

## Tactics of the physician-controlled counter—detail and the imminent risk of not changing pharma’s detail relationship with physicians

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### ABSTRACT

*The traditional relationship between physicians and drug companies is imperiled because the perceived clinical value of the sales detail is found to be increasingly barren of clinical relevancy by physicians. There is an urgent need to train physicians to more effectively mine and refine the data offered by pharma for the benefit of present and future patients. The ability of doctors to use medicines for chronic disease states such as chronic pain, diabetes, hyperlipidemias, depression would be vastly improved if doctors were in possession of clinically relevant data that pharma has, but does not share with clinicians. Doctors must take control of the detail to extract this vital clinical information.*

Consider the many and varied functions and purposes for the pharmaceutical sales detail. Certainly, it is to inform or educate the physician providing carefully selected fundamental or complex clinical information about the characteristics, risks, values, and indications of the medication so that the clinician can confidently integrate the product into his armamentarium. Certainly, it is to sell the product to the physician, delivering a unique selling proposition to the doctor in such a manner that the caregiver will understand the particular strengths of the featured product against the alleged manifest weaknesses of competitive preparations. Certainly, it is an attempt to befriend the physician providing a brief respite for an otherwise harried work day by light conversation, premium gift giving a meal, or through the nonquantifiable esthetic value of a particular salesperson’s pulchritude. Certainly, it is to deliver samples to the doctor so that he can practice dispensing the product to the appropriate patients. But at the end of the day, these several purposes exist to raise corporate Pharma’s ledger’s bottom line to make a promoted pharmaceutical product handsomely pay off its expensive investment.

At present, there are 400,000 practicing physicians in the United States; 250,000 of these write 80 percent of all of the prescriptions. Of this scribbling number, 150,000 are selectively targeted by the pharmaceutical industry for detailing. In the past 8 years, the number of physicians has increased by 15 percent while the pharma sales force has fully doubled in size. In this mix, each doctor of the 150,000 targeted physicians would need to interact with one sales rep every 2 hours to justify the expense of the sales force. In fact, few reps speak to the physician at all. Of those who do, few are remembered (pulchritude notwithstanding). Of 100 visits, 15 depart before reaching reception, 28 merely drop off samples with the receptionist, 12 speak to the doctor but are not remembered by the physician, and 38 drop samples at the sample closet and are remembered, but of those, only 7 visit with the doctor for longer than 2 minutes.<sup>1,2</sup>

These abysmal sounding sales contact data generate enormous prescribing behavior changes in doctors. But Doctors are mightily influenced by the frequent brief details, so Voila! the vast sales force can be justified and is vindicated by its fiscal success. It creates blockbuster drug mentalities in the mind of the prescriber. It inculcates the doctor with just enough knowledge to dispense a particular drug, but not enough to make an informed decision between pharmacotherapeutic alternatives. It teaches the doctor the name and dose and indications for the product, but not risks, interactions, and contraindications, or appropriate means by which one modifies doses in the elderly patients, or in the renal or hepatically impaired. This vital information is not exactly neglected, but is simply not stressed. It is in any case available in the Physician’s Drug Reference or in the optically challenging “Product Insert” where few treaters appear to (or can) delve.

Is the doctor destined to be a mere passive recipient of the pharma message or can he become the agent of active solicitation and organization of data from the sales rep for purposes of improving care for patients, and not simply improving sales for pharma? These two endpoints

are not mutually exclusive. The problem is that in the present sales model only one party, the detail rep, has an active and demonstrable stake in the interaction. Who is standing for the patient? Not the doctor, surely, as he is willing to adopt the most fatuous sales pitch to get past the detail and onto lunch, say. Who questions the rep about the validity of the data, about the design of the drug study, about the choice of statistics used to report outcomes? Who challenges the rep to expose risks in the promoted drug or hazards in its use or flaws in its claims of safety and efficacy? Who teaches the doctor to interrogate the rep and to do so on behalf of his patients living and dead? Who trains the physician to conduct a product "review of systems" of the rep so that the doctor can become a true learned intermediary with respect to the product under scrutiny? Who believes the FDA is capable of protecting the public on its lonesome? What is the profession's responsibility to help the government do its work?

A \$1,000,000 grant from the Department of Aging of the Commonwealth of Pennsylvania struck at the problem of overly savvy marketers of pharmaceuticals and under-savvy physicians by a process of "counter detailing." Well-informed counter pharma-detailers informed doctors which drugs were best by using evidence-based data. Ten consultants, former drug reps, and another dozen physicians have made 1,200 calls to primary care providers tailing drug reps and meeting with the doctor after the departure of the rep to provide a balanced analysis of a pharmaceutical company's data on a variety of drug therapies. The antipharma detail alters the prescribing behavior of the listener in favor of a nonbranded preparation.<sup>3</sup>

Why not prospectively teach doctors to be skeptical about details and give them skills to dissect pharmaceutical data on their own? Then they will not need Yin and Yang details to grasp the point of sales pitches and be prepared to do their job properly. They can be trained in medical schools and residencies, fellowships, and in their current practice how to conduct themselves and to negotiate information with reps. They can be trained to extract the most useful data available from the drug representatives. The doctor can be in charge of the detail. The physician just needs to know what to ask. The physician is not in control now, however, because the doctor has had no training on the subject. The rep has had a great deal of training on data presentation and so has a considerable home court advantage. The industry thinks it knows how doctors conduct themselves and has based its sales approach on those assumptions. What would it do if physicians changed their interactive behaviors in relation to reps in general and the data in particular? The sales pitch would have to change. The universe would shift. The door would open to reason. Knowledge might pass through the portal. Patient care might improve.

Details might be perceived as valuable. Lunch might be foregone. So what questions to ask?

We recommend taking the rep into a quiet room to forge a physician-controlled drug rep-to-doctor contract. In this alliance, the doctor offers to listen attentively to the detail if, and only if, it contains information the doctor requires to reasonably learn the place of the drug in his treatment regimens. The rep accepts the offer (after management, FDA and Office of the Inspector General approval, which in view of the foreseeable clinical value of the proposition seems certain) and a meeting of the minds is forged. Henceforth, the rep will give the name of the drug, its indications, its doses and its kinetics, stressing the effect of food, drink, and other medications on its efficacy and adverse effects. The rep will describe any changes in the Product Insert since the last visit. He will describe the metabolic pathway, the product uses including pathway induction and inhibition, and effects on comorbid products. Specific cautions for use by the elderly patients will be emphasized together with the specific doses for various stages of renal and hepatic function and impairment. Patient responsibilities for the use of the product will be described and a description of who should not receive the drug conveyed. Henceforth, in keeping with his end of the bargain, the doctor will listen intently and the rep must be prepared to deliver the clinical science in its entirety.

Clinical data (measures of effectiveness), as stipulated in the Contract, should be reported using absolute risk reduction values and not the universally employed relative risk frequency of beneficial effects, which can be misleading if not incomprehensible. The number needed to treat, to reach a desired dependent measure should be provided to put a stated clinical endpoint in clinically useful perspective. The treatment time and expense to achieve the desired endpoint should be explicit.<sup>4</sup> We must insist on receiving data in this format if we are to ever make informed judgments about pharmacotherapeutic effectiveness and value.

A full description of populations not mentioned in a study such as women and ethnic minorities should be addressed, because the reason that a particular group was not mentioned in the outcome may be that there was no difference between the treatment groups making generalization of clinical effects to the invisible populations hazardous. Whenever possible, cost, safety, and efficacy comparison data with other products, branded and generic, should be discussed.

Today, the pharmaceutical industry has a disproportionate effect on the prescribing behavior of American doctors who live in a "culture of entitlement" with respect to the largesse of the pharma industry.<sup>5</sup> Its influence drives the healthcare economy in a northerly direction with respect to costs, but southerly or horizontally with respect to favorable clinical outcomes. This flat or

negative line of effectiveness occurs because the primary reliance on the use of pharmaceuticals in the care and treatment of complex disease states like diabetes or cigarette smoking reduction is not enough to modify clinical outcomes. Drugs are not self-contained “complete” therapies. Doctors are often merely “pilling” a disease state and not effectively managing it. The promoted medicinal tools that pharma gives us and the context in which they are given fosters this error. The explicit notion that a given disease state can be treated via a mere drug and only a drug as opposed to a management program in which the drug is a component is rife within the medical community. The pharma industry knows that doctors have little or no disease management skills. They know that doctors will use the drug as the total therapy because they have no other therapeutic vocabulary. For them, the drug is the “full Monty.”

Doctors for their part need to learn outpatient management skills to use pharma’s products most effectively. They must use them in the context of a complete management care plan, which includes behavior modification, and not as magic bullets as they are apt to do. Physicians must have a clear understanding of the utility and risk of the drugs they use, and must have a fully developed routine of management, which is evidence-based in nature. They can receive such an understanding about pharma products from a radically modified detail. They can receive disease management training from a radically and urgently needed shift in the content of medical education.

If the rep-doctor detail pattern does not change, physicians will stop or at least be advised to stop seeing reps altogether. This is already a consideration for some and has been adopted by others. There is much mutual benefit in the relations between the doctor and the rep. Before we throw the pharma baby out with the sullied bath water, we should make an effort to determine if the old relationship that American medicine has with the pharmaceutical industry can be reshaped and salvaged and improved for the benefit of the entire healthcare system. A shift in the detail in the direction suggested above will permit the physician to focus on the demonstrable clinical values of the product and not merely claims about it. It will drive the detail interaction in a direction

more suitable for our troubled and troubling healthcare system. The proper acquisition and use of pharmaceutical data will improve the healthcare of patients in the United States. Instructional efforts such as those at the University of Missouri School of Medicine which exposes its students to marketing techniques of the industry do not seem to take the next logical step which is to train the student to actively mine the detail for its literally buried riches.<sup>6</sup> That is very step advocated here.

More or less come what may, as dictated by bottom line analysis, the industry will continue to go about with its business of direct-to-consumer, Continuing Medical Education offerings, sampling, and efforts to “educate” doctors as it makes its daily rounds.<sup>7</sup> But until an adequate pharmaceutical database is available for physicians to rely on to perform their work intelligently, and until physicians learn to use pharma’s products in a comprehensive management of care model, the desired outcome offered by excellent pharmaceutical products and well-trained clinicians can never be realized.

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