"The Human Advantage: Academic Detailing in the Age of AI & Misinformation"

Podcast Episode 30: August 2026

Guest: Jerry Avorn, MD, Co-Founder & Special Adviser, NaRCAD

You're listening to Changing Minds: Transformative Talks for Healthcare Improvement. Grab a coffee or tea and join our team as we chat with leaders in the academic detailing space. For more information on academic detailing, visit us at narcad.org.

Bevin: Hello everyone, and welcome to another episode of *Changing Minds*. It is our podcast where we explore clinical education and the different ways that behavior change is so critical in the clinical space to making change for the better. In this particular instance, focusing in on what clinicians need to provide the best care for their patients. And I am happy to say our special guest today is none other than Jerry Avorn, the originator of academic detailing.

We check in with him from time to time because we want to know, are we on the right path here, especially from the person who started these early studies in the early 80s and has seen the field take off, and bloom and blossom and also come up against different historical periods where academic detailing has had to change course a bit. So first of all, welcome Jerry! How are you doing this morning?

Jerry: I'm well, thank you. As well as one can be in these times.

Bevin: Yes, yes. Heard, heard and seconded!

We have some things we would love to pick your brain about today since we have you in the hot seat. And because our annual conference here in Boston is coming up November 12th and 13th, and we do encourage everyone to join us either in Boston or virtually, we'd love to hear from you, Jerry, what you think. We always have a fancy little theme here at NaRCAD and we're very proud of our themes, but we're talking about the actual theme, which is charting our course and re-imagining the academic detailing ecosystem. That re-imagining is important.

We again encourage you to attend, to be part of those conversations about how we move forward. But I think before we talk about how we move forward, Jerry, I'd love to really pick your brain about where we've been, especially the past year and a half and this past, you know, six to eight months of this year.

And so what I'd love to start off with is, how do you think the current landscape of healthcare is affecting detailing as a field? And the flip of that is how can detailers really show up for this hard work, and why should they continue to show up for this hard work? So I'm going to throw that over to you.

Jerry: Okay, great! Thanks Bevin. It's good to be with you again and those are certainly very timely questions, especially in these very complicated times that we're all trying to work through. And last November, when we had our very encouraging and useful annual meeting, the phrase that kept going through my mind was academic detailing now more than ever.

And it was a little swimming upstream, as we like to discuss over at Alosa, in the sense that, it was a time when a lot of people were thinking about loss of funding and tightening of belts. And the issue that many people were concerned about at last year's meeting, and I'm sure it will come up again this November, is, well, is academic detailing kind of a nice to have but not

imperative, frill kind of thing that in these times when so many people in healthcare are losing their jobs or dealing with much more constrained budgets, and we know that in the coming year, we are going to see so many of our patients kicked off of Medicaid because of the so-called One Big Beautiful Bill that the President passed last year. And we've already seen the withdrawal of the Obamacare subsidies, pushing many other millions of people off of their own health insurance.

Should we really be even talking about something like academic detailing in these times? Or should we just devote all of our energy to managing to just deliver the care that we are committed to delivering? And my reaction last year, and I think even more so this November, is going to be, yes, we should, and now more than ever. And let me take a minute to say why I think that's true.

Bevin: Please do!

Jerry: If we are dealing, as we are, with more aggressive disinformation in terms of healthcare and medications and vaccines than I've ever encountered in almost a half a century of being a doctor, and if we are also seeing stark reductions in coverage that we have seen and will be seeing, this is a moment when we really got to be sure that we are communicating way more than ever with our patients and with each other, and providing clinicians with the tools they need to do that communication with both the patients and also in interrogating the evidence, because the evidence ain't, well, the evidence is what it used to be, but the official pronouncements of that evidence have become downright anti-scientific and counterfactual.

So, there's really two prongs to the now more than ever piece I'd like to put before the listeners. One is that the degradation of information out there in the space that patients and doctors live in has never been worse, and the need to just have a clear voice about this is true and this is not true is way more pressing than it ever has been in the last, you know, 50 years at least.

And the other is resources, as we all know, are really, really getting constrained, and I was at a talk the other day when somebody said that the trillion dollars that the administration is going to knock off of the Medicaid budget and other kinds of healthcare coverage happens to be eerily close to the trillion dollars they want to add to the military budget, and so we are seeing a reallocation of resources away from healthcare, especially for the most vulnerable patients. And so what that means is not, oh, we can't afford to do this, you know, educational outreach stuff, because we don't have enough funds. I think what it tells me is that we do not have a dime to waste when it comes to having people getting medications that we know are cost-effective and are going to keep them out of the hospital, whether it is with COVID or a childhood disease that we know how to prevent, or in older people having heart attacks or hip fractures or strokes that we know are very well treated by medications we have.

We don't have any slack in the system that can allow us to have suboptimal prescribing or other forms of care because it's just going to take away from something else that we got to do. So, the fiscal stringencies that we are facing really make evidence-based prescribing and other forms of healthcare more adamantly necessary, almost on an emergency basis. So yeah, now more than ever.

Bevin: And, I just want to piggyback on you saying now more than ever and on an emergency basis. You were saying to me a few moments ago before we hopped on this podcast the idea that the ripple effect of not doing this could result in hospitals and ERs being just overly stuffed. Can you speak more about that?

Jerry: Sure! And I think there's people out there who do not follow these issues the way we and our listeners do as closely who think, 'well, I've still got my employer-based coverage or I'm on Medicare, so too bad about those other people who are losing their coverage, but I'm okay.' And what I think people don't realize but will realize like a thunderclap in the coming months and year is that our ERs are going to become the place where people end up having to go when their chest pain from their angina is no longer bearable even though medication might have prevented it or their heart failure is out of control or an instance that I heard about from a colleague which for me summed a lot of it up was that somebody lost their health insurance coverage and had been an asthmatic who was very well compensated on their ongoing asthma meds for years, and years and then they could not afford their inhaler. They tried to stretch out the doses, they tried to do without, and sure enough they ended up not just in the emergency room with a horrendous asthma attack but it was untreatable as asthma attacks can do when somebody's not been able to get the meds they need, and they ended up having to be in the intensive care unit for many, many days before they could be brought back to some normal clinical state.

Bevin: Wow!

Jerry: And I'm sure that if anybody who knows how to do arithmetic were to ask how would the cost of the inhaler have compared with the cost of five days in ICU? But besides that, that person ended up in the ER waiting for a very long time and all the other people who may think, 'hey this ain't my problem, I've got my coverage,' were needing to wait even longer and our ERs as we know are just hideously backed up as it is for people having emergencies. So when a person does, you know, get into a car crash or fall down a flight of stairs or end up with a recurrence of some chronic illness and they think, 'hey I've got my coverage, I'll go to the ER,' they are going to then find a horde of miserable suffering people with a crew of overwhelmed doctors, nurses and other healthcare workers and it's going to affect everybody and that'll kick in in 2027 even more than now.

Bevin: Wow, wow! So really thinking about the importance of our community doing this academic detailing is so much bigger than the 1:1 visit that they might have on a Thursday afternoon. That the ripple effect of good that can come out of this and preventing the kind of things you're talking about, bottlenecked ERs and so forth and people being able to get the care that they need is so important.

I want to ask you a little bit more, Jerry, about the current state of things and the current administration and the ways in which the impact on the CDC over the past 18 months have made it really difficult for clinicians not only to trust where their evidence is coming from but to have conversations with patients who are getting disinformation, and who are coming in hot saying, "I don't want this vaccine" or "this would be bad for me." So the clinicians are kind of maybe more so having a little bit of a battle with trying to convince patients that the care they're offering is safe and sound and the right way to go. We are hearing as a result of that from many of our detailing community members that they're going in to meet with clinicians who are so stressed and burnt out about having these conversations.

What detailing programs are starting to do, and maybe some of them who are listening are well into this practice, is building patient-facing tools, and also scripts for not prescriptions but scripts for clinicians to use to speak some sense with their patients, and say, "this is what the evidence says" and "here is why X vaccine is good for you" or "X approach is good for you." What we're seeing is detailers coming in kind of being in a place where they are one of the few spaces where a clinician can offload and vent and de-stress. And while we want to very much protect our detailing community and know you are not there to therapize, what do you think we can offer our listening detailing programs - and the members of those programs,

detailers, program managers, etc - what do you think we can offer them for support in terms of the ways in which their role is sort of changing? They're coming in still trying to offer that evidence-based non-commercial, non-ideological content, but the human piece being what clinicians seem to be relying on more than ever. Any thoughts on that?

Jerry: Yeah, thanks, Bevin! And those are two really important ways in which the situation facing not just healthcare in general but academic detailing in particular is quite different than it was even two years ago and that we need to reflect that new reality as best we can.

I think this will be a subject of a lot of interesting conversation at the November meeting among ourselves as part of the academic detailing community and also perhaps hearing from others who are outside of our little community, but who are grappling with these issues. And those two very related but different issues that I think academic detailing now has to confront in a way we didn't used to ever have to confront are, one, the rampant disinformation that is out there, and two, dealing with the physician who is, or other prescriber, who is facing prescribing and clinical stresses that are, I think it's fair to say, unprecedented. So let me take them one at a time.

Rampant disinformation is something that I've never encountered in my increasingly long career. And by that I mean, you know, it used to be that we would worry about, oh, how do we make sure that the over-marketing of a certain expensive drug that's no better than a comparable drug, you know, and how do we make it, make sure that people understand that it's, you know, that's not really worth prescribing, or how do we alert people to under-recognized side effects, or how do we tell them that generics, or more recently biosimilars, work just as well even though they may have their patients not believe that at first. I mean, those were kind of modest kinds of disinformation that we were trying to combat.

And we, I think as an academic detailing community, did a pretty good job of that over the years. We are now facing a kind of nuclear level disinformation campaign coming from the very highest levels of government about the safety or non-safety of medical products. Vaccines come to mind, but in just the last month, we've seen peptides out there as something which has been endorsed now, or actually the FDA's newly stacked advisory committee endorsed the use of peptides for a lot of situations for which there is no decent evidence of efficacy and certainly no demonstration of safety.

So it's not just vaccines, it's having the doors open wide to these treatments that a lot of clinicians are going to have patients coming to them. And, you know, this is so orders of magnitude worse than, you know, was a given drug company overstating the benefits of its non-steroidal anti-inflammatory compared to others. This is stuff that doesn't work and could be dangerous in the case of peptides, for that example, or wrecking the schedule of vaccinations as we've heard in the last week from both the President and the Secretary of Health and Human Services, which we know is going to create the sense that vaccines in a combination are somehow going to make our kids sick. So, this is really weaponized and even more grotesquely inaccurate misinformation than we've ever had to try and deal with before in the world of academic detailing and healthcare in general.

And the other piece that is kind of new and different in this year compared to years in the past is that, as you just said, Bevin, doctors and other healthcare professionals are getting confronted by their patients who have consumed or been subjected to a lot of this disinformation in ways that we never saw before. You know, we've never had, well, actually during COVID, we did have the President advocating hydroxychloroquine and bleach, as well as convalescent plasma to treat COVID, none of which made any sense.

So, we did have a little bout of that in Trump one, but that kind of receded with the epidemic receding. And now we are seeing it coming back in a way more, speaking of gain of function research, we are seeing a way more virulent kind of disinformation coming. And I'm sure if I was a patient and didn't know better, I would think, 'hey, it's the Secretary of Health and Human Services, and the President warning us about vaccines or saying peptides are okay.'

So there is that other aspect. And that opens up either a new need or a new opportunity for academic detailing, which is to be maybe one of the few voices that the clinician can talk to and say, "I've also got this other problem in that my patients don't trust what I'm recommending: they think I'm prescribing things that could hurt them. They want me to give them stuff that isn't going to work. And then I, the clinician, look like the bad person because I either don't want to go along with it or I have to tell them, no, what you believe is not true." And that's a stress that doctors have always had a little bit of to deal with, but now they have to deal with it in a mega dose kind of way.

I think that opens an opportunity for the academic detailing to do what we do best, which is in a 1:1 conversation with the clinician and say, "you know, this must be a very hard time for you in relation to your patients, either refusing or demanding X, Y, or Z. How is that? And what can I offer you to help make that a little bit less unbearable?" And that opens the door, of course, to the patient-facing materials that you mentioned that I know at Alosa, we've always tried to make sure there's something for the doc to give the patient to underline why this is a good idea, whether it's about your inhaler or back when we had a vaccine module that was going that will be resuscitating before long. But the patient-facing materials and the talking with the doctor about the stresses about communicating with patients are also new elements for academic detailing this year and next.

Bevin: I wonder, Jerry, when you say, you know, the patient-facing materials, which I know I brought up, that's one way that they can sort of arm clinicians with something to offer. And I do remember, and I always love this story, and you'll do a better job telling it, about the non-prescription, right? The non-prescription for when patients really, really wanted an antibiotic for something they didn't need an antibiotic about. Can you give us a quick brief on that and what Alosa did as a result to kind of make the patient feel like they had something to take home?

Jerry: Absolutely! I'm always pleased to talk about that. I think we called it the un-prescription, but it's the same idea. And it actually started in 1983 when I did the first academic detailing study because we did focus groups, and that's relevant for the conversation we're having now because we've always learned, whether it was before Alosa, during Alosa, or many of our colleagues around the country and world who are doing this, you learn so much by talking to doctors and talking to patients in focus group or just 1:1 market research kinds of conversations. The way, of course, you know, anything we know, we learned about communication from our colleagues in the drug industry, and they would never mount a promotion campaign without having groups of doctors come together in small groups or 1:1 and say, "tell me, Dr. Avorn, what do you think about the use of this medicine for diabetes or hypertension?" And then the Dr. Avorns of the country or world would tell them, and they would understand, as we understand when we're doing our own focus groups in the current moment, about what doctors really think.

And, you know, we got to accept the fact that what doctors are really bringing to their decision-making is often quite different from what any of us might have expected them to be bringing about beliefs and attitudes and knowledge base and values that, if you don't take that into account, you don't really know. So we learned, to come back to your question, Bevin, we learned about why doctors were using antibiotics for viral upper respiratory infections.

And we learned many things in those early focus groups in the early 1980s, and one of them was that the doctors knew all about how viruses don't respond to antibiotics or that you're not going to change the natural history of their upper respiratory viral infection by giving them a penicillin-type drug. But what they said to us was, "I know all that stuff, but what I find is that either I give a 20-minute lecture on microbiology and infectious disease to my patient, and explain why I'm not giving them an antibiotic for their sniffles, and then they just go off angry and go down the street and get it from some other doctor anyway." So we learned to produce what we began calling, 40-plus years ago, an un-prescription, where it was something that was, in lay language, intelligible, addressed concerns of patients, and it basically said, here is why an antibiotic could actually make you sicker than not getting an antibiotic, and why your doctor is doing a good job of caring for you by withholding that antibiotic. And then there were places where the doctor could write the patient's name on top, check some boxes about...

Bevin: Orange juice and vitamin C.

Jerry: Yeah, exactly right!

Well, not vitamin C, but decongestants and aspirin if you're having pain, or all the kind of mom-and-apple-pie stuff that we know is true, and then sign the doctor's name at the bottom and give it to the patient as kind of this un-prescription. What we learned is that that made it much easier for doctors to give information to patients that patients are initially not ready to accept, by having user-friendly, appropriately worded information for them to give to the patient, rather than saying, "no, I'm not going to divide up your measles, mumps, rubella vaccinations into three different doses of things, like you can't even get those products," or "no, I'm not going to give you peptides so that you can be more virile," or "no, you don't need testosterone." But to have patient-facing material so that the doctor does not have to spend all day long, which we all know can be a just completely deflating way of spending your day, trying to convince patients that what they believe is untrue, at least have some materials that are well-worded, responsive to where the patients are coming from, that'll make that task of evidence-based prescribing a little easier.

Bevin: Yes, and so with that example, with something like antibiotics, I know that a lot of the people in our field right now are kind of scratching their heads and starting to figure out how can we provide clinicians with, whether it's a scripting tool or a handout, but something that makes it so that clinicians aren't wasting their precious time with patients arguing about whether the disinformation is, in fact, valid or not. And then the other piece is part of the service of academic detailing, and this will be kind of closer to where we wrap up, Jerry, and I would love to hear from you about just the foundations and the early theories of AD and what we've seen evolve and what you think about this.

One of the foundations of AD is that it is indeed a service. It's a human-to-human service. It's not someone going on UpToDate and typing in, 'what do I do in this instance,' and getting a printout and then following that printout. There is something so critical about being able to assess the unique needs of a specific individual on a given day in a given clinic or hospital.

So, I would love to wrap up with you just telling us, what do you think is so key about this coming from a human versus an app or a book or a Grand Rounds or a lecture, but one human who's there to say, "Dr. Avorn, I'm going to spend 20 minutes with you." What is the magic of that?

Jerry: I'm so glad you mentioned that before we wrap Bevin, because it is not, and frankly, if they went to UpToDate, that would be infinitely better than a lot of the sources that people

are now going to, whether they be patients or doctors, about prescribing information. At least UpToDate is, while it's not the most scintillating text, it's accurate. It is literally up-to-date and it is evidence-based. But what I worry about, and I know you do based on the question and what a lot of our listeners worry about, is basically just going to an AI bot and saying, 'I have chest pain' or 'I have this funny black mole that won't go away' or whatever. And the quality control of what is out there in AI land is non-existent.

And some of it might happen to be right, some of it might not be. But the extent to which, and I read a paper just yesterday about how they are now having AI bots that are manifested on video as an avatar. So it actually looks like you're talking to a human that is saying these things, but the words are all coming out of, you know, Claude or ChatGPT or someplace.

And again, we know that they have been unreliable before. Will they be more reliable in the coming years? Quite possibly. And then we'll have a whole other conversation, but I bet that in November, one of the things that we will be talking about as a community is how do we also deal with this totally separate, unrelated issue of AI as a resource that patients are turning to.

It was bad enough when they would all come in with a printout from what we'd refer to as Dr. Google, but now it is even more unrestrained in terms of getting information from various AI sources. And it comes back to what you just said. We are people, we are conscientious, we understand the fact that when a person is at a doctor, it is one human who is having a medical problem talking to another human.

We've been doing a lot of work with the Arnold Gold Foundation out of New York that if listeners don't know about, you should check out. Their entire raison d'etre for years and years has been humanism in medicine and there's a meeting in September in Pittsburgh in which a lot of us are going to talk about.

So, where do we humans fit into the whole process of prescribing and of clinical care at a moment when the bots are on the march? And yes, we need to, at least for the moment, embrace the fact that we academic detailers are able to offer something that is better than any bot, at least in 2026-27. That is, we're kind of there for the doctor. We care about the doctor just as the doctor cares for the patient.

And that is an element that you can't just log on and get out of a computer. And we need to kind of embrace that. Our 1:1 interactions in person whenever possible, certainly reinforce that idea that we've still got something that you can't get on a laptop or an iPhone. And that that is better than, at least at the moment, what you can get from a computer- whether I'll still be able to say that in one or two or three years, we'll just have to get together and find out.

Bevin: We'll have to wait till the three-dimensional holograms come. I think that's really what we're going to have to wait for.

Jerry: Yeah!

Bevin: But you hit the nail on the head. And I think this is a rallying cry to anyone listening who is interested in clinical outreach education, in evidence-based medicine, in making sure that frontline providers have what they need to provide optimal care for their patients. And Jerry, thank you for being here today.

I just want to take a quick moment to plug the conference one more time. This is going to be a truly phenomenal program that we've just put together and registration is now open on narcad.org. Jerry will be our kickoff keynote on day one with his Annual AD Talk. You won't

want to miss that. We have just such a great program. We're looking at expansive applications and adaptations to the AD model. We are indeed looking at AI. We'll have a breakout in terms of thinking about can this work for you? Are you still a holdout for the non-AI world? And will you be forever? And what can you do in either instance?

We will have people from Norway, from Canada. We've invited people from Puerto Rico, Brazil. There's AD happening all across the globe. What's most important is this is one of the few opportunities to really see each other in person. Going back to that AD model of why this works is it's in person and it's relationship building.

Come be with us at the Fairmont Copley Plaza in downtown Boston, right in Copley Square. We have an evening reception at the end of day one, which is November 12th, and it is such a blast. You can come chat with Jerry himself. We also have a lot of really, really interesting content where we are looking at how can you flex your communication skills? How can you ignite stakeholder support during a time where so many things are underfunded and really pitch AD in a way that gets people excited? And of course, networking is the number one thing, getting to see the people across the globe who are as committed to doing this work as you are. So please do register today at narcad.org. We are in the midst of our early bird registration special. You will not want to miss that.

And if you are listening to this podcast and you type in the code JERRY, you will also get early bird registration for one additional week. So only those of you who listened all the way to the very end will know. All caps JERRY will get you what you need. You'll get 300 bucks off, and that ain't nothing in these trying times. So Jerry, anything else you want to add before we sign off for the day at *Changing Minds*?

Jerry: Well, Bevin, I loved your wrap-up just now comparing the 1:1 encounters that we do with doctors to the 1:1 encounters that we'll do with one another in November, because there's so much that, as we all know, you're not going to put in a memo or have happen on a Zoom or read in a journal, but it's that human interaction about how do you feel about this? What is your understanding? Can we talk a little bit more? That just doesn't happen except when people are together or even as a fallback online, although that's not quite as good, but for some people it's the closest you can come. But yeah, in a sense, the meeting is to academic detailing as academic detailing is to clinical decision making.

It's putting the human element back in it, the interactivity back in it. And yeah, I will be there. I'll also probably talk unashamedly about my book, *Rethinking Medications* with All issues and a Substack that's going to be coming out later in the fall, which I'll probably have up and running at that point.

And until then, there's a lot of stuff on LinkedIn that I just spew forth periodically about my thoughts and concerns and hopes for prescribing and healthcare in general that people can follow until that day comes. And also, the very exciting development with the Gold Foundation, getting our book and our reading guide I'm putting together with a wonderful bioethicist about bringing these issues to medical students and nursing students in a way that, and the Gold Foundation is just going to give them the book, which is nice for everybody, to bring these issues into the classroom or into out-of-class exercises. So, we're all doing our best, as I know all the listeners are, and we will get through this one way or another.

And the meeting in November, I guess, will be right after the Midterm Elections. So, we will have a lot to talk about around the future of healthcare at that moment.

Bevin: We will indeed!

So do join us. NaRCAD2026 is Thursday, November 12th, and Friday, November 13th, down here in Boston and online. It's called “Charting Our Course: Reimagining the AD Ecosystem” and we do not want to reimagine it without you there.

So again, check everything out online and stay tuned for the next episode of *Changing Minds*. Thanks for being with us, Jerry. Appreciate you!

Jerry: It's a pleasure. Thank you, Bevin.