manage conflicts of interest, but this study shows that disclosure might not be an effective remedy. If, as the study suggests, disclosure has the paradoxical effect of benefiting the individual with the conflict, alternative methods for managing conflicts of interest need to be considered. (Reviewer-Michael Green, MD, MS).

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## Free Samples Strongly Influence Prescribing Decisions

*Do Drug Samples Influence Resident Prescribing Behavior? A Randomized Trial.*

Adair RF, Holmgren LR:

Am J Med 2005; 118 (August): 881-884

Free drug samples do not necessarily help patients keep drug costs down because the resident physicians with access to these samples tend to prescribe the more expensive advertised drugs.

**Background:** When allowed, pharmaceutical companies make free drug samples readily available in residents' clinics. Two commonly held beliefs are that free drug samples are not a form of marketing, and they help patients manage drug costs. How these free samples influence resident education and patient care is not known.

**Objective:** To determine if prescribing decisions made by internal medicine residents are influenced by access to free drug samples.

**Design:** Prospective randomized trial.

**Participants:** All residents working in a primary care clinic affiliated with a teaching hospital in Minneapolis. Residents were not told about the true nature of the study.

**Methods:** Residents were randomly assigned to 1 of 2 groups. The first group was allowed access to free drug samples. The second group agreed not to use free drug samples available in the clinic. Five drug-class pairs were monitored throughout the study. Resident prescribing practices were evaluated from July to December of 2003.

**Results:** During the study, new drug therapies were initiated 390 times. Residents who had access to free drug samples were more likely to initiate treatment with advertised drugs than were residents without access to free samples. Access to free samples of NSAIDs, proton-pump inhibitors, and acid blockers was especially influential to the residents' prescribing practices as they tended to prescribe inexpensive drugs significantly less than the more expensive advertised drugs.

**Conclusions:** Access to free drug samples strongly influences the prescribing practices of resident physicians. Residents with access to free drug samples are more likely to prescribe heavily advertised (more expensive) drugs and are less likely to recommend over-the-counter drugs. Therefore, it appears that free drug samples serve as a form of marketing by the pharmaceutical companies that influence the practices of resident physicians. In addition, free drug samples do not necessarily help patients keep drug costs down because the resident physicians with access to these samples tend to prescribe the more expensive advertised drugs.

**Reviewer's Comments:** Free drug samples are very popular among physicians and patients alike. However, one recent study found that well-off patients with health insurance are more likely to receive free prescription samples than are low-income uninsured patients. The study reported here suggests that free samples contribute to rising health care costs, because physicians with access to the samples tended to prescribe expensive medications rather than their generic counterparts. It would appear that free samples might not be so "free" after all. (Reviewer-Michael Green, MD, MS).

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Keywords: Conflicts of Interest, Free Drug Samples, Influence on Prescribing Practices

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## Meeting With Drug Reps -- Big Time Outlay for Little Gain

*The Company We Keep: Why Physicians Should Refuse to See Pharmaceutical Representatives.*

Brody H:

Am Fam Med 2005; 3 (January/February): 82-86

Meeting with pharmaceutical representatives is a time-consuming practice for physicians that conflicts with the ethical goals of patient care and provides them with highly biased information.

In this opinion article, the author discusses ethical issues surrounding the practice of physicians interacting with pharmaceutical representatives (reps). **Physicians' Ethical Goals:** Two of the primary ethical duties of physicians are as follows: First, they must serve the interests of their patients while avoiding conflicts that divert them from this duty. Second, they must seek to be clinically competent, meaning that their practices must be based on well-grounded unbiased medical evidence. **Pharmaceutical's Goals:** Pharmaceutical companies have a primary goal of increasing profits. One way to meet this goal is to influence the prescribing practices of physicians by persuading them to prescribe the most expensive drugs. It is not that pharmaceutical reps are acting inappropriately, but it is that their profit-based goals potentially conflict with the ethical goals of physicians. **Doctor-Rep Interactions:** Available evidence from literature reviews confirms that the frequency with which physicians have contact with pharmaceutical reps is directly related to the likelihood that physicians will make prescribing decisions that are more favorable to the pharmaceutical industry and less favorable to the patient. For example, controlling hypertension is more likely when physicians have free choice of the drugs they prescribe than when physicians provide the patient with free drug samples from a pharmaceutical company. Even in the face of such evidence, physicians often believe that information provided by pharmaceutical reps is educational and unbiased. This tells us that physicians are not good judges of the influence being exerted on them by pharmaceutical companies. When meeting with pharmaceutical reps, physicians receive gifts, both large and small. Studies have shown that these gifts incite a sense of reciprocity, whether the physician is aware of it or not. Therefore, to meet physicians' ethical goals, they should not accept gifts, either large or small, from pharmaceutical companies. In addition, studies show that information provided by pharmaceutical reps is biased in favor of the drug company's product. The physician's time would be better spent researching and reading unbiased and evidence-based data sources. Even if physicians elect to meet with pharmaceutical reps, they should dedicate time to double-checking the information provided.

**Conclusions:** Meeting with pharmaceutical reps is a time-consuming practice for physicians that conflicts with their ethical goals of patient care and provides them with highly biased information. From a time-management perspective alone, the physician's time would be better spent researching and reading unbiased and evidence-based data sources.

**Reviewer's Comments:** While many physicians bristle at the suggestion that they can be influenced by the salesmanship practices of pharmaceutical representatives, research has shown that marketing works. If doctors are influenced by drug reps, the question is what to do about it. This article suggests that doctors should police themselves. If they fail in this role, history has shown that the profession is likely to be policed by others, via legislation and regulation. (Reviewer-Michael Green, MD, MS).

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To reduce conflicts of interest in academic medical centers, industry should not be permitted to underwrite continuing education events. However, they can deposit funds in a central repository that will be privately dispersed.

**Background:** Financial conflicts of interest create challenges for medical ethics, scientific integrity, and the avoidance of bias in decision making for physicians.

**Objective:** To outline a series of guidelines to help academic medical centers deal with conflicts of interest involving gifts from pharmaceutical and device industries. **Inappropriate Interactions:** In clinical medicine, a conflict of interest occurs when a situation is present that has the potential to undermine the doctor's primary duty to the patient's best interest in favor of the doctor's own self-interest. In the context of doctor-industry relations, some interactions that have the potential to undermine neutrality include gifts, payment for attendance at lectures and conferences (includes online activities), free continuing medical education (CME), payment for participation in speakers' bureaus, ghostwriting services, free drug samples, and grants for research projects. **Myths:** Two commonly held beliefs among physicians are that (1) small gifts do not significantly influence physician behavior and (2) disclosure of financial conflicts sufficiently protects patients' interest. Compelling research by sociologists has shown that even small gifts provoke a sense of reciprocity in physicians, causing them to lose their objectivity. Other research has shown that interactions with pharmaceutical representatives or attending industry-sponsored seminars result in a significant change in prescribing practices by physicians. Disclosures of conflicts of interest are not effective because (1) the accuracy of these disclosures is uncertain, (2) people receiving the disclosure are not experienced enough to recognize the extent of bias in the information they receive, and (3) disclosures may mislead people regarding the extent of a physician-industry relationship. **Recommendations:** All gifts, free meals, and payments for participation in meetings or online CME seminars sponsored by drug and medical device companies should be prohibited for all physicians at academic medical centers. Free drug samples should be prohibited and replaced by a voucher system for low-income patients. All interactions with pharmaceutical representatives should be discontinued. Physicians with ties to drug or medical device companies should be excluded from hospital and medical group formulary committees and from committees overseeing purchases of medical devices. CME events that are underwritten by industry should be prohibited, and a central repository should be created for funds from manufacturers wishing to support educational opportunities. These funds will be privately dispersed to approved programs, and the amount of funding by corporations should be posted on a publicly available Web site. The authors provide many other recommendations to help academic medical centers safeguard against market-driven conflicts of interest.

**Reviewer's Comments:** This groundbreaking article has greatly influenced academic medical centers (AMCs) across the country. Since its publication, many of the leading AMCs have developed new policies that prohibit or regulate interactions between physicians and industry. While aimed at AMCs, the principles also apply to other forms of medical practices, and physicians should be aware of implications for their own work. (Reviewer-Michael Green, MD, MS).

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# Behavioral Economics Anticipates Irrational Decisions

*Introduction to Behavioral Economics: Part 1.*

Peter A. Ubel, MD

Peter A. Ubel, MD -Special Presentation

Behavioral economics is very relevant to medical practice because we must worry about whether informed consent is achieving its goal when patients do not make decisions that maximize their best interests.

(Card 1 of 2) Behavioral economics is the overlap of psychology and economics -- applying insights from psychology to questions more traditionally answered by economists. This field grew out of the awareness that traditional economic theory relies too much on the idea that people are rational decision makers. Most economic models used by economists in government or academia start by assuming that people are rational decision makers and then predict what will happen from there. Behavioral economics is an area of research that says, "People are not completely rational all the time. If you really want to know how they're going to behave, you need to account a fuller idea of what human nature really means and how people really behave."

**Relevance to Health Care:** Informed consent works best when a patient is given comprehensible information about their treatment alternatives, understands this, and has freedom to choose which treatment maximizes his or her best interests. In other words, if a patient gets information and makes a rational decision, we are on our way to having good informed consent. Therefore, behavioral economics is very relevant to medical practice because we must worry about whether informed consent is achieving its goal when patients cannot or do not behave rationally -- when they do not make decisions that maximize their best interests. **Decision Making:** To make good decisions in life, you first need to make predictions. For example, to decide if you are going to live in California or Michigan, you first must decide where you would be happier. Will a warmer climate in California bring you happiness compared to the cold winters in Michigan? Research has shown that climate has very little effect on people's overall well-being. Knowing this, then someone who is making the decision on where to live based on climate might not be making a good decision. The same goes for medicine. For example, I had a patient once with severe ulcerative colitis (UC) who had daily cramps and bloody diarrhea despite being on maximum medical therapy. UC can be cured by removing the colon, but the surgery requires that the patient be hooked up permanently to a colostomy bag. I talked to this gentleman and said, "Medicines aren't really doing the job anymore. Would you consider having a colostomy? I'm a primary care doctor and don't do these surgeries, but I wondered if you wanted to talk to a surgeon." He answered, "No way. I'd be miserable if I had a colostomy." However, research on people who have colostomies shows they are basically as happy as people who are healthy, and they quickly adapt emotionally to having a colostomy. (Reviewer-).

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Keywords: Behavioral Economics, Decision Making

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## Do Not Assume -- Know Research on Patient Outcomes

*Introduction to Behavioral Economics: Part 2.*

Peter A. Ubel, MD

Peter A. Ubel, MD -Special Presentation

Unlike a patient facing a decision for the first time, the doctor is probably already experienced with the situation. Before proceeding, physicians must be familiar with general patient satisfaction for various treatment options.

(Card 2 of 2) My patient was miserable with diarrhea and yet he could not believe that he would be happy if he had a colostomy. Unlike patients such as this who are unfamiliar with certain conditions or outcomes, many doctors have seen the same situation hundreds of times. Therefore, the doctor may have a better sense of what the treatment outcome will likely be, compared to the patient. Then, as clinicians, what is our job? I would say that job one is to find out how confident we are that we really do know more than the patient about a given topic. Sometimes we physicians make mistakes, too. We assume that people with certain health conditions are miserable or happy, but we have not looked at data -- we have not dug in to find out the truth. We might actually be making assumptions about our own patients without evidence to back it up. In the case of my patient with ulcerative colitis, I knew the literature on colostomy. I knew this man was probably wrong to expect that he would be miserable if he had a colostomy. One option I had was to give him information about most colostomy patients being quite happy and quickly adapting to the colostomy bag. This is what informed consent would have had me do. However, my patient was not persuaded by the information. So what else could I do as a clinician? I was not going to coerce the patient. In this case, I told the patient, "Next time you're seeing the gastroenterologist, why don't you talk to some colostomy patients and find out what their actual experiences are? See if you can learn from their experience." As it turned out, the patient returned a couple months later, and he had learned that these other patients thought a colostomy was not nearly as bad as they had originally anticipated. Nonetheless, he still refused the surgery, believing that the information he had gathered did not apply to him. At that point, my job as a clinician was done. I could not force him to have surgery. I could continue to talk to him on follow-up visits, but to bring it up every time would threaten other parts of our relationship. I believed he had made an informed decision -- even if it was the wrong decision, it was ultimately his decision to make. (Reviewer-).

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## Are We Blind to What Controls Our Behaviors?

*Who Is in Control? Forces at Play in Making Personal Choices.*

Peter A. Ubel, MD

Peter A. Ubel, MD -Special Presentation

Many people hold individuals responsible for their health woes, especially those problems brought on by personal behaviors. However, many behaviors are influenced by forces beyond people's awareness.

Generally, people in the United States tend to think of themselves as free agents. They get to make choices, they reap the benefits when things go well, and they suffer the consequences when things go badly. We tend to apply this to both financial matters and our health. Many people would hold individuals personally responsible for their health woes, especially when the woes are brought on by personal behaviors. If someone smokes, drinks excessively, or engages in risky behaviors that lead to an illness or disability, then some folks would say, "You know, it's your fault, so it's your problem. You brought this on by your behavior. It's not our problem, it's your problem." This reasoning is only partially correct. I just finished a month of taking care of general medicine patients in the hospital. About two thirds of patients I saw had illnesses that could be blamed at least partly on behaviors: smoking, drinking, drugs, overeating, lack of exercise, etc. With that said, we must ask what percentage of people's behavior is their fault? I am not God, so I cannot answer that question from that perspective. However, I can say that research in behavioral economics has shown many ways in which these kinds of behaviors are not conscious decisions and are influenced by forces beyond people's awareness, and even sometimes beyond their complete control. Of course, some would say, "If somebody lights up a cigarette and sticks it in their mouth, then that's their choice. Nobody's got a gun to their head and tells them they have to smoke." In answer to this charge, it is true that the individual has the best ability to stop the behavior if anyone can. The question is how did that person get addicted to tobacco in the first place? Most people start smoking before adulthood, so they become addicted at a young age. Self-control centers of the brain are still developing, even in early adulthood. Before a person is a mature decision-making human being, we often have someone who is already addicted. If someone is already addicted at age 18 years, many people still say, "Look, they are in control. They need to quit." Look at all the physiology that is lined up against them to make it hard to quit. Most clinicians have worked with many patients on weight loss, drinking abstinence, or smoking cessation, and we realize the difficulty of these tasks. While we embrace and rejoice when our patients are able to overcome these challenges, we recognize that the same challenges are beyond many people's abilities. I am not sure what purpose it serves to completely blame these people for all their behaviors. (Reviewer-).

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Keywords: Behavioral Economics, Informed Decision Making, Personal Choices, Influences

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## Physician's Role Is to Help, Not Judge Patients

*Helping Patients With Behavior-Related Issues.*

Peter A. Ubel, MD

Peter A. Ubel, MD -Special Presentation

As physicians, our role is to try to help patients with health issues, regardless of the cause. Rather than judging our patients, we need to understand their behaviors well enough to be able to influence them.

As physicians, people come to us for help with their health issues, and we have to help them to clean up the mess they may have made with bad lifestyle choices. We ask ourselves, "Just how much actual control do people have over their health? Is health entirely under the patient's control, or does the patient virtually have no control?" **Physician's Role:** I believe our role as physicians mainly is to promote our patients' best interests -- not to judge them for their behaviors but to help them improve their behaviors. Only in rare circumstances does a behavior rule out treatment. For example, liver transplant surgeons know that someone who is actively drinking alcohol is not a candidate for a liver transplant. These patients need to show 6 months' abstinence from alcohol. On the other hand, as a primary care physician, I am not going to refuse to give someone cholesterol medicine just because they keep eating too much. I would not say, "Once you exercise and stop eating, then I'll give you a pill if your cholesterol is still high." As physicians, our role is to try to help our patients. You want to understand their behaviors well enough to be able to influence them.

**Little Tricks, Big Results:** Many of my patients have a hard time taking their medicines every day. Maybe they have a twice-a-day pill to treat their blood pressure. They come into my office and their blood pressure is still high. I look on the computer and notice they have not renewed their medicines for a while, so they are clearly not taking their pills every day. I could scold the patient for not taking the pills, but I do not believe this is a very effective approach. First, I usually try to make sure they understand why blood pressure pills are important. Then, I try to determine if they are having side effects from the pills that are discouraging them from being compliant. Next, I try to determine if they find the pills unaffordable. After having these discussions, I try to figure out how I can help them make taking their pills an effortless habit. Typically, I will ask them how often they brush their teeth, and they usually tell me twice a day. In these cases, I say, "Lay your toothbrush on top of the pill bottle. Twice a day when you lift that toothbrush to brush your teeth, you'll be reminded to take your pills." I am sure every clinician has little tricks like this to help their patients. These are just a few examples of the many things we can do to help our patients without judging their behaviors. (Reviewer-).

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Keywords: Behavioral Economics, Lifestyle Issues, Health Care

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## Outside Influences, Not Willpower Alone, Affect Obesity

*Obesity Epidemic: Willpower Has Not Changed, but Outside Influences Have.*

Peter A. Ubel, MD

Peter A. Ubel, MD -Special Presentation

Although more people are struggling with obesity than ever before, people are no weaker-willed than they were a couple of generations ago. Instead, many other things are influencing us to eat too much.

In the United States, given how quickly obesity rates have grown, it is clear that the cause of the obesity epidemic is not simply human nature, because human nature has not changed that much in the last few generations. If we are still evolving in Darwinian terms, we are evolving incredibly slowly. Therefore, many forces must be working together to cause the current obesity epidemic. I believe that a practicing clinician will find it useful (1) to get a better understanding of why patients are eating too much and (2) to help people to recognize that their eating behaviors are caused by more than a lack of willpower and choosing to eat too much. **Lifestyle Influences:** The workplace has changed: industrialized countries have much less physical labor than in the past. In addition, the food industry has changed dramatically: we now have delicious, affordable foods that are incredibly easy to prepare and clean up. The cost of calories, in terms of both time and money, has dropped significantly. **Appetite Influences:** Several unconscious forces influence our appetites. For example, I can influence you to increase your calorie consumption by 25% if I give you a large dinner plate rather than a small one. You will not consciously decide to eat more food, but instead, you will be influenced by the visual stimulation of this plate and what looks like the right amount of food to put on it and by your mother's voice from your childhood memories telling you to clean your plate of all food. I can change the size of glass I offer you at dinner and change how much soda you put in it. Even unconsciously, the flavor of food changes for people based on whether they think the food is healthy or unhealthy. Signals that tell us a food is unhealthy will make that food taste better to us. The same exact food will not taste as good if it is described as being healthy. People are no weaker-willed than they were a couple of generations ago. Instead, many other things are influencing us to eat too much. **Clinical Applications:** In the clinic, I recommend that patients put away their large dinner plates and get out smaller plates. I also remind people that if they can see food, they are more likely to eat it without even deciding to eat it. Therefore, put food out of sight. Reorganize the kitchen so that certain foods are harder to reach, making it less likely to eat those foods without forethought. **Resource:** Ubel PA. *Free Market Madness: Why Human Nature Is at Odds With Economics -- and Why It Matters*. Boston, MA; Harvard Business School Press: 2009. (Reviewer-).

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Keywords: Behavioral Economics, Informed Decision Making

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## Listen Up -- Patient Values, Understanding Influence Decisions

*Helping Direct Medical Decisions: Pay Attention to Choice of Words and Patient Values.*

Peter A. Ubel, MD

Peter A. Ubel, MD -Special Presentation

To make good treatment recommendations, a physician must understand how a patient interprets the physician's words and what the patient cares most about in life -- quality or quantity of life.

We, as physicians, can influence people in many ways. As clinicians, we have a tremendous amount of power, and we could convince most patients to do almost anything. Respecting patients' autonomy is a good thing, and coercing people is not appropriate. The lines between coercion, manipulation, persuasion, and simply informing people are fuzzy, if not indistinguishable at points. As clinicians, we must live with some discomfort as to whether our persuasion has tipped over into coercion, etc. To help us do a better job, we must first understand patients. The more we understand what our patients care about and value, the more likely we are to help guide them toward the right decision. For example, a patient had lung cancer that had metastasized to the brain. He had undergone neurosurgery to remove 1 tumor in his brain but not another. He had lung surgery to remove 1 part of his lung tumor but not the rest. The tumor continued to grow despite radiation and chemotherapy, and then pneumonia developed. He was clearly dying. His doctors were still proposing more aggressive treatment. So I asked him, "What have the doctors told you about your chances?" He said, "They said they can't cure me, but they can treat me." Although that was true, it is the same thing we would say to someone with diabetes or someone with HIV infection who did not have AIDS -- people who could live for decades with their diseases. However, this man was clearly going to die within the next few months, no matter what was done. So I asked him what he thought his doctors meant, and he said, "I guess it means I have hope." He looked at me, and that is when I had to explain to him what really was happening. When we physicians communicate with patients, we are trying to help them make decisions. We have to think what our words mean to them. When we tell someone, "We can't cure this, but we can treat it," we might be trying to say, "I was being honest. I told him he was going to die of cancer." However, this man's doctors never said he was going to die of cancer. So what he heard was, "I guess that means I have hope." When we speak to our patients, we need to understand how they interpret our words. In addition, we must find out what they care most about in life -- quality or quantity of life. Without this information, it is difficult for us to make good treatment recommendations. (Reviewer-).

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Keywords: Behavioral Economics, Doctor-Patient Conversations, Treatment Recommendations

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## Good Conversations Improve Patient Care

*The Doctor-Patient Conversation as a Time-Effective Tool for Improving Patient Care.*

Peter A. Ubel, MD

Peter A. Ubel, MD -Special Presentation

A good conversation can improve patient care by helping the physician understand what the patient values and by helping the physician understand just what the patient knows about their disease.

To make good treatment recommendations, we, as physicians, must understand how a patient interprets our words and what the patient cares most about in life -- quality or quantity of life. The more we understand about what our patients value, the more likely we are to help guide them toward the right medical decision. To elicit that information, I will sit down at the bedside and ask, "What do you understand about what's going on with your health? What do you think is happening to you? For what are you hoping? What do you think is going to happen?" Just learning about their understanding of the disease is enormous. I also ask these questions in the clinic. For example, if someone comes in with high blood pressure, I will ask them, "What do you think high blood pressure is?" Many patients think high blood pressure is an emotion. Even among many of those who know that it is not an emotion, they may not realize that high blood pressure is essentially a risk factor, not a disease. Therefore, when I find out what they understand about the disease, then I can go on to better educate them. Once they understand the disease, then I can try to find out what matters to them. For example, if the patient is financially strapped and really hates taking pills, and if the risk of a heart attack or stroke in the next few years is really small whether the pills are taken or not, then the best decision might be that the patient go without the pills. However, I first have to learn about the patient's financial situation and personal preferences before helping them make a sound decision. **Time Constraints vs Patient Communications:** Many clinicians wonder if this is a time-effective and reasonable way to practice medicine, given the very real time constraints in their practices. I believe it actually saves time when you practice medicine this way. No doubt, there are patients with whom the conversations last a long time, and our system does not reimburse very well for those conversations. And no doubt, there are just as many times, as you are ready to walk out of the room, the patient stops you and says, "Oh, and one more thing ..." It is then that you realize you have not listened to them enough to find out what they care about, and you have to sit back down and talk about a problem you could have gotten to 10 minutes earlier. Even when we have all these conversations and do all these tests, you may find out that they are not taking their pills because they do not understand something. A good conversation can really improve care. (Reviewer-).

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Keywords: Behavioral Economics, Doctor-Patient Conversations, Treatment Recommendations

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## Docs Must Be Alert to Patient Perspectives

*Patients Need Information, Time, and Understanding to Negotiate Medical Decisions.*

Peter A. Ubel, MD

Peter A. Ubel, MD -Special Presentation

It is easy for physicians, who know so much more than do patients about a diagnosis, to forget what it is like to be a patient and receive what seems like bad news.

In the doctor-patient conversation, patients must be able to articulate their values and desires. However, patients facing diseases that are new to them do not know what to expect. For example, a patient who is newly diagnosed with diabetes does not know what the illness will be like. Or a patient needing a colostomy does not know what to expect regarding the colostomy bag. Because decisions people make before and after having experienced something may be very different, patients with an unfamiliar diagnosis will only be able to give their physicians partially formed perspectives. Therefore, when we are dealing with patients who really do not know what a disease or disability is going to be like, we must ask them about what matters to them, what they care about, etc. **Remember the Patient's Perspective:** We studied interactions between urologists and men with newly diagnosed prostate cancer. At the beginning, the urologist would tell the man he had cancer. Within a minute, the patient was receiving elaborate technical detail about the stage and grade of his cancer. Then, the doctor and patient would have a lengthy and often technical discussion of treatment options. A treatment decision was made within 20 minutes of the patient learning of his cancer. In this study, almost no time was allowed to acknowledge or manage the patient's emotional response to the news that he had cancer. As we discussed this point with a group of clinicians, one urologist said, "Well, why do we have to take time to acknowledge their emotions? It's not like we gave them bad news." Here is the danger: when physicians know so much more than patients, we forget what it is like to be a patient. The urologist knew that diagnosis of early stage prostate cancer is not a big deal, perhaps no worse than diagnosing mild diabetes in an older man. However, when you tell a patient that he has cancer, you cannot expect him to feel like this is good news. We still need to know where our patients are coming from, how they are feeling, what questions they have, and what they are going through so that we can give good clinical advice and help them negotiate the news of their illness. **Helpful Resources:** To learn more about these types of issues, I have a Web site called [www.peterubel.com](http://www.peterubel.com), where I regularly write about these issues and give people kind of a different way of thinking about the world. (Reviewer-).

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## Risks, Options Determine Decision-Making Approach

*A Typology of Shared Decision Making, Informed Consent, and Simple Consent.*

Whitney SN, McGuire AL, McCullough LB:

Ann Intern Med 2004; 140 (January 6): 54-59

Informed consent is a useful decision-making process in situations with significant risk, while shared decision making applies when  $\geq 2$  treatment options exist, regardless of the risk.

The authors describe the importance and application of informed consent, simple consent, and shared decision making in doctor-patient interactions. These 3 measures are each designed to enhance the patient's control over his or her medical care via a collaborative interaction with the physician. The process of shared decision making was developed from a patient-centered perspective, while informed consent was developed from a legal perspective. **Informed Consent:** Informed consent is a formal process in which doctors and patients must participate before certain institutions will permit the performance of a procedure. Legally, informed consent is meant to reduce a physician's liability. However, the true intent of informed consent is for the doctor and patient to have a conversation (or a series of conversations) about the patient's condition, proposed and alternative treatment choices, the option of non-treatment, and risks and benefits of each option. In the end, the physician and patient will have selected an intervention together. Legally, informed consent is required when an intervention (or failure to intervene) poses a significant risk of harm – a consideration of risk versus benefit. Therefore, when little or no risk exists, the decision-making process does not involve informed consent. **Simple Consent:** Simple consent is a decision-making process in which the patient either agrees or disagrees to a proposed plan of care. The patient's permission to proceed with a treatment plan is explicit with informed consent and may be implicit with simple consent (agree to plan by filling prescription or altering diet according to doctor's recommendations). Therefore, simple consent is a useful decision-making process for low-risk decisions. **Shared Decision Making:** This type of decision-making process occurs when real choice exists for treatment, and the physician and patient are actively involved in making the decision. This is a collaborative process. **Appropriate Use of Each Process:** Informed consent is needed for decisions that involve high risk and for which only 1 treatment choice exists. In these situations, informed consent may appear to be an educational process rather than a decision-making process. Simple consent is used in low-risk decisions, whether only 1 or several treatment options exist. Shared decision making should be applied when  $\geq 2$  reasonable treatment options exist, regardless of the risk (high vs low). If a high-risk decision has  $>1$  reasonable treatment option, both informed consent and shared decision making should be applied, with a goal of making a choice that feels right to the patient.

**Reviewer's Comments:** Informed consent and shared decision making are not simply legal processes but ethical and psychological ones as well. Mastering skills of eliciting informed consent and engaging in shared decision-making discussions are not easy. But to respect patient autonomy and help patients make decisions, we need to understand how to master these skills. (Reviewer-Michael Green, MD, MS).

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## Cognitive Errors May Lead to Irrational Choices

*Is Information Always a Good Thing? Helping Patients Make “Good” Decisions.*

Ubel PA:

Med Care 2002; 40 (September): V39-V44

Patients often make cognitive errors during the medical decision-making process, and their choices appear irrational or inconsistent with their preferences. Patients can be confused by probabilities and overwhelmed by information.

When confronted with the need to make good health care decisions, patient preferences play a critical role. However, patients often make cognitive errors during the decision-making process, resulting in choices that appear irrational or inconsistent with their preferences. To help patients make sound decisions, decision aids have been developed to provide specific information (treatment options, survival rates, potential complications) relevant to different medical decisions. Nonetheless, many patients make cognitive errors during the decision-making process. **Innumeracy (Poor Math Knowledge):** When discussing treatment options, we typically discuss probabilities of certain outcomes, such as survival or complications. Studies have shown that people generally find probabilities and percents difficult to understand. Therefore, when outcomes are communicated in terms of probabilities and percents, many patients become confused and make what appear to be irrational choices. **Too Many Options:** Most people can select between 1 of 2 treatment options. However, when additional options are introduced, they may be unable to make a rational choice. Studies show that, when faced with 3 options, and selecting between the 2 best options is particularly difficult, patients will sometimes select the least preferable third option. **Number of Side Effects:** Sometimes patients are intimidated by the number of complications associated with a treatment option. Overwhelming patients with too much information about side effects associated with various treatment options can scare them away from the “best” option. **Testimonials:** Some patients want to hear from other patients who have had to make similar medical decisions. As a result, some patients become overwhelmed by the vividness of testimonials, or they may be influenced by the number of pro or con testimonials. Either way, irrational decisions may result. **Recommendations:** When multiple treatment options are available, we can help patients make more rational decisions by comparing various options as paired sets. Patients may be asked if they prefer option A over option B. Next, they are asked to compare options B and C and then to compare options A and C. Through the process of elimination of options in paired sets, patients can more rationally select between multiple options. Another approach is to lump treatment options into “surgical options” and “medical options.” Options in the surgical category can be discussed together, helping the patient to see which of the surgical options they would prefer. The same discussion can be had for the medical category. Then, by comparing the top choice from each category, the preferred choice can be determined. **Reviewer's Comments:** If doctors are to help patients make the best possible decisions about their health, it is important to understand common pitfalls in decision making that patients experience. This article provides useful information about how people actually decide, and suggests that more information isn't necessarily better for patients. (Reviewer-Michael Green, MD, MS).

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Keywords: Behavioral Economics, Informed Decision Making, Cognitive Errors

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## Burden of Decision Appears to Shift With Physician Recommendations

*“What Should I Do, Doc?” Some Psychologic Benefits of Physician Recommendations.*

Ubel PA:

Arch Intern Med 2002; 162 (May 13): 977-980

For certain high-stakes medical decisions, physician recommendations shift the psychology of the situation so that someone else appears to share in the responsibility of the decision along with the patient or family.

During the “good old days” of physician paternalism, physicians basically made all health care decisions for their patients without consideration for patient preferences. Today, patients still ask their physicians for recommendations in the medical decision-making process. The effect of patient-requested physician recommendations can influence the final decision, which makes many physicians uneasy. **Commission vs Omission:** Psychologists tell us that people, when looking forward (making decisions), are more fearful of the harms associated with doing something (“harms of commission”) than they are of the harms associated with not doing something (“harms of omission”). However, when looking back on their lives, people state greater regret for things not done (omissions) rather than for things done (commissions), regardless of the success or failure of the things done. People may fear harms of commission in the decision-making process because they do not want to be responsible for making a mistake with their decision. **Gains vs Losses:** In general, we tend to perceive losses on a larger scale than we perceive similarly sized gains. Therefore, people may have a harder time making a medical decision because they perceive harms of commission as losses. Medical decisions of omission may be easier to make because they view harms of omission as gains, not losses. Therefore, a patient’s medical decision can be subtly influenced by how a treatment option is represented to them -- as a loss versus a gain. **Responsibility:** An unwillingness to be responsible for high-stakes decisions also influences a patient’s or family’s ability to make medical decisions. Physician recommendations shift the psychology of the situation so that someone else appears to share in the responsibility of the decision. Therefore, certain high-stakes decisions should be framed as a recommendation rather than an open-ended question. For example, when discussing the decision for a do-not-resuscitate order for a family member, the physician can help the family by recommending that the patient not be resuscitated and then asking the family if they agree. **Tips:** In the case of cancer patients, physicians should consider delaying their recommendations until after having a long discussion of treatment options and patient preferences. Second opinions should be encouraged when the physician is concerned that his or her recommendation is being influenced by self interests or personal/professional biases. When making recommendations, physicians should remind patients that they may disagree and the physician will still be most willing to work with them.

**Reviewer's Comments:** It has long been known that how we frame treatment options can greatly influence decisions that patients make. Patients need to understand their options and know that they have the right to choose among them, but this doesn’t abrogate the physician’s responsibility to use their professional expertise and judgment to advise patients and to provide considered recommendations. This article provides some interesting psychological underpinnings of why this matters in clinical practice. (Reviewer-Michael Green, MD, MS).

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Keywords: Behavioral Economics, Informed Decision Making, Physician Recommendations

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## People Overestimate Effects of Disability on QOL

*Do Nonpatients Underestimate the Quality of Life Associated With Chronic Health Conditions Because of a Focusing Illusion?*

Ubel PA, Loewenstein G, et al:

Med Decis Making 2001; 21 (May-June): 190-199

People who are unfamiliar with a particular chronic health condition tend to overestimate negative impacts that the condition will have on quality of life. The reason for this overestimation remains unknown.

**Background:** People who are unfamiliar with a particular chronic health condition tend to overestimate the negative impacts that the condition will have on quality of life (QOL). This is thought to occur because people focus on the parts of life that will be most affected by the illness rather than focusing on all aspects of a person's life. As a result, when making a medical decision pertaining to a newly diagnosed chronic illness, people tend to overreact and make poor choices.

**Objective:** To describe the results of 3 experiments investigating causes of overestimating the effects of chronic health conditions on QOL, and to determine if people can be helped to refocus their perceptions through exercises that look at the effects of the disability on all aspects of life.

**Methods:** People were asked to give an overall estimate of QOL associated with paraplegia, below-knee amputation (BKA), or partial blindness in 1 eye (largely correctable with eyeglasses). Next, participants were given a defocusing exercise in which they were asked to look at various aspects of a person's life and estimate how the condition would affect each of these domains. In 2 experiments, these domains included overall health, standard of living, work, love life, family life, social life, spiritual life, and leisure activities. In the third experiment, patients selected 5 life domains of their own choosing and estimated the effects on the condition on them. Finally, participants were asked to re-estimate how the disability would affect QOL after the defocusing session was completed.

**Results:** Unexpectedly, final estimates varied widely, with some participants having unchanged QOL estimates, some having higher estimates (improved QOL), and some having decreased estimates (poorer QOL). Those who decreased their final estimates stated that the defocusing exercise made them think more seriously about consequences of the disability on all aspects of their lives.

**Conclusions:** These authors could not prove that a focusing illusion affected people's QOL estimates for unfamiliar chronic medical conditions. This could be interpreted as resulting from the fact that a focusing illusion does not influence the public's QOL estimates for various chronic health conditions. An alternative interpretation is that the focusing illusion exists, but experiments in this study failed to identify the impact of the focusing illusion. Further studies are needed to help clarify this issue.

**Reviewer's Comments:** One of the challenges that physicians face when trying to help patients make informed medical decisions is that patients often have inaccurate assumptions about what life would be like if they were ill. It is important to have effective strategies to counter such biases, but as this study shows, there is no "one size fits all" solution to this vexing problem. (Reviewer-Michael Green, MD, MS).

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Keywords: Behavioral Economics, Chronic Illness, Quality-of-Life Perceptions

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