The Drug Pushers

As America turns its health-care system over to the market, pharmaceutical reps are wielding more and more influence—and the line between them and doctors is beginning to blur

CARL ELLIOTT | APRIL 2006 ISSUE | TECHNOLOGY

Back in the old days, long before drug companies started making headlines in the business pages, doctors were routinely called upon by company representatives known as "detail men." To "detail" a doctor is to give that doctor information about a company's new drugs, with the aim of persuading the doctor to prescribe them. When I was growing up, in South Carolina in the 1970s, I would occasionally see detail men sitting patiently in the waiting room outside the office of my father, a family doctor. They were pretty easy to spot. Detail men were usually sober, conservatively dressed gentlemen who would not have looked out of place at the Presbyterian church across the street. Instead of Bibles or hymn books, though, they carried detail bags, which were filled with journal articles, drug samples, and branded knickknacks for the office.

Today detail men are officially known as "pharmaceutical sales representatives," but everyone I know calls them "drug reps." Drug reps are still easy to spot in a clinic or hospital, but for slightly different reasons. The most obvious is their appearance. It is probably fair to say that doctors, pharmacists, and medical-school professors are not generally admired for their good looks and fashion sense. Against this backdrop, the average drug rep looks like a supermodel, or maybe an A-list movie star. Drug reps today are often young, well groomed, and strikingly good-looking. Many are women. They are usually affab

The Drug Pushers

As America turns its health-care system over to the market, pharmaceutical reps are wielding more and more influence—and the line between them and doctors is beginning to blur

CARL ELLIOTT | APRIL 2006 ISSUE | TECHNOLOGY

Back in the old days, long before drug companies started making headlines in the business pages, doctors were routinely called upon by company representatives known as "detail men." To "detail" a doctor is to give that doctor information about a company's new drugs, with the aim of persuading the doctor to prescribe them. When I was growing up, in South Carolina in the 1970s, I would occasionally see detail men sitting patiently in the waiting room outside the office of my father, a family doctor. They were pretty easy to spot. Detail men were usually sober, conservatively dressed gentlemen who would not have looked out of place at the Presbyterian church across the street. Instead of Bibles or hymn books, though, they carried detail bags, which were filled with journal articles, drug samples, and branded knickknacks for the office.

Today detail men are officially known as "pharmaceutical sales representatives," but everyone I know calls them "drug reps." Drug reps are still easy to spot in a clinic or hospital, but for slightly different reasons. The most obvious is their appearance. It is probably fair to say that doctors, pharmacists, and medical-school professors are not generally admired for their good looks and fashion sense. Against this backdrop, the average drug rep looks like a supermodel, or maybe an A-list movie star. Drug reps today are often young, well groomed, and strikingly good-looking. Many are women. They are usually affable and

sometimes very smart. Many give off a kind of glow, as if they had just emerged from a spa or salon. And they are always, hands down, the best-dressed people in the hospital.

Drug reps have been calling on doctors since the mid-nineteenth century, but during the past decade or so their numbers have increased dramatically. From 1996 to 2001 the pharmaceutical sales force in America doubled, to a total of 90,000 reps. One reason is simple: good reps move product. Detailing is expensive, but almost all practicing doctors see reps at least occasionally, and many doctors say they find reps useful. One study found that for drugs introduced after 1997 with revenues exceeding $200 million a year, the average return for each dollar spent on detailing was $10.29. That is an impressive figure. It is almost twice the return on investment in medical-journal advertising, and more than seven times the return on direct-to-consumer advertising.

But the relationship between doctors and drug reps has never been uncomplicated, for reasons that should be obvious. The first duty of doctors, at least in theory, is to their patients. Doctors must make prescribing decisions based on medical evidence and their own clinical judgment. Drug reps, in contrast, are salespeople. They swear no oaths, take care of no patients, and profess no high-minded ethical duties. Their job is to persuade doctors to prescribe their drugs. If reps are lucky, their drugs are good, the studies are clear, and their job is easy. But sometimes reps must persuade doctors to prescribe drugs that are marginally effective, exorbitantly expensive, difficult to administer, or even dangerously toxic. Reps that succeed are rewarded with bonuses or commissions. Reps that fail may find themselves unemployed.

Most people who work in health care, if they give drug reps any thought at all, regard them with mixed feelings. A handful avoid reps as if they were vampires, backing out of the room when they see one approaching. In their view, the best that can be said about reps is that they are a necessary by-product of a market economy. They view reps much as NBA players used to view Michael Jordan: as an awesome, powerful force that you can never really stop, only hope to control.

Yet many reps are so friendly, so easygoing, so much fun to flirt with that it is virtually impossible to demonize them. How can you demonize someone who brings you lunch and touches your arm and remembers your birthday and knows the names of all your children? After awhile even the most steel-willed doctors may look forward to visits by a rep, if only in the self-interested way that they look forward to the UPS truck pulling up in their driveway. A rep at the door means a delivery has arrived: take-out for the staff, trinkets for the kids, and, most indispensably, drug samples on the house. Although samples are the single largest marketing expense for the drug industry, they pay handsome dividends: doctors who accept samples of a drug are far more likely to prescribe that drug later on.

Drug reps may well have more influence on prescriptions than anyone in America other than doctors themselves, but to most people outside the drug industry their jobs are mysterious. What exactly do they do every day? Where do they get their information? What do they say about doctors when the doctors are not around? Reps can be found in hospitals, waiting rooms, and conference halls all over the country, yet they barely register on the collective medical consciousness. Many doctors notice them only in the casual, utilitarian way that one might notice a waitress or a bartender. Some doctors look down on them on ethical grounds. "Little Willy Lomans," they say, "only in it for the money." When I asked my friends and colleagues in medicine to suggest some reps I could talk to about detailing, most could not come up with a single name.

These doctors may be right about reps. It is true that selling pharmaceuticals can be a highly lucrative job. But in a market-based medical system, are reps really so different from doctors? Most doctors in the United States now work, directly or indirectly, for large corporations. Like reps, many doctors must answer to managers and bureaucrats. They are overwhelmed by paperwork and red tape. Unlike my father, who would have sooner walked to Charleston barefoot than take out an ad for his practice, many doctors now tout their services on roadside billboards. My medical-school alumni magazine recently featured the Class of

1988 valedictorian, who has written a diet book, started her own consulting firm, and become the national spokesperson for a restaurant chain. For better or worse, America has turned its health-care system over to the same market forces that transformed the village hardware store into Home Depot and the corner pharmacy into a strip-mall CVS. Its doctors are moving to the same medical suburb where drug reps have lived for the past 150 years. If they want to know what life is like there, perhaps they should talk to their neighbors.

The King of Happy Hour

Gene Carbona was almost a criminal. I know this because, thirty minutes into our first telephone conversation, he told me, "Carl, I was almost a criminal." I have heard ex–drug reps speak bluntly about their former jobs, but never quite so cheerfully and openly. These days Carbona works for *The Medical Letter*, a highly respected nonprofit publication (Carbona stresses that he is speaking only for himself), but he was telling me about his twelve years working for Merck and then Astra Merck, a firm initially set up to market the Sweden-based Astra's drugs in the United States. Carbona began training as a rep in 1988, when he was only eleven days out of college. He detailed two drugs for Astra Merck. One was a calcium-channel blocker he calls "a dog." The other was the heartburn medication Prilosec, which at the time was available by prescription only.

Prilosec is the kind of drug most reps can only dream about. The industry usually considers a drug to be a blockbuster if it reaches a billion dollars a year in sales. In 1998 Prilosec became the first drug in America to reach $5 billion a year. In 2000 it made $6 billion. Prilosec's success was not the result of a massive heartburn epidemic. It was based on the same principle that drove the success of many other 1990s blockbusters, from Vioxx to Viagra: the restoration of an ordinary biological function that time and circumstance had eroded. In the case of Prilosec, the function was digestion. Many people discovered that the drug allowed them to eat the burritos and curries that their gastrointestinal systems had placed off-limits. So what if Prilosec was $4 a pill, compared with a quarter or so for a Tagamet? Patients still begged for it. Prilosec was their savior. Astra

Merck marketed Prilosec as the "purple pill," but, according to Carbona, many patients called it "purple Jesus."

How did Astra Merck do it? Prilosec was the first proton pump inhibitor (a drug that inhibits the production of stomach acid) approved by the Food and Drug Administration, and thus the first drug available in its class. By definition this gave it a considerable head start on the competition. In the late 1990s Astra Merck mounted a huge direct-to-consumer campaign; ads for the purple pill were ubiquitous. But consumer advertising can do only so much for a drug, because doctors, not patients, write the prescriptions. This is where reps become indispensable.

Many reps can tell stories about occasions when, in order to move their product, they pushed the envelope of what is ethically permissible. I have heard reps talk about scoring sports tickets for their favorite doctors, buying televisions for waiting rooms, and arranging junkets to tropical resorts. One rep told me he set up a putting green in a hospital and gave a putter to any doctor who made a hole-in-one. A former rep told me about a colleague who somehow managed to persuade a pharmacist to let him secretly write the prescribing protocol for antibiotic use at a local hospital.

But Carbona was in a class of his own. He had access to so much money for doctors that he had trouble spending it all. He took residents out to bars. He distributed "unrestricted educational grants." He arranged to buy lunch for the staff of certain private practices every day for a year. Often he would invite a group of doctors and their guests to a high-end restaurant, buy them drinks and a lavish meal, open up the club in back, and party until 4:00 a.m. "The more money I spent," Carbona says, "the more money I made." If he came back to the restaurant later that week with his wife, everything would be on the house. "My money was no good at restaurants," he told me, "because I was the King of Happy Hour."

My favorite Carbona story, the one that left me shaking my head in admiration,

took place in Tallahassee. One of the more important clinics Carbona called on was a practice there consisting of about fifty doctors. Although the practice had plenty of patients, it was struggling. This problem was not uncommon. When the movement toward corporate-style medicine got under way, in the 1980s and 1990s, many doctors found themselves ill-equipped to run a business; they didn't know much about how to actually make money. ("That's why doctors are such great targets for Ponzi schemes and real-estate scams," Carbona helpfully points out.) Carbona was detailing this practice twice a week and had gotten to know some of the clinicians pretty well. At one point a group of them asked him for help. "Gene, you work for a successful business," Carbona recalls them saying. "Is there any advice you could give us to help us turn the practice around?" At this point he knew he had stumbled upon an extraordinary opportunity.

Carbona decided that the clinic needed a "practice- management consultant." And he and his colleagues at Astra Merck knew just the man: a financial planner and accountant with whom they were very friendly. They wrote up a contract. They agreed to pay the consultant a flat fee of about $50,000 to advise the clinic. But they also gave him another incentive. Carbona says, "We told him that if he was successful there would be more business for him in the future, and by 'successful,' we meant a rise in prescriptions for our drugs."

The consultant did an extremely thorough job. He spent eleven or twelve hours a day at the clinic for months. He talked to every employee, from the secretaries to the nurses to the doctors. He thought carefully about every aspect of the practice, from the most mundane administrative details to big-picture matters such as bill collection and financial strategy. He turned the practice into a profitable, smoothly running financial machine. And prescriptions for Astra Merck drugs soared.

When I asked Carbona how the consultant had increased Astra Merck's market share within the clinic so dramatically, he said that the consultant never pressed the doctors directly. Instead, he talked up Carbona. "Gene has put his neck on

the line for you guys," he would tell them. "If this thing doesn't work, he might get fired." The consultant emphasized what a remarkable service the practice was getting, how valuable the financial advice was, how everything was going to turn around for them—all courtesy of Carbona. The strategy worked. "Those guys went berserk for me," Carbona says. Doctors at the newly vitalized practice prescribed so many Astra Merck drugs that he got a $140,000 bonus. The scheme was so successful that Carbona and his colleagues at Astra Merck decided to duplicate it in other practices.

I got in touch with Carbona after I learned that he was giving talks on the American Medical Student Association lecture circuit about his experiences as a rep. At that point I had read a fair bit of pharmaceutical sales literature, and most of it had struck me as remarkably hokey and stilted. Merck's official training materials, for example, instruct reps to say things like, "Doctor, based on the information we discussed today, will you prescribe Vioxx for your patients who need once-daily power to prevent pain due to osteoarthritis?" So I was unprepared for a man with Carbona's charisma and forthright humor. I could see why he had been such an excellent rep: he came off as a cross between a genial con artist and a comedic character actor. After two hours on the phone with him I probably would have bought anything he was selling.

Most media accounts of the pharmaceutical industry miss this side of drug reps. By focusing on scandals—the kickbacks and the fraud and the lavish gifts—they lose sight of the fact that many reps are genuinely likeable people. The better ones have little use for the canned scripts they are taught in training. For them, effective selling is all about developing a relationship with a doctor. If a doctor likes a rep, that doctor is going to feel bad about refusing to see the rep, or about taking his lunches and samples but never prescribing his drugs. As Jordan Katz, a rep for Schering-Plough until two years ago, says, "A lot of doctors just write for who they like."

A variation on this idea emerges in *Side Effects*, Kathleen Slattery-Moschkau's 2005 film about a fictional fledgling drug rep. Slattery-Moschkau, who worked

for nine years as a rep for Bristol-Myers Squibb and Johnson & Johnson, says the carefully rehearsed messages in the corporate training courses really got to her. "I hated the crap I had to say to doctors," she told me. The heroine of *Side Effects* eventually decides to ditch the canned messages and stop spinning her product. Instead, she is brutally honest. "Bottom line?" she says to one doctor. "Your patients won't shit for a week." To her amazement, she finds that the blunter she is, the higher her market share rises. Soon she is winning sales awards and driving a company BMW.

For most reps, market share is the yardstick of success. The more scripts their doctors write for their drugs, the more the reps make. Slattery-Moschkau says that most of her fellow reps made $50,000 to $90,000 a year in salary and another $30,000 to $50,000 in bonuses, depending on how much they sold. Reps are pressured to "make quota," or meet yearly sales targets, which often increase from year to year. Reps who fail to make quota must endure the indignity of having their district manager frequently accompany them on sales calls. Those who meet quota are rewarded handsomely. The most successful reps achieve minor celebrity within the company.

One perennial problem for reps is the doctor who simply refuses to see them at all. Reps call these doctors "No Sees." Cracking a No See is a genuine achievement, the pharmaceutical equivalent of a home run or a windmill dunk. Gene Carbona says that when he came across a No See, or any other doctor who was hard to influence, he used "Northeast-Southwest" tactics. If you can't get to a doctor, he explains, you go after the people surrounding that doctor, showering them with gifts. Carbona might help support a Little League baseball team or a bowling league. After awhile, the doctor would think, Gene is doing such nice things for all these people, the least I can do is give him ten minutes of my time. At that point, Carbona says, the sale was as good as made. "If you could get ten minutes with a doctor, your market share would go through the roof."

For decades the medical community has debated whether gifts and perks from reps have any real effect. Doctors insist that they do not. Studies in the medical

literature indicate just the opposite. Doctors who take gifts from a company, studies show, are more likely to prescribe that company's drugs or ask that they be added to their hospital's formulary. The pharmaceutical industry has managed this debate skillfully, pouring vast resources into gifts for doctors while simultaneously reassuring them that their integrity prevents them from being influenced. For example, in a recent editorial in the journal *Health Affairs*, Bert Spilker, a vice president for PhRMA, the pharmaceutical trade group, defended the practice of gift-giving against critics who, he scornfully wrote, "fear that physicians are so weak and lacking in integrity that they would 'sell their souls' for a pack of M&M candies and a few sandwiches and doughnuts."

Doctors' belief in their own incorruptibility appears to be honestly held. It is rare to hear a doctor—even in private, off-the-record conversation—admit that industry gifts have made a difference in his or her prescribing. In fact, according to one small study of medical residents in the *Canadian Medical Association Journal*, one way to convince doctors that they cannot be influenced by gifts may be to give them one; the more gifts a doctor takes, the more likely that doctor is to believe that the gifts have had no effect. This helps explain why it makes sense for reps to give away even small gifts. A particular gift may have no influence, but it might make a doctor more apt to think that he or she would not be influenced by larger gifts in the future. A pizza and a penlight are like inoculations, tiny injections of self-confidence that make a doctor think, I will never be corrupted by money.

Gifts from the drug industry are nothing new, of course. William Helfand, who worked in marketing for Merck for thirty-three years, told me that company representatives were giving doctors books and pamphlets as early as the late nineteenth century. "There is nothing new under the sun," Helfand says. "There is just more of it." The question is: Why is there so much more of it just now? And what changed during the past decade to bring about such a dramatic increase in reps bearing gifts?

An Ethic of Salesmanship

One morning last year I had breakfast at the Bryant-Lake Bowl, a diner in Minneapolis, with a former Pfizer rep named Michael Oldani. Oldani grew up in a working-class family in Kenosha, Wisconsin. Although he studied biochemistry in college, he knew nothing about pharmaceutical sales until he was recruited for Pfizer by the husband of a woman with whom he worked. Pfizer gave him a good salary, a company car, free gas, and an expense account. "It was kind of like the Mafia," Oldani told me. "They made me an offer I couldn't refuse." At the time, he was still in college and living with his parents. "I knew a good ticket out of Kenosha when I saw one," he says. He carried the bag for Pfizer for nine years, until 1998.

Today Oldani is a Princeton-trained medical anthropologist teaching at the University of Wisconsin at Whitewater. He wrote his doctoral dissertation on the anthropology of pharmaceutical sales, drawing not just on ethnographic fieldwork he did in Manitoba as a Fulbright scholar but also on his own experience as a rep. This dual perspective—the view of both a detached outsider and a street-savvy insider—gives his work authority and a critical edge. I had invited Oldani to lecture at our medical school, the University of Minnesota, after reading his work in anthropology journals. Although his writing is scholarly, his manner is modest and self-effacing, more Kenosha than Princeton. This is a man who knows his way around a diner.

Like Carbona, Oldani worked as a rep in the late 1980s and the 1990s, a period when the drug industry was undergoing key transformations. Its ethos was changing from that of the country-club establishment to the aggressive, new-money entrepreneur. Impressed by the success of AIDS activists in pushing for faster drug approvals, the drug industry increased pressure on the FDA to let companies bring drugs to the market more quickly. As a result, in 1992 Congress passed the Prescription Drug User Fee Act, under which drug companies pay a variety of fees to the FDA, with the aim of speeding up drug approval (thereby making the drug industry a major funder of the agency set up to regulate it). In 1997 the FDA dropped most restrictions on direct-to-consumer advertising of

prescription drugs, opening the gate for the eventual Levitra ads on Super Bowl Sunday and Zoloft cartoons during daytime television shows. The drug industry also became a big political player in Washington: by 2005, according to the Center for Public Integrity, its lobbying organization had become the largest in the country.

Many companies started hitting for the fences, concentrating on potential blockbuster drugs for chronic illnesses in huge populations: Claritin for allergies, Viagra for impotence, Vioxx for arthritis, Prozac for depression. Successful drugs were followed by a flurry of competing me-too drugs. For most of the 1990s and the early part of this decade, the pharmaceutical industry was easily the most profitable business sector in America. In 2002, according to Public Citizen, a nonprofit watchdog group, the combined profits of the top ten pharmaceutical companies in the Fortune 500 exceeded the combined profits of the other 490 companies.

During this period reps began to feel the influence of a new generation of executives intent on bringing market values to an industry that had been slow to embrace them. Anthony Wild, who was hired to lead Parke-Davis in the mid-1990s, told the journalist Greg Critser, the author of *Generation Rx*, that one of his first moves upon his appointment was to increase the incentive pay given to successful reps. Wild saw no reason to cap reps' incentives. As he said to the company's older executives, "Why not let them get rich?" Wild told the reps about the change at a meeting in San Francisco. "We announced that we were taking off the caps," he told Critser, "and the sales force went nuts!"

It was not just the industry's ethos that was changing; the technology was changing, too. According to Oldani, one of the most critical changes came in the way that information was gathered. In the days before computers, reps had to do a lot of legwork to figure out whom they could influence. They had to schmooze with the receptionists, make friends with the nurses, and chat up the pharmacists in order to learn which drugs the local doctors were prescribing, using the right incentives to coax what they needed from these informants. "Pharmacists are

like pigeons," Jamie Reidy, a former rep for Pfizer and Eli Lilly, told me. "Only instead of bread crumbs, you toss them pizzas and sticky notes."

But in the 1990s, new information technology made it much simpler to track prescriptions. Market-research firms began collecting script-related data from pharmacies and hospitals and selling it to pharmaceutical companies. The American Medical Association collaborated by licensing them information about doctors (including doctors who do not belong to the AMA), which it collects in its "Physician Masterfile." Soon reps could find out exactly how many prescriptions any doctor was writing and exactly which drugs those prescriptions were for. All they had to do was turn on their laptops and download the data.

What they discovered was revelatory. For one thing, they found that a lot of doctors were lying to them. Doctors might tell a rep that they were writing prescriptions for, say, Lipitor, when they weren't. They were just being polite, or saying whatever they thought would get the rep off their backs. Now reps could detect the deception immediately. (Even today many doctors do not realize that reps have access to script-tracking reports.)

More important, script-tracking helped reps figure out which doctors to target. They no longer had to waste time and money on doctors with conservative prescribing habits; they could head straight to the "high prescribers," or "high writers." And they could get direct feedback on which tactics were working. If a gift or a dinner presentation did not result in more scripts, they knew to try another approach.

But there was a rub: the data was available to every rep from every company. The result was an arms race of pharmaceutical gift-giving, in which reps were forced to devise ever-new ways to exert influence. If the Eli Lilly rep was bringing sandwiches to the office staff, you brought Thai food. If GSK flew doctors to Palm Springs for a conference, you flew them to Paris. Oldani used to take residents to Major League Baseball games. "We did beer bongs, shots, and really partied," he told me. "Some of the guys were incredibly drunk on numerous occasions. I

used to buy half barrels for their parties, almost on a retainer-like basis. I never talked product once to any of these residents, and they took care of me in their day-to-day practice. I never missed quota at their hospital."

Oldani says that script-tracking data also changed the way that reps thought about prescriptions. The old system of monitoring prescriptions was very inexact, and the relationship between a particular doctor's prescriptions and the work of a given rep was relatively hard to measure. But with precise script-tracking reports, reps started to feel a sense of ownership about prescriptions. If their doctors started writing more prescriptions for their drugs, the credit clearly belonged to them. However, more precise monitoring also invited micromanagement by the reps' bosses. They began pressuring reps to concentrate on high prescribers, fill out more paperwork, and report more frequently back to management.

"Script-tracking, to me at least, made everyone a potentially successful rep," Oldani says. Reps didn't need to be nearly as resourceful and street savvy as in the past; they just needed the script-tracking reports. The industry began hiring more and more reps, many with backgrounds in sales (rather than, say, pharmacy, nursing, or biology). Some older reps say that during this period the industry replaced the serious detail man with "Pharma Barbie" and "Pharma Ken," whose medical knowledge was exceeded by their looks and catering skills. A newer, regimented style of selling began to replace the improvisational, more personal style of the old-school reps. Whatever was left of an ethic of service gave way to an ethic of salesmanship.

Doctors were caught in a bind. Many found themselves being called on several times a week by different reps from the same company. Most continued to see reps, some because they felt obligated to get up to speed with new drugs, some because they wanted to keep the pipeline of free samples open. But seeing reps has a cost, of course: the more reps a doctor sees, the longer the patients sit in the waiting room. Many doctors began to feel as though they deserved whatever gifts and perks they could get because reps were such an irritation. At one time a

few practices even charged reps a fee for visiting.

Professional organizations made some efforts to place limits on the gifts doctors were allowed to accept. But these efforts were halfhearted, and they met with opposition from indignant doctors ridiculing the idea that their judgment could be bought. One doctor, in a letter to the *American Medical News*, confessed, "Every time a discussion comes up on guidelines for pharmaceutical company gifts to physicians, I feel as if I need to take a blood pressure medicine to keep from having a stroke." In 2001 the AMA launched a campaign to educate doctors about the ethical perils of pharmaceutical gifts, but it undercut its message by funding the campaign with money from the pharmaceutical industry.

Of course, most doctors are never offered free trips to Monaco or even a weekend at a spa; for them an industry gift means a Cialis pen or a Lexapro notepad. Yet it is a rare rep who cannot tell a story or two about the extravagant gifts doctors have requested. Oldani told me that one doctor asked him to build a music room in his house. Phyllis Adams, a former rep in Canada, was told by a doctor that he would not prescribe her product unless her company made him a consultant. (Both said no.) Carbona arranged a $35,000 "unrestricted educational grant" for a doctor who wanted a swimming pool in his back yard. "It was the Wild West," says Jamie Reidy, whose frank memoir about his activities while working for Pfizer in the 1990s, *Hard Sell: The Evolution of a Viagra Salesman*, recently got him fired from Eli Lilly. "They cashed the check, and that was it. And hopefully they remembered you every time they turned on the TV, or bought a drink on the cruise, or dived into the pool."

The trick is to give doctors gifts without making them feel that they are being bought. "Bribes that aren't considered bribes," Oldani says. "This, my friend, is the essence of pharmaceutical gifting." According to Oldani, the way to make a gift feel different from a bribe is to make it personal. "Ideally, a rep finds a way to get into a scriptwriter's psyche," he says. "You need to have talked enough with a scriptwriter—or done enough recon with gatekeepers—that you know what to

give." When Oldani found a pharmacist who liked to play the market, he gave him stock options. When he wanted to see a resistant oncologist, he talked to the doctor's nurse and then gave the oncologist a $100 bottle of his favorite cognac. Reidy put the point nicely when he told me, "You are absolutely buying love."

Such gifts do not come with an explicit *quid pro quo*, of course. Whatever obligation doctors feel to write scripts for a rep's products usually comes from the general sense of reciprocity implied by the ritual of gift-giving. But it is impossible to avoid the hard reality informing these ritualized exchanges: reps would not give doctors free stuff if they did not expect more scripts.

My brother Hal, a psychiatrist currently on the faculty of Wake Forest University, told me about an encounter he had with a drug rep from Eli Lilly some years back, when he was in private practice. This rep was not one of his favorites; she was too aggressive. That day she had insisted on bringing lunch to his office staff, even though Hal asked her not to. As he tried to make polite conversation with her in the hall, she reached over his shoulder into his drug closet and picked up a couple of sample packages of Zoloft and Celexa. Waving them in the air, she asked, "Tell me, Doctor, do the Pfizer and Forest reps bring lunch to your office staff?" A stony silence followed. Hal quietly ordered the rep out of the office and told her to never come back. She left in tears.

It's not hard to understand why Hal got so angry. The rep had broken the rules. Like an abrasive tourist who has not caught on to the code of manners in a foreign country, she had said outright the one thing that, by custom and common agreement, should never be said: that the lunches she brought were intended as a bribe. What's more, they were a bribe that Hal had never agreed to accept. He likened the situation to having somebody drop off a bag of money in your garage without your consent and then ask, "So what about our little agreement?"

When an encounter between a doctor and a rep goes well, it is a delicate ritual of pretense and self-deception. Drug reps pretend that they are giving doctors

impartial information. Doctors pretend that they take it seriously. Drug reps must try their best to influence doctors, while doctors must tell themselves that they are not being influenced. Drug reps must act as if they are not salespeople, while doctors must act as if they are not customers. And if, by accident, the real purpose of the exchange is revealed, the result is like an elaborate theatrical dance in which the masks and costumes suddenly drop off and the actors come face to face with one another as they really are. Nobody wants to see that happen.

The New Drug Reps?

Last spring a small group of first-year medical students at the University of Minnesota spoke to me about a lecture on erectile dysfunction that had just been given by a member of the urology department. The doctor's Power-Point slides had a large, watermarked logo in the corner. At one point during the lecture a student raised his hand and, somewhat disingenuously, asked the urologist to explain the logo. The urologist, caught off guard, stumbled for a moment and then said that it was the logo for Cialis, a drug for erectile dysfunction that is manufactured by Eli Lilly. Another student asked if he had a special relationship with Eli Lilly. The urologist replied that yes, he was on the advisory board for the company, which had supplied the slides. But he quickly added that nobody needed to worry about the objectivity of his lecture, because he was also on the advisory boards of the makers of the competing drugs Viagra and Levitra. The second student told me, "A lot of people agreed that it was a pharm lecture and that we should have gotten a free breakfast."

This episode is not as unusual as it might appear. Drug company–sponsored consultancies, advisory-board memberships, and speaking engagements have become so common, especially among medical-school faculty, that the urologist probably never imagined that he would be challenged for lecturing to medical students with materials produced by Eli Lilly. According to a recent study in The *Journal of the American Medical Association*, nine out of ten medical students have been asked or required by an attending physician to go to a lunch sponsored by a

drug company. As of 2003, according to the Accreditation Council for Continuing Medical Education, pharmaceutical companies were providing 90 percent of the $1 billion spent annually on continuing medical education events, which doctors must attend in order to maintain their licensure.

Over the past year or two pharmaceutical profits have started to level off, and a backlash against reps has been felt; some companies have actually reduced their sales forces. But the industry as a whole is hiring more and more doctors as speakers. In 2004, it sponsored nearly twice as many educational events led by doctors as by reps. Not long before, the numbers had been roughly equal. This raises the question, Are doctors becoming the new drug reps?

Doctors are often the best people to market a drug to other doctors. Merck discovered this when it was developing a campaign for Vioxx, before the drug was taken off the market because of its association with heart attacks and strokes. According to an internal study by Merck, reported in *The Wall Street Journal*, doctors who attended a lecture by another doctor subsequently wrote nearly four times more prescriptions for Vioxx than doctors who attended an event led by a rep. The return on investment for doctor-led events was nearly twice that of rep-led events, even after subtracting the generous fees Merck paid to the doctors who spoke.

These speaking invitations work much like gifts. While reps hope, of course, that a doctor who is speaking on behalf of their company will give their drugs good PR, they also know that such a doctor is more likely to write prescriptions for their drugs. "If he didn't write, he wouldn't speak," a rep who has worked for four pharmaceutical companies told me. The semi-official industry term for these speakers and consultants is "thought leaders," or "key opinion leaders." Some thought leaders do not stay loyal to one company but rather generate a tidy supplemental income by speaking and consulting for a number of different companies. Reps refer to these doctors as "drug whores."

The seduction, whether by one company or several, is often quite gradual. My

brother Hal explained to me how he wound up on the speakers' bureau of a major pharmaceutical company. It started when a company rep asked him if he'd be interested in giving a talk about clinical depression to a community group. The honorarium was $1,000. Hal thought, Why not? It seemed almost a public service. The next time, the company asked him to talk not to the public but to practitioners at a community hospital. Soon company reps were making suggestions about content. "Why don't you mention the side-effect profiles of the different antidepressants?" they asked. Uneasy, Hal tried to ignore these suggestions. Still, the more talks he gave, the more the reps became focused on antidepressants rather than depression. The company began giving him PowerPoint slides to use, which he also ignored. The reps started telling him, "You know, we have you on the local circuit giving these talks, but you're medical-school faculty; we could get you on the national circuit. That's where the real money is." The mention of big money made him even more uneasy. Eventually the reps asked him to lecture about a new version of their antidepressant drug. Soon after that, Hal told them, "I can't do this anymore."

Looking back on this trajectory, Hal said, "It's kind of like you're a woman at a party, and your boss says to you, 'Look, do me a favor: be nice to this guy over there.' And you see the guy is not bad-looking, and you're unattached, so you say, 'Why not? I can be nice.'" The problem is that it never ends with that party. "Soon you find yourself on the way to a Bangkok brothel in the cargo hold of an unmarked plane. And you say, 'Whoa, this is not what I agreed to.' But then you have to ask yourself, 'When did the prostitution actually start? Wasn't it at that party?'"

Thought leaders serve an indispensable function when it comes to a potentially very lucrative marketing niche: off-label promotion, or promoting a drug for uses other than those for which it was approved by the FDA—something reps are strictly forbidden to do. The case of Neurontin is especially instructive. In 1996 a whistle-blower named David Franklin, a medical-science liaison with Parke-Davis (now a division of Pfizer), filed suit against the company over its off-label

promotion of this drug. Neurontin was approved for the treatment of epilepsy, but according to the lawsuit, Parke-Davis was promoting it for other conditions—including bipolar disorder, migraines, and restless legs syndrome—for which there was little or no scientific evidence that it worked. To do so the company employed a variety of schemes, most involving a combination of rep ingenuity and payments to doctors. Some doctors signed ghostwritten journal articles. One received more than $300,000 to speak about Neurontin at conferences. Others were paid just to listen. Simply having some of your thought leaders in attendance at a meeting is valuable, Kathleen Slattery-Moschkau explains, because they will often bring up off-label uses of a drug without having to be prompted. "You can't get a better selling situation than that," she says. In such circumstances all she had to do was pour the wine and make sure everyone was happy.

The litigation over Neurontin cost Pfizer $430 million in criminal fines and civil damages for the period 1994 to 2002. It was well worth it. The drug's popularity and profitability soared. In spite of the adverse publicity, Neurontin generated more than $2.7 billion in revenues in 2003, more than 90 percent of which came from off-label prescriptions.

Of course, sometimes speakers discover that the drug they have been paid to lecture about is dangerous. One of the most notorious examples is Fen-Phen, the diet-drug combination that has been linked to primary pulmonary hypertension and valvular heart disease. Wyeth, the manufacturer of Redux, or dexfenfluramine—the "Fen" in Fen-Phen—has put aside $21 billion to cover costs and liabilities from litigation. Similar events played out, on a lesser scale, with Parke-Davis's diabetes drug Rezulin, and Wyeth's pain reliever Duract, which were taken off the market after being associated with life-threatening complications.

And what about reps themselves? Do they trust their companies to tell them about potential problems with their drugs? Not exactly. As one veteran rep, voicing a common sentiment, told me, "Reps are the last to know." Of course,

for a rep to be detailing a drug enthusiastically right up to the day it is withdrawn from the market is likely to erode that rep's credibility with doctors. Yet some reps say they don't hear about problems until the press gets wind of them and the company launches into damage control. At that point, Slattery-Moschkau explains, "Reps learn verbatim how to handle the concern or objection in a way that spins it back in the drug's favor."

Some believe that the marketing landscape changed dramatically for both reps and doctors in 2002, after the Office of the Inspector General in the Department of Health and Human Services announced its intention to crack down on drug companies' more notorious promotional practices. With the threat of prosecution in the air, the industry began to take the job of self-policing a lot more seriously, and PhRMA issued a set of voluntary marketing guidelines.

Although most reps agree that the PhRMA code has changed things, not all of them agree that it changed things for the better. Some say that as long as reps feel pressure to meet quota, they will find ways to get around the rules. As one former rep pointed out, not all drug companies belong to PhRMA, and those that don't are, of course, not bound by PhRMA's guidelines. Jordan Katz says that things actually got worse after 2002. "The companies that tried to follow the guidelines lost a ton of market share, and the ones who didn't gained it," he says. "The bottom line is that if you don't pay off the doctors, you will not succeed in pharmaceuticals. Period."

A World Without Doctors?

In 1997, John Lantos, a pediatrician and ethicist at the University of Chicago, wrote a book called *Do We Still Need Doctors?* We will always need health care, of course. But, as Lantos observes, it is not clear that we will always need to get our health care from doctors. Many of us already get it from other providers—nurses, physical therapists, clinical psychologists, nutritionists, respiratory therapists, and so on. The figure of "the doctor" is not cast in stone. It is really just a particular configuration of roles and duties and responsibilities, each of which

can be changed.

Many have already been changed. Sometimes I think of my father as one of the last small-town, solo family doctors left in America. His kind of practice has been largely replaced by teams of specialists working in group practices underwritten by insurance companies and for-profit health-care chains. I doubt that any of the doctors my family has ever visited, except for a pediatrician who took care of our children when we lived in Montreal, would recognize us if they passed us in the street. Last year, while driving in Wisconsin, I filled up my car at a combination gas station, pharmacy, and walk-in medical clinic. I don't mean to complain. As long as our health insurance has been paid up, we have usually gotten good care. We simply live in a country that has decided that the traditional figure of the doctor is not worth preserving in the face of modern economics. Instead, we put our trust in the market.

Perhaps we are right to do so. We can get used to a world without doctors. As Lantos points out, we have gotten used to a world where we have shoes but no cobblers. We can copy documents without scriveners, make tools without blacksmiths, and produce books in the absence of bookbinders. We have left the old world behind, and for the most part, we don't miss it.

As the figure of the traditional doctor fades away, it is being replaced by a figure akin to the drug rep, one whose responsibilities are to compete as vigorously as possible in the medical marketplace. Patients are being replaced by "health-care consumers," who shop for the best medical bargains they can find. If it is true that the drug rep does not put my interests first, the same is true of everyone else in the marketplace; and we believe that such problems in the marketplace will be sorted out by the invisible hand. Buyers will stop buying from sellers who provide them with inferior goods. This model of medicine is not unlike that advocated thirty years ago by Robert Sade, a surgeon at my old medical school, the Medical University of South Carolina. Writing in The *New England Journal of Medicine*, Sade argued, "Medical care is neither a right nor a privilege: it is a service provided by doctors and others to people who wish to purchase it." He is now the

vice chair of the AMA's Council of Ethical and Judicial Affairs.

Many doctors seem resigned to this shift. They see themselves as a beleaguered group whose lives are made miserable by third-party payers, personal-injury attorneys, and hospital bureaucrats. Whatever idealism they may have had about the practice of medicine is being pushed aside by the concrete realities of hustling in the new medical marketplace. Many academic physicians seem cowed by the power of the drug companies, upon whom some depend for research funding. For some, it's not so much a question of whether medicine has become a business as what kind of business it has become. When I talked recently to a gastroenterologist at an Ivy League medical school about his work as a thought leader for a variety of drug companies, he shrugged and said, "Better a whore than a concubine."

Which is not to say that pockets of resistance can't be found, especially among younger physicians and medical students. The American Medical Student Association may be the only mainstream medical organization with a principled position against taking industry gifts. It stands in striking contrast to the American Academy of Family Practice, which last year refused to grant exhibition space at its annual conference to No Free Lunch, a physician-led advocacy group that advises physicians to "Just say no to drug reps." The AAFP said that the group's goals were "not within the character and purpose" of the conference. But it allowed pharmaceutical companies, McDonald's, and the Distilled Spirits Council of the United States to exhibit. (It reversed its decision about No Free Lunch after protests by a number of AAFP members.)

Whether doctors and reps are all that different from one another is no longer clear. Doctors know a lot more about medicine, and drug reps dress a lot better, but these days both are Organization Men, small cogs in a vast health-care machine. They are just doing their jobs in a market-driven health-care bureaucracy that Americans have designed, and that we defend vigorously to critics elsewhere in the world. Like anyone else, doctors and reps are responding to the pressures and incentives of the system in which they work.

When Michael Oldani and I were having breakfast, he told me a story about a rep he interviewed for his dissertation. The rep had recently spent a day doing a "preceptorship," a practice in which a drug company pays doctors to let a rep shadow them while they see patients. This rep was shadowing a high-prescribing psychiatrist (she called him "Dr. C") at a med-check clinic. Med-check clinics are extremely busy sites where psychiatrists see large numbers of patients in quick succession, mainly to make sure that their medications are in proper order. At one point during the day, the rep said, a cheerful man in a wheelchair rolled into the office. Barely looking up from the stack of charts on his desk, Dr. C started quizzing the man about his medications. After a few minutes the man interrupted. "Look at me, Dr. C. Notice anything different?" Dr. C pushed his glasses up on top of his head and looked carefully at the patient for a few seconds before replying, "No, I don't. What's up?" The man smiled and said excitedly, "I got my legs cut off!"

After a moment of silence, Dr. C smiled. The man laughed. Neither seemed upset. In a few minutes the session ended, and the next patient came in.