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

BY CARL ELLIOTT

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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-19th 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

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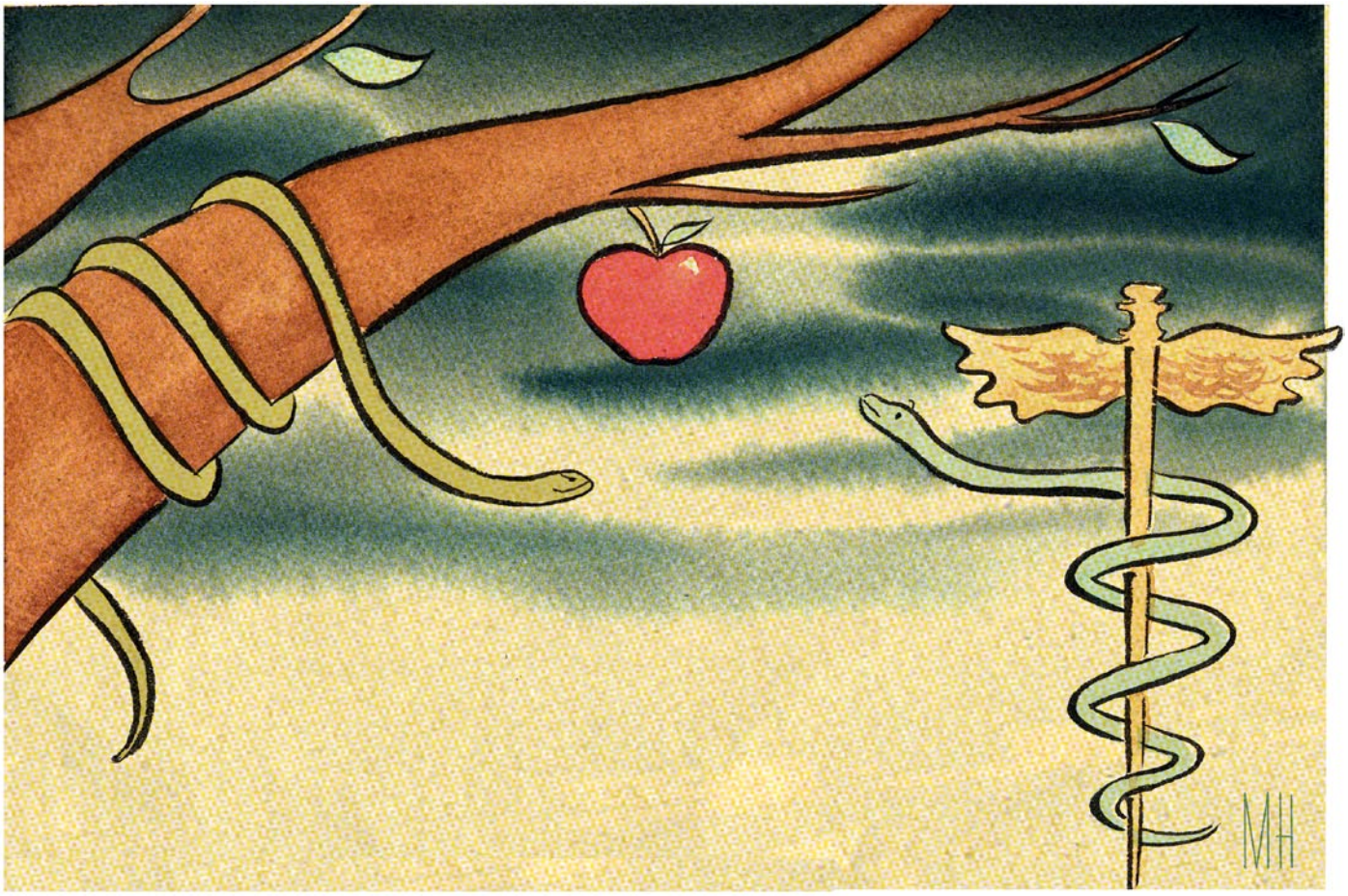
$200 million a year, the average return for each dollar spent on detailing was $10.29. That is an impressive figure. It is almost twice the return on investment in medical-journal advertising, and more than seven times the return on direct-to-consumer advertising.

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 byproduct 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,



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

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

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.

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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 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,"

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

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-Moschau's 2005 film about a fictional fledgling drug rep. Slattery-Moschau, 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-Moschau 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 hand-

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 19th 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

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

In the 1990s, new technology made it easy for any rep to track any doctor's prescriptions. The result was an arms race of pharmaceutical gift-giving. If GSK flew doctors to Palm Springs for a conference, you flew them to Paris.

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

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