Two substantial and inter-related errors illustrate the ideological rather than empirical disagreement between Huddle (2010) and the Association of American Medical Colleges (AAMC). First, and perhaps most importantly, there is no mention of the field research that has largely confirmed the conclusions of controlled studies in behavioral economics. Second, Huddle argues that the AAMC’s recent recommendation is ideologically, rather than empirically, motivated. He claims that the AAMC’s position outstrips the warranted conclusions of the empirical work in behavioral economics. I will show, that in a delicious twist of accusations, Huddle’s criticisms are ideologically-based in precisely the same way.

Field Research

Huddle characterizes what seems his primary concern as follows: “the generalizability of laboratory experiments to the field setting of [pharmaceutical] detailing will depend upon the extent to which we can be assured that the laboratory setting has recreated the essential features of the detailing interaction as perceived by physicians and pharmaceutical representatives.” (11) Put generally, this is a worry that robust conclusions of research in controlled settings may turn out to be less robust when re-evaluated in the field. Accordingly, when deciding between a policy based on (A) controlled-setting research and (B) controlled-setting and field research, the prudent choice is to pick (B). I certainly agree that more field research in medical practice
regarding the conclusions of behavioral economics is needed (Schwab, 2008). And yet, there is previously published field research that provides general support for the conclusions drawn from controlled settings. Moreover, much of this field research not only supports the controlled-setting conclusions but is salient for medical decision-making.

Almost two decades ago, Baumann and colleagues (1991) completed field research illustrating that health care providers suffer from overconfidence in their judgments. They examined physician and nurse confidence in their treatment recommendations. They showed that individual physicians and nurses had very high levels of confidence that his or her recommendation was the best recommendation even though these recommendations were mutually exclusive and inconsistent across physicians and nurses. That is, when physician A had very high confidence in treatment A and physician B had very high confidence treatment B, they could not both be right, but they were both very sure that they were. Baumann et al. (1991) dubbed this “micro-certainty, macro-uncertainty.”

More recently, field research by Salovey and Williams-Piehota (2004) confirmed the effects of framing on health care decisions. Specifically, they began with the hypothesis that a gain-framed message about sunscreen use would foster preventative (or risk-averse) behavior, and a loss-framed message about mammography will foster diagnostic seeking (or risk-seeking) behavior. This is precisely what the controlled studies would predict and precisely what the field research showed.

Even though the studies mentioned above and other field research has also supported the controlled setting conclusions of behavioral economics (e.g., William-
Piehota, Pizarro, Schneider, Mowad & Salovey, 2005), none of it speaks directly to pharmaceutical detailing per se. It may be tempting, then, to brush off this field research as inconsequential. Such a move would be compatible with Huddle’s response to the application of the controlled-setting conclusions, but alongside Huddle’s response, would be a more ideologically-based than empirically-based response.

The Delicious Twist

As Huddle approaches the conclusion of his argument, he claims the following: “Whatever the type, prevalence and severity of cognitive and motivational error that may be demonstrated by field work on pharmaceutical detailing, physician susceptibility to such error is both unlikely to be uniform and likely be improvable through education.” (16) As others have noted (e.g., Appelbaum, 2010), he provides no empirical support for this claim. And yet, the lack of empirical support for his position is not what indicates the ideological nature of the response; instead, it is the decision to (1) favor the empirically unsupported policy over (2) the empirically supported policy (3) in opposition to other empirical evidence.

No more needs to be said in support of (1) than that the claims made near the conclusion of Huddle’s argument contain no references to empirical support. To amplify the significance of this absence, note that there is not even reference to controlled-setting conclusions to support this view.

Regarding (2), there is empirical support available at two levels. First, as Huddle notes, there is substantial empirical work in controlled settings that could lead to AAMC’s conclusions. Second, as discussed in the first section of this commentary, field
research has confirmed a number of the conclusions of behavioral economics drawn from controlled-setting research. In addition, some of this field research speaks directly to the possible effects of pharmaceutical detailing. Because physicians are subject to the confirmation bias, when they are invited to endorse the efficacy of new pharmaceutical as a result of detailing, the nature of their judgment will be an obstacle to doing otherwise. Because physicians are subject to overconfidence in their diagnoses and treatment recommendations, when they endorse the efficacy of a new pharmaceutical as a result of detailing, they are too likely to believe in its efficacy. Accordingly, it seems that the AAMC policy may in fact be the most prudent.

As Huddle has clearly argued, such a policy would find better support from field research that evaluated pharmaceutical detailing directly. I agree. And yet, given the lack of empirical evidence for Huddle’s recommendation and the indirect evidence favoring the AAMC policy, it is difficult to find an empirical basis for Huddle’s position.

Moreover, regarding (3) from above, the basis for Huddle’s position appears even more ideological when the empirical research into debiasing (or avoiding what he calls “cognitive and motivational error”) is considered. This literature, to date, has been limited to controlled settings and meta-analyses. Nonetheless, some successful debiasing has been achieved, but these effects tend to attenuate but not eliminate the bias. (Hirt, Kardes, & Markman, 2004; Hirt & Markman, 1995) Furthermore, even when individuals and or groups are aware of the predictable biases, neither this awareness nor increased cognitive efforts to avoid the known bias will always or regularly debias a decision (Fischhoff, 1982; Lerner & Tetlock, 1999). Hence, Huddle’s suggestion that the errors in
judgment identified in pharmaceutical detailing can be adequately handled through additional educational efforts is contradicted by empirical research.

Conclusion

Even though field research on the effects of pharmaceutical detailing would be a more comfortable backdrop for determining the appropriate policy, a policy (be it implicit or explicit) must be in place. Given the balance of empirical evidence (in controlled settings and in the field), it seems that the prudent policy would be to prohibit pharmaceutical detailing because of its likely biasing effects. In turn, I have suggested that Huddle’s challenge to this conclusion and, subsequently, his challenge to AAMC’s recommendation for a change in policy regarding pharmaceutical detailing is very likely ideologically-based. Of course, I could be mistaken—it could simply be the result of the status quo bias. (Samuelson and Zeckhauser, 2005)

REFERENCES


Huddle T.S. (2010). The pitfalls of deducing ethics from behavioral economics: why the Association of American Medical Colleges is wrong about pharmaceutical detailing. *American Journal of Bioethics*


