

Tales From The “Script”: An Insider/Outside View Of Pharmaceutical Sales Practices

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The ultimate goal of the pharmaceutical industry is to make money. . . The goal of medicine is curing people. One is self-interest, one is altruism. It's an intersection of two different social systems. [Dr. Erdem Cantekin, quoted in Crossen 1996:166]

What has come to differentiate one company's chances for competitive success over others is . . . competency in *externally oriented activities*, most notably marketing innovation. [Appelbaum 1998:327, emphasis added]

Introduction

Multinational corporations that manufacture and market pharmaceutical products exist within a self-perpetuating ethical paradox. As biomedical research driven institutions, pharmaceutical companies provide innumerable advances in biomedical therapy for humankind. However, to satisfy shareholders with increases in profit these companies must maximize their investment in research and development (R&D) through aggressive sales and promotion of pharmaceutical products in the health care marketplace. Salespersons working for these companies are engaged in a variety of “externally oriented activities” and must perform at this intersection of the profit motive and human health care. From 1989 to 1998, I was a pharmaceutical salesperson for a multinational pharmaceutical corporation, Company X.¹ As a “drug rep” or a “detail man” my goal was to persuade, to influence, and ultimately to convince physicians to write a prescription, a “script” in medical-industry jargon, for one of Company X's products.² Prescription generation is accomplished through a variety of means, including multimedia advertising (print, Internet, television, etc.), participation in gift exchanges, and promotion (“detailing”) of pharmaceutical products (often “off-label”).

During my last four and half years with Company X, while still actively participating in the complicated social milieu of the pharmaceutical sales, I returned to graduate school to study cultural anthropology, completed my Master's degree, and eventually left the industry altogether to pursue doctoral studies. As part of my ongoing graduate training, I have scrutinized my pharmaceutical experiences ethnographically. In this paper, I specifically explore salespersons' off-label promotion of pharmaceutical products to healthcare providers. Products are sold “off-label” when promoted to treat conditions outside of the current Food and Drug

Administration (FDA) approved package insert (PI) (e.g., promoting an anti-fungal drug for fungal toenail infections when it is only “indicated” for oral thrush).³ Pharmaceutical salespersons not only ignored FDA policy at times, but also departed from their own company’s policy regarding product promotion by engaging in tactics that were seen as contrary to official corporate policy.⁴ Despite breaking the “rules” of the FDA or the company, pharmaceutical salespersons, including myself and others within my circle of colleagues, liked to “cheat,” or to be “creative” when promoting our products; it became an everyday practice and was even encouraged by managers and fellow workers.

My interest in how salespersons promoted pharmaceuticals stems from my own involvement in a district-wide scandal the last year and a half of my employment with Company X. I was caught “cheating” during a time when, according to company gossip, the corporation was “cracking down” on maverick representatives⁵ who did not adhere to the company’s new “zero tolerance” policy regarding product promotion.⁶ We had begun to hear rumors in the “field” that representatives were actually being fired for various types of cheating. Over coffee with my sales colleagues, I can remember realizing that the company had suddenly become serious about disciplining representatives for what had previously been routine everyday actions. A Southern Region representative had been “let go” for distributing to physicians embroidered baseball caps with the phrase “Prozac Sucks” (Prozac was a key competitor to Company X’s own successful antidepressant. These hats had been spotted and confiscated by our competitors, sent to the FDA, and eventually Company X was forced to take action against the employee. Considering how widespread this type of activity was in my own district (personalized party-favors were quite common), the story caught our attention. However, we laughed at this representatives lack of *good judgment*. This was truly over the top in terms of product promotion.

My own activities eventually caught up with me (an event I will explain in detail shortly), and I was “demoted” from a Senior Institutional Healthcare Representative to a “trainee.” Ironically, for the first time in eight years, Company X had released me from the pressures of making quota (i.e., increasing prescriptions for Company X’s products).⁷ As a trainee I was put in pharmaceutical sales limbo and I was free for over a year to begin my transition from detail man to anthropologist. My final year with Company X was a strange mix of ethnographic observation, legal maneuverings, and psychological stress. My pharmaceutical sales career came to an end after I was denied a transfer out of my trainee territory to join my wife, who had accepted a job in another state. A Fed-Ex package arrived at our new home with a letter of termination and a final paycheck. Looking back today, I realize how I could never have freely walked away from the money and the material benefits of corporate America. I needed to be pushed away, and my termination by the corporation finally started me on the road to anthropology. This paper is about my ethnographic return to Company X and a critical reassessment of my experiences there, as both insider and outsider—first as salesperson and then as ethnographer.

To Cheat or not to Cheat? : A Personal History of Pharmaceutical Knowledge Games

Detail-man's Oath: I do hereby solemnly swear that I will tell the doctor the truth, the whole truth, and nothing but the truth; that I will make no exaggerated claims of superiority or safety; that I will always give adequate assurance and proof that no medication is 100% effective in all patients and that even a placebo will cause distressing side effects in some patients; and that the difference between the product I am detailing and the product the doctor has been using is much smaller in his eyes than in my own, and any exaggeration of this difference will only serve to confirm his previous prescription writing habit. [Sutton 1960, quoted from Smith 1968]

During the late 1980s and early 1990s, Company X's salesforce was divided into two divisions, "A" and "B", with different product portfolios. My division, B, had historically been the less glamorous of the two; as my colleagues put it then "we have to sell, they, Division A, don't." Division A had historically received better products to promote. Division A introduced an important calcium channel blocker in the late 1980s for the treatment of angina and hypertension that was a new advancement for treatment. Physicians embraced this product—they *wanted* to see sales representatives from Division A. Conversely, until the early 1990s, Division B had sold products in the highly competitive antibiotic arena, where Company X's antibiotics competed with products superior in terms of efficacy, ease of administration, safety, and cost. I sold one antibiotic that was initially seen by corporate headquarters as having low potential in sales revenue. However, this product's annual rise in sales revenue represents the type of success Division B came to be known for—an ability to sell marginal products through creative promotional tactics. Pharmaceutical sales had shifted from a time where the "good old boys" met and participated in "truthful" exchanges of information into the era of "spin" selling⁸ and "guerrilla marketing."⁹

In addition to this divisional schism, widely differing sales philosophies prevailed among the marketing teams at the corporate headquarters in New York City (busy developing "Madison Ave" product advertisement pamphlets) and the "field forces" of salespersons that cover every geographic region of the United States. My first manager clearly instilled in us the belief that Division A sold products the "New York way," our division would follow a different strategy. Our district teams would meet quarterly to discuss these strategies regarding product promotion. At these plan of action (POA) meetings, which lasted for three to four days, representatives of a district (usually ten to twelve reps working in a large metropolitan area or a less populous state) would meet with their district manager (DM) and outline sales strategies for the next three months. These strategies were then re-assessed at

subsequent quarterly POAs. These meetings were also a time for disseminating marketing information from Company X’s New York city corporate headquarters to the field force.

As a new hire for Division B in 1989, I attended my first district meeting beginning my indoctrination into how my district sold Company X’s products. There were two competing ideologies for product promotion in Company X, the “New York way” and the “Division B way.” In 1989, the Division B way was based the principle that corporate marketing teams in New York did not sell in the field (they relied on market surveys) and therefore failed to realize what was necessary to say to doctors, what information needed to be presented (visually and verbally) and what product information needed to be omitted. We took care of this “problem” at the local level—during district meetings and subsequently through everyday practice. Our district manager embodied resistance to the New York way. His routine performance involved standing in front of his team with newly designed product promotion pieces from New York, making sarcastic comments about the effectiveness of New York marketing, and then tossing them on the ground or in the garbage. His act garnered many laughs from all of us in attendance,¹⁰ but he was also empowering us to defy corporate policy. After we had “reviewed” these promotional pieces, our manager would then hand out the *real* sales material for our detail book. This would often include off-label clinical articles pertaining to our products and “cut-and-paste” visual aids.

A pattern had been established in my district whereby many sales representatives were led to believe the only real way to sell effectively and to expand market share was to cheat by using one’s own source material—or at the very least to look skeptically at any and all information from New York. The district manager’s actions reflected this belief, and we were rewarded for creative presentations at POA meetings (i.e. reps with the best “stuff” in the detail book were praised and usually asked to share this good information). Moreover, we fully understood that the FDA would only approve clinical articles and company visual aids that were seen as “balanced,” giving equal attention to efficacy, side effects and drug interactions. FDA-approved clinical articles, such as randomized, double-blind studies, were seen considered as the most challenging types of articles to use for promoting product superiority. Therefore, most of the information used to sell and promote products came from our own sources, such as unapproved clinical articles from JAMA and the Archives of Internal Medicine or from non-peer-reviewed journals.¹¹

There was a vast network of “underground” sharing and distribution of this information and rep-generated material circulating between salespersons. District managers would usually send information through inter-district mail or distribute things at POA meetings. Sales reps would also share information through informal gatherings. Even *official* corporate mailings would identify the best clinical articles available for cheating by stamping them with the words: “DO NOT DETAIL.” In this

case, material that was sent to reps varied from extremely positive articles regarding the efficacy of a Company X product to extremely negative articles about our competition (i.e. unwanted side effects, newly discovered drug to drug interactions, recent deaths associated with a competitive product, etc.). The “DO NOT DETAIL” company warning was an obvious liability avoidance strategy for the corporation, but more importantly, identified to reps that, if in fact we are being told not to use it, this material must be worth looking at and possibly incorporating into our sales presentations. At the very least, representatives could incorporate this “DO NOT DETAIL” material into their *verbal* sales repertoire without leaving a “paper trail” of unapproved product information. Later in my tenure, I would come to question the motives of Company X regarding the “do not detail” material which clearly contradicted the corporation’s ability to maintain a “zero-tolerance” policy instituted in the mid-1990s. Why give sales representatives on-going access to information that creates legal liability both for the individual and the institution? One answer lies in the company’s own need to create the most “knowledgeable” representatives possible in order to establish rapport with their key clients-physicians. The profitability of a product hinges on the representative’s ability to persuade doctors to write prescriptions for their respective drugs. Knowledgeable reps are a key link in confidence building between industry and medicine, and can ensure both the long-term success of a product and of a company.

Thus, representatives who could increase their overall knowledge about diseases and products were at an extreme advantage. The quickest way to earn a physician’s trust was by demonstrating overall medical knowledge.¹² Once trust was established, many physicians would defer to representatives regarding product knowledge. It was not uncommon to be contacted by physicians who had questions regarding one of Company X’s products or even ask questions regarding a competitor’s product. Establishing rapport also allows for representatives to become teachers for emerging new “illnesses,” especially new and *treatable* mental health disorders. In the early 1990’s during POA’s we talked about “educating” the family practice physician on how to recognize and treat depression before we could actually sell them on using our new SSRI.¹³

Gaining a doctor’s trust could also involve “selling the competition first.” For example, a veteran sales representative taught me a valuable strategy early in my career at Company X. Her “trick” with influential doctors was to build trust by presenting or providing them with specific information (usually in the form of a clinical article) that was related to their own research interests. I liked her strategy and “targeted” an influential “no-see”¹⁴ infectious disease doctor who treated serious fungal infections, but first I needed to get an appointment from the “gatekeepers”—the receptionists. This required a little “drug rep 101” (a phrase coined by my first district manager) which simply means getting the office personnel on *your side*. This took time and varied from case to case. At this infectious disease clinic I discovered that a quiet persistence was rewarded with increasing empathy towards my efforts to

"just have a few minutes of DR. Z's time to discuss important information about my product." The "quiet approach" combined with several hand-deliveries of strawberry frozen custard shakes eventually persuaded the head nurse to schedule an appointment. I arrived at the meeting with clinical information regarding the use of inhalable amphotercin B (my competition) for the treatment of fungal lung infections. I sold the competition first and Dr. Z's words to me were "I can really use this, thanks." I did not mention my product for treatment of fungal infections at all during this first meeting and only asked if it would be possible to schedule another appointment "when I have good information regarding my product." He agreed.

By the time I left Company X, all three physicians in this clinic were seeing me on a regular basis. I was allowed to support financially the local infectious disease society through company "grants," and we did several speaker trade-offs (I cover expenses for a speaker of their choice and they allow me to bring in one of my "experts" at a later date.). My initial "trick" was rewarded with years of exchanges that benefited both of our needs. Dr. Z and his colleagues were highly respected in their field, and I was able to mention their names support of my products to other doctors when detailing. In fact, Dr. Z influenced most of the use of anti-infectives at the largest dollar volume hospital in the state (which reps coined "St. Lucratives") and his eventual support of *all* of my products helped me to consistently achieve my yearly goals and helped to rank our district "number one" in 1997. My relationship with Dr. Z became a district standard to try and achieve with other influential and respected doctors and it all started with a bit of off-label information and custard shakes. My various "successes" with Dr. Z. were always included in my weekly report and held up by my manager at later district meetings as a model for my colleagues to emulate.

Getting Caught at the "Game"

In my district there was no clear distinction made between both FDA and corporate policies regarding the "tricks," "cheating," and "games" we used for gaining physician trust and confidence in our products. As salespersons we were quite adept at playing in the "gray area," and through the mid-1990s the corporation let us play. However, for very clear reasons during the late 1990s, Company X began to initiate very black and white policies regarding product promotion. Once a minor player in the global pharmaceutical market, Company X had grown into a major force in pharmaceutical sales by the end of the 1990s. A pharmaceutical product portfolio that in the 1980s was made up of a few products approaching one hundred million dollars in annual sales has grown into a portfolio that, after a recent acquisition of another pharmaceutical manufacturer by Company X in 2000, will include seven products with at least one billion dollars each in annual sales. The sales force has also expanded greatly. In 1989 when I began with Company X the combined number of sales representatives of the two divisions was a little under a thousand. Today, Company X employs approximately 5,400 representatives in nine divisions. Part of

the Company X's current success can be tied directly to its investment in research and development (R&D) in the 1970s and 1980s. Products being introduced to the market in the 1990's were "blockbuster" type of products.¹⁵ As Company X's profits increased (total revenues increased by 284% in 1990s) and stock value soared (three 2-for-1 splits and one 3-for-1 split in the 1990s) the corporation became more and more self conscious of its corporate image and more "black and white" regarding product promotion—zero-tolerance policies focusing on product sales became a corporate mantra.¹⁶

Managers, and representatives, myself included, were operating in denial on several levels. On one hand, our risky behavior was part of a machismo or bravado that was constantly being displayed and reinforced;¹⁷ most importantly we were rewarded through increased sales. On the other hand, management and representatives had always agreed to a *policy of denial* (i.e., simply lying to upper management) if ever caught breaking official policy or questioned regarding any of the types of activity described above. This was stressed at our POA district meetings where, during discussions regarding the consequences of cheating, my second manager with Company X, would trigger the familiar group-chant: "Deny! Deny! Deny!" This secret policy of denial would be in operation until my last days with Company X.

In 1996, my third district manager took over the reigns and actually strengthened our local (district) resistance to corporate and FDA policies. Her agenda fit well with my own. Intellectually, I was shifting away from sales and the corporate world and more towards anthropology and academia. Yet, I had committed myself to finishing my sales career on top. I saw 1997 as my final year with Company X and deliberately "setup" my sales territory for success.¹⁸ The missing piece to ending my career on a high note in terms of financial rewards was increasing the sales of Company X's antidepressant, a selective serotonin reuptake inhibitor (SSRI) that competes with Prozac, Paxil, and other antidepressants in one of the most highly competitive markets in medicine. My third manager was very skilled at "noise level" sales tactics. I made bi-weekly anonymous "mail blitzes" to a data bank of physicians. The strategy operated under the logic that more often a physician "sees" your product name the more familiar he becomes with it, and the more likely the doctor will write a script. As a class of medications, SSRIs are indicated for the treatment of major depression and their indications for uses in other areas were expanding at the time into panic disorder, social anxiety, and obsessive compulsive disorder ("OCD"). Company X's SSRI was lagging behind in getting approval from the FDA for these indications. In the field we kept hearing from "corporate" headquarters that we were close. However, as the competition received indications, representatives began to adjust strategies and to use any information we could find regarding the use of Company X's SSRI for these other, off-label, indications. The process of distributing this information became easy, and my initial efforts had good results. Sales numbers in key accounts were increasing, and physician comments

validated my covert efforts. I was being told more often that they (the doctor) had recently read an article or "heard something" about using Company X's SSRI for OCD, or for panic disorder, and they were going to give it a try. The "little bird" was of course my anonymous mailings making it to their desk.

With my territory in "cruise control," I left town for a vacation and returned to find my corporate demise in process.¹⁹ While I was gone, events were transpiring that would forever change my pharmaceutical sales experience. A physician in our district had turned into the FDA a computer-generated flyer she or he had received from a Company X rep which described Company X's SSRI as the product that would "lift the gray cloud of depression." When I returned home I received a call instructing me to participate in the regional corporate ritual of denial. This normally involves a handful of representatives being called into the regional manager's office where the "illegal" visual aid is presented and being asked if we were responsible for its creation. We all denied ever seeing the material or knowing who in fact created the piece. (In this particular case most of us knew who the culprit was, but we kept it to ourselves at the meeting and subsequent public forums.) We were all warned against this type of activity.

At this particular regional meeting the events unfolded, however, with one surprise. The regional manager had contacted several representatives from other sales divisions within Company X to inquire about the origin of this illegal promotional piece and had unintentionally turned up another. As he presented this to the group, I realized it was my creation as did one of my colleagues. True to form, we all denied ever having seen it, but as I left the conference room I had a sense that my career was going to end on a low instead of a high. On the way home I discussed this with two colleagues whom I trusted, and we convinced each other that I may have handed it out at a POA meeting – sharing of "good material" was after all a common practice. The next week, I was called down to the regional office with my district manager. I was confronted with a file filled with each bi-weekly mailer I had sent. The regional manager looked me in the eyes and said, "You're looking at the most being fired and at the least losing your yearly bonus."

The story that unfolded was at first hard for me to believe, though I now realize it was essentially true. A colleague of mine had transferred from our district to become a "psychiatric specialist" for Company X. We had worked together on large psychiatric accounts where the stakes are highest for drugs.²⁰ While visiting the office of a psychiatrist we had both called on, he was handed a cut-and-paste advertisement I had created and mailed anonymously to all the doctors at his institution. The ad reminded doctors to write more prescriptions for Company X's SSRI. My colleague kept this document, and when interrogated by the regional manager concerning the other off-label ad handed into the FDA, he faxed my cut-and-paste example to the regional office probably thinking he had helped to solve a company "crime."²¹

By coincidence, a different psychiatrist at this institution, who shared a secretary with the aforementioned doctor, was on sabbatical. My colleague and his psychiatrist-friend were able to rummage through several months of his collected mail and sent all of it into the regional office. When I was confronted with the evidence I had mailed, I had no choice but to admit my guilt (my days of denial were clearly over) and wait for corporate headquarters to hand down their decision regarding my future employment with Company X.

I had misjudged the seriousness with which Company X now regarded the enforcement of the new “zero tolerance” policies. They were now actually *disciplining* representatives who were breaking product promotion guidelines. While waiting to hear about my fate, I was reassured by both managers and sales reps of the corporation’s historic “hand-slapping” policies. In fact, I found out through these stories and general gossip that a good deal of current managers in my division had actually lost many bonus checks as punishment for similar activities, but never their jobs or their current positions. Most recently, my own manager had been reprimanded for a questionable form of product promoting and had confided in me while she was being scrutinized by upper management.²²

Days, weeks and months passed as I awaited my fate. I began to realize that I was left alone to deal with a powerful corporation. I waited for my manager to step forward and admit to encouraging and “incentivizing” representatives to cheat. This never happened. I waited for the representative who had created the “gray cloud” piece sent to the FDA to come forward. This representative never did. I was confident that other reps in my district who were *friends*, and who looked up to me as a mentor, and who all participated in the same types of activity, would step forward and admit wrong-doing in hopes that our shared guilt would lessen my punishment. Of course, this never occurred either.

Instead, I was isolated, forced to deal with Company X by myself. My lonely experience culminated in a trip to Company X’s corporate headquarters in New York City. I was questioned and given a chance to tell my side of things. Looking back I appreciate the amount of stress I was under.²³ My meeting with the Vice President of Division B, the Vice President of the entire United States pharmaceutical group, two company lawyers and one human resources person, all clearly positioned to intimidate me with their fast and formal questions. After exchange we exchanged greetings, I received their apologies for the long plane ride and lack of sleep. A “good-cop, bad-cop” interrogation followed with the VP of my division demanding answers regarding all of my activities as well as the activities of others, including managers. He wanted names. The VP of Company X’s pharmaceutical group consoled me at times and even offered me a soft drink. I stayed loyal to my district “teammates” and named no one. I raised some issues regarding the history of this activity and the fact that my division had always played with the “gray area” of product promotion. In a previous “letter of mercy” sent to these superiors I had implied that my first manager (now

retired and thus a good scapegoat) had encouraged us to use "creative" selling techniques, and I mentioned that my practices were common everyday events. My interrogators, especially the two VP's, reacted to my remarks regarding company-wide rule-breaking with continual surprise, insisted on names, and wanted to know if my current manager encouraged us to sell in this manner. She did, but I protected her. After twenty-five minutes, we reached an impasse, shook hands and parted company. I flew home and, two weeks later, I was demoted to a "trainee."²⁴ I was assured by my regional manager that this was a temporary, one year, demotion. I would be back on track soon after. He assured me that my colleagues would see me as a powerful "example" regarding the consequences of breaking company policy. All was forgiven. We could finally move on.

From Scapegoat to Ethnographer

My first act as a demoted representative was to stand before my district "teammates" at our Summer POA meeting and inform them of my demotion. Rumors had been floating around that I was in "trouble," and for weeks I had done a reasonably good job of remaining calm and in a good frame of mind. My emotions and the humiliation of the spectacle got the better of me during my telling of the ordeal to my district teammates and, after several attempts, I finally regained composure enough to tell them all I had been demoted and reassigned as a trainee within our district. I pleaded with them to think twice before breaking the zero-tolerance policies of Company X—the consequences were serious this time. An assistant to the Vice President of Division B was on hand taking notes, and he left (without introductions) soon after my confession, which was followed by tears, hugs, and shocked stares from my colleagues.²⁵ After an awkward day of meetings, we played a round of golf, participated in alcohol-induced "company bashing" and even smoked a sort of anti-victory cigar—all the while being constantly reassured that I still had my health, and most importantly my high salary. The next day we resumed our POA meeting and within twenty-four hours it was business as usual, except with a twist. The district representatives and our manager were on their best behavior during this first post-demotion meeting. In a show of solidarity, we threw out all unapproved material that was in our detail books and swore to adhere to zero-tolerance policies in the future.

By the fall POA meeting, I had begun to commit myself to anthropology full-time, finishing course work for my Masters, and applying to doctoral programs. With the responsibility of making quota removed, I was able to fully participate academically in graduate studies – research, writing, and teaching. During the Fall semester of 1997, I enrolled in an ethnographic methods class and began to analyze and write about the pharmaceutical industry.²⁶ My own experiences and later developments in my district began to fuel my ethnographic research.

One thing I learned as a salesperson was that successful habits die hard—*quotas only increase*—and beginning with the Fall POA meetings, management and representatives began to show signs of returning to previous product promotional techniques. During the meeting our manager had begun to ask us to “alter” the package insert (PI) of Company X’s SSRI and the PI’s of Prozac and Paxil, our competition. At first I was truly dumbfounded by this obvious breach of zero-tolerance policy. However, I was awakened from my stupor by objections to this strategy being raised by my *replacement*, who subsequently became the moral barometer for the district.²⁷ We had worked together on my old accounts and he knew my story intimately. He would have nothing to do with playing in the gray area of product promotion. The district manager and other reps did not quite know how to react to his resistance (this was a new phenomena for our district), yet the meeting continued on, albeit awkwardly.

Apparently, some representatives throughout our Midwest region were having success promoting Company X’s SSRI by comparing the PI’s while detailing physicians (i.e. highlighting and pasting key phrases of Company X’s PI together on one page with our competition’s PI sections to maximize the visual presentation while comparing products). This new technique had diffused over to our district. I started to look around the room at my colleagues who were all watching me. Their faces seemed to ask the same question: How could we be asked to do this after what happened to you? There was some confusion and the meeting was on the brink of falling apart when my manager asked me, “How do you *feel* about this, Mike.” At that moment, all my bottled up anger, all my past rationalizations came pouring out of me. I knocked over a chair, mumbled some obscenities, and stormed out of the meeting room followed only by the manager asking me to come back. My district manager joined my outside and kept telling me she was “sorry” and asking me what should be done to make people more relaxed. We eventually walked back into the meeting together and she suggested we all take a break. When the meeting reconvened the district manager made a brief announcement in which she repeated an older mantra regarding how we were going to promote our products. She started with the familiar phrase “we are all adults here” and went on to basically tell her “team” to make the right decision regarding how each one of us will promote our products. What was clear is that she was not adhering to the zero tolerance policy of Company X (i.e., telling us not to break the rules). Instead, she was playing an old managerial card, which constantly placed the decision of how to promote products specifically with the rep. After this meeting I was left with the realization that one is not an “example” to spare others of a similar fate but a “scapegoat” who existed to satisfy the needs of higher corporate power.²⁸ In my district it was business as usual.

In the days that followed, I watched and listened while my colleagues’ confusion grew regarding how to promote Company X’s products. A paradigm shift was in effect. Some representatives continued to push the off-label style of promotion while others, especially my replacement, embraced the “zero tolerance” policy

regarding product promotion. I had gone “clean” on the day of my demotion and over several months realized (ironically) that I could still sell following corporate guidelines. More importantly, my replacement had always been clean and was very successful selling Company X’s products. He was promoted to my old position based on his past performance. So why did I need to break these rules when others did not?

As an ethnographer, I realize that my effectiveness as a sales rep never changed after my demotion. I was using only FDA and Company X approved material, and I could still *sell*. My past activities were related to a hegemonic apparatus that was entrenched at Company X, one where district and regional managers helped maintain the risky ideology of off-label promotion even after the onslaught of zero-tolerance corporate policies. Historically many reps felt it was the only way to operate – it provided our sales edge. Corporate management at Company X knew off-label information was important, sometimes vital, in expanding market share over the competition. However, why should the company risk having a representative rummage through the journals in medical libraries in hopes of finding information on a Company X product, when they could set up official corporate channels to disseminate this information in accordance with the FDA?

The corporation no longer needed reps to fill the off-label void – this was too risky in the then current FDA climate. Company X overcame this risk by having reps, when solicited for information by doctors for an unapproved indication, send a request to the medical department. The doctor would then receive an official letter signed by a Company X clinical researcher (e.g., a doctor or PharmD) telling the physician for example that “although Company X’s SSRI is not indicated for the treatment of panic disorder, I have provided you with several articles discussing its use for this mental disorder” – in essence off-label promotion done legally. The paradigm shift I was a part of was aimed at negating specific risky rep behavior and not off-label promotion in general, the latter being a core tactic for expanding market share and increasing sales. Renegade sales activity, which previously had accomplished the same goals as “medical department requests,” was being eliminated and thereby improved the corporate image of Company X in the eyes of the FDA. More importantly, Company X was able to sustain off-label business through official (and legal) corporate channels.²⁹

As an ethnographer I began to turn this zero-tolerance policy upside down and ask more critical questions. I discovered that zero-tolerance policies, which created a morally polarized atmosphere (at district meetings in particular) of good reps and bad reps, was in fact *corporate camouflage* – an ingenious Company X diversionary tactic. By publicly punishing rule breakers and renegades within the corporation and thereby demonstrating its commitment to being ethical, Company X could assure the FDA, as well as physicians that the normal, daily activities of its salespersons were both moral and ethical, and in the best interest of patients, not pharmaceutical manufacturers. By shifting the emphasis to rogue representatives (like myself) and

managers who encouraged creative regional and district policies, the company had shielded itself from more critical outside assessments while continuing to promote pharmaceuticals aggressively, in this case, off-label, all the while generating large profits in return.

“Tricksters” of the Everyday

Looking back at my nine years as a pharmaceutical salesperson for Company X, I have struggled to interpret and critically examine the everyday events that led to my corporate demise and that continue to operate today.³⁰ Situating the pharmaceutical salesperson in the field of anthropological discourse remains a crucial task for critical medical ethnographers if we are to further our understanding of pharmaceutical sales practices. Anthropological literature concerning “pharmaceuticals” in general continues to grow but what remain scarce in the literature are specific interpretations of pharmaceutical sales practices.

Shorris’s *The Nation of Salesmen* (1994) provides a useful point of entry for interpreting the activities of the drug rep. Shorris is a non-anthropologist who uses an ethnographic-like method in his analysis of American salespersons in general. He borrows from structural anthropologists and their comparative studies concerning folk stories and myths to understand “a quality of selling” that is “common across time, distance, and cultural difference” (35). Shorris finds these early mythical salespersons have particular qualities in common:

They speak. They influence others to act, but do not themselves participate in the action. They have the advantage of superior knowledge; that is they know more about others than others know about them. They know a great deal about the world of things. They are privy, either through observation, interrogation, or intuition, to the deepest desires of others. And they are always outsiders, floaters, wanderers, creatures without roots, more act than substance. [1994:36]

Whether described as “trickster, devil, courtesan, culture bearer, merchant or god,” one of their goals is conversion from the world of myth to historical reality (1994:36). Shorris centers the role of these mythical characters around knowledge—“knowledge as the connection between God and man”—where the trickster/salesperson is the possessor of superior information.

Shorris focuses on trickster myths, such as the Aztec trickster, the Tezcatlipoca/Smoking mirror, and the Navaho’s “Coyote,” where the trickster becomes the mediator between life and death (1994:39). Tricksters “can foresee nothing beyond the desires of their customers (or subjects); they have no other advantage in the world; they are merely the oracles of desire” (1994:40). The

intellectual burden on the trickster is twofold; they must know both desire (of their customers) and the world and must be able to choose the one object that can best satisfy desire. If the object is new or dangerous (prohibited by the gods) the other quality of the trickster comes into play—language, the "*sine qua non* of selling" (1994:41). The ambiguous character of the trickster allows it to be the "mediator" between worlds (between paradise and civilization, between good and evil). The trickster exists at the level of necessity and is often "punished" because he is operating at the level of contradiction. Shorris's salesperson becomes the modern incarnation of the trickster who succeeds by guile as an outside force causing actions he has no stake in—neither the maker nor the consumer, but the pure communicator (1994:41-2). The tales I have described above do portray a world where the pharmaceutical salesperson simultaneously crosses and maintains boundaries between different and often contradictory worlds—the marketplace and human healthcare. And like the tricksters of myth, I and other representatives were punished when our activities were exposed, when we were caught playing our games.

Hyde (1998) in *Trickster Makes this World* has also described a trickster as a "boundary-crosser:"

Every group has its edge, its sense of in and out, and trickster is always there, at the gates of the city and the gates of life, making sure there is commerce. He also attends that internal boundaries by which groups articulate their social life. We constantly distinguish – right and wrong, sacred and profane, clean and dirty, male and female, young and old, living and dead – and in every case trickster will cross the line and confuse the distinction. Trickster is the creative idiot, therefore, the wise fool, the gray-haired baby, the cross dresser, the speaker of sacred profanities. Where someone's sense of honorable behavior has left him unable to act, trickster will appear to suggest an amoral action, something right/wrong that will get life going again. Trickster is the mythic embodiment of ambiguity and ambivalence, doubleness and duplicity, contradiction and paradox. [1998:7]

Hyde is more cautious than Shorris when discussing an earthly embodiment of the trickster, however he does see a protagonist of a reborn trickster myth in the American version of the "(con)fidence man" (1998:11). Through this line of reasoning he goes on to speculate that perhaps America, with its land of rootless wanderers and the free market, represents the "Apotheosis" of a trickster – he's pandemic (a parallel to Shorris's "nation of salesmen"). Yet tricksters such as Coyote are complex. Modern thieves and wanderers lack an important element of the trickster's world; his sacred context—the ritual setting—is missing. "Trickster belongs to polytheism or, lacking that, he needs at least a relationship to other powers, to people and institutions and traditions that can manage the odd double attitude of both insisting that their boundaries be respected and recognizing that in the long run their liveliness depends

on having those boundaries regularly disturbed” (1998:13). This is precisely where I see the metaphor of trickster applying to the pharmaceutical salesperson. The doctor-sales rep interaction has become a sacred/ritualized space (often occurring in the physician’s office) where gifts are exchanged and the boundaries between competing worldviews and powers between the drive for profits in the marketplace and the patients health interests are blurred and confused.³¹ The end result is often “the sell” or “the commitment” to write a prescription, where both the rep and the physician have (re)established their own boundaries (i.e., improving sales and helping to cure sick patients) thus allowing both to maintain their *livelihood*. The pharmaceutical representative, like the trickster of myth and folklore, isn’t a run-of-the-mill liar and thief. “When he lies and steals, it isn’t so much to get away with something or get rich as to disturb the established categories of truth and property and, by so doing, open the road to possible new worlds” (1998:13)—in the case of pharmaceuticals, new markets.

Hyde reminds us that the trickster is not a crook but a “culture hero” who belongs to the “periphery.” In the world of pharmaceutical sales and marketing that I participated in, the “best” reps ultimately became culture heroes both among colleagues (i.e., other reps) and within the higher structures of the corporation, such as upper management.³² Moreover, my experiences at Company X parallel Hyde’s observation regarding the paradoxical nature of this type of hero: “If trickster were ever to get into power, he would stop being trickster” (1998:13). The best salespersons within Company X often became legendary and most reps wanted to know their sales “bag of tricks”—how they remained consistently on top. Others, however, used their status and accepted promotions to management positions (i.e., starting their movement into the “core” of the corporation).³³ As a result, these reps would lose their trickster “powers” (this would be the case with my third manager) and, ironically, were forced to combat trickster behavior among the reps they oversaw.³⁴

Much of what I have recounted during my time as a pharmaceutical rep is simply the trickster-like communicative acts of *everyday* interaction, the performances and language games that are embodied in the actions of pharmaceutical representatives and other “players” within the biomedical-industrial complex. The emphasis here has been on the pharmaceutical industry side of the equation, however, I want to stress that pharmacists, nurses, and doctors are part of a complex and dynamic interaction – all of which influences and leads to the generation of millions of pharmaceutical prescriptions for patients.

It should come as no surprise that many physicians are quite adept at mediating the boundaries between the market and healthcare. For example a central part of my job as a drug rep was to “develop” psychiatrists I would ask to speak about depression to other community physicians in order to help generate more prescriptions for Company X’s antidepressant. Doctor D., a “key-influential” doctor – one who

essentially changed prescription habits—was a typical case. What I discovered as a representative is that physicians like Doctor D. were marvelous salespersons. Better than the best reps. Doctor D was quite adept at giving a balanced presentation (i.e. giving equal time to all antidepressant medication in terms of side effects and efficacy) and would begin his talk by listing all his industry sponsors over the years. This was a very clever maneuver because most attendees at these speaker programs expect at some level a “commercial.” Doctor D simply was able to “spin” a possible objection (i.e., “you are working for Company X, so this talk is biased”) into a benefit and strengthen his credentials (i.e., “I have spoken for so many different companies and done research on so many products that what I am going to tell you today is therefore an unbiased medical presentation of all my experiences.”).

Moreover, Doctor D showed his true talent during question and answer sessions by weaving the benefits of Company X’s SSRI together with powerful anecdotal (individual patient) success stories. He and I would often discuss strategies before such programs: Could I “plant” a question or two? What type of audience am I dealing with? Are they skeptical of Ivory Tower medicine (should he “dumb it down a bit”)? Finally, Doctor D knew how to negotiate his “stipend.” I specifically remember him being upset that he was not on the “national speakers bureau” because these “product experts” were getting up to \$1,500 a lecture. At the time he was being paid around \$500 to \$750 for approximately a one hour of speaking. Dr. D therefore became a “manager’s call”—wanting to talk with my boss or my boss’s boss in order to tap into larger budgets and speaker funds.³⁵ The point I want to stress (and the irony of the opening quote of this paper on medical “altruism” by Dr. Cantenkin should be apparent) is that the social dynamic involved between the physician and the pharmaceutical representative is complex. To begin by saying the pharmaceutical industry can influence physician prescribing habits may be a valid statement in a variety of contexts.³⁶ However, the day-to-day relationship between doctors and reps needs to be unraveled further—trickers are everywhere! Critical medical anthropology can play a vital role by creating a deeper understanding and a richer ethnographic picture of the doctor-representative interaction and its wider societal implications.

Controlling Processes

The “culture of cheating” that I have described thus far is complex and multidimensional. It is far too simple to limit (and label) the activities of representatives (and physicians) as merely cheating or not cheating, engaging in right or wrong activities (as defined by the FDA). The term “culture” in this sense is restrictive as well. As mentioned above, not all reps were engaged in the same activities. Although we were expected both to follow the company’s main goal—increasing prescriptions—and adhering to all of the “rules,” representatives were motivated at times by different factors. I have argued that Company X created a “black and white” system of right and wrong (that is subject to public/FDA scrutiny).

However, coinciding with this system is another more ambiguous system, a gray area where much of the “selling” takes place. Many representatives (myself included) thrived in this space where we could incorporate our own ideas into our day-to-day practices. How we sold products was only questioned as Company X began to increase in size and profits. What was *natural* to us began to change. We had previously been empowered by an corporate system that not only provided us with knowledge and information (through both official and unofficial channels), but also was reinforced both through success stories (pharmaceutical folk tales) by veteran representatives and managers and through rewards and incentives (such as bonus payments). Theoretically, these influences on the activities and practices of certain individuals can be further articulated by using the Comaroffs’ discussion of hegemony, ideology, and culture as a guide (1991:19-27). Building on the work of Williams (1977) and Bourdieu (1977) regarding Gramsci’s (1971) prison notebooks, Comaroff and Comaroff (1991:23) understand hegemony to be “the order of signs and practices, relations and distinctions, images and epistemologies—drawn from a historically situated cultural field—that come to be taken-for-granted as the natural and received shape of the world and everything that inhabits it.” Before I was demoted, I existed in a particular kind of sales hegemony. As this old order began to crumble, particularly in my district, I began to witness first hand the clash of subordinate ideologies embodied in representatives who realized that there were different ways to exist at Company X.

The sales “culture” of Company X can now be seen as a relationship (or an interaction) between a particular hegemony (such as stressing the importance of off-label promotions) and various forms of ideology where “power enters—or more accurately is entailed” (Comaroffs 1991:22). Within a corporation like Company X, much of the power is embodied in management, and as I have described above, this managerial power was used to influence our promotional strategies throughout my entire career. When I departed from Company X, new managerial ideologies were beginning to emerge to combat this older hegemony regarding product promotion. However, even though these managers may have differing opinions and belief systems regarding the nuances involved in product promotion, they were united by Company X’s singular drive for profits through increasing product prescriptions and the overall expansion of pharmaceutical product market share. This drive for profits led Company X to develop the slogan “number 1 by 2001” in the mid-1990s as a way of motivating representatives and impressing Wall Street investors. This, of course, was not part of the public image of Company X, but a specific internal ideological message passed on to representatives during POA meetings through managerial speeches and company videos as well as to investors at shareholder meetings.

At the same time Company X’s public image was being (re)structured both around the phrase “we are part of the cure” and public proclamations (usually through media outlets) regarding the amount of money spent annually on research and development. These messages were a direct response to the negative publicity

surrounding President Clinton's first-term scrutiny of the pharmaceutical industry. His administration had uncovered "price gauging" by the industry (annual increases in drug prices above the rate of inflation) and had labeled pharmaceutical manufacturers as part of the problem of rising health costs. These conflicting messages help to explain some of the motivations behind my (and other representatives') daily practices and the ideologies that are part of the central ethical paradox of the pharmaceutical industry.

A sales atmosphere was created where a *culture of winning* (Oldani, n.d.) helped to produce specific activities. For instance, I was extremely comfortable walking into intensive care units (ICUs) in the early morning hours with several dozen of donuts and bagels, plastic pens, and paper scratch pads ready to talk to doctors and nurses about using company X's anti-fungal drug for extremely sick patients. The best case scenario would be to get a doctor (or nurse) to discuss a patient in the ICU who might be a "candidate" for product F. The "hard close" would entail asking the doctor to "call down to pharmacy" and order product F for her or his patient that morning. Occasionally, this would prove successful and a feeling of elation would pour over me as I walked out of the ICU, past the waiting room full of family and friends, and through the hospital—I was walking tall. This was a "good call;" it had served the ultimate dual purpose—curing the sick and making the sale. However, the patient was always kept in the background and more often than not, "rankings," "quotas" and company "profits" were the benchmarks of our success and not actual patient "cures" by our products.³⁷

Moreover, in the mid-1990s "generating scripts" became our main concern and our direct way to winning, as representatives (and the pharmaceutical industry in general) began to utilize information technology through "third parties."³⁸ "Script tracking" (or learning doctors' prescribing habits) empowered sales reps with "I know exactly what prescriptions you are writing" information. This increasingly put physicians at a serious disadvantage during the negotiations of a typical sales call. I could now enter an office completely aware of a physician's habits; curtail my presentation to this knowledge (i.e., highlight my product's advantages over the specific competitive product that the doctor was writing); and, return on the next call informed by new script tracking information (i.e., did she or he actually write any scripts for my product). Around the time I left Company X (1998), "high prescribers," doctors who daily write extremely high amounts of prescriptions for pharmaceuticals, were being inundated with sales calls by pharmaceutical representatives, gifts of every sort by the industry, and an abundance of free samples.

Script tracking completely changed my daily routine while at Company X and is now reshaping the interactions of representatives and doctors as well as the nature and scope of pharmaceutical industry power. According to my current informants, prescription information is now downloaded weekly into "doctor profiles" that are contained in the databases of every representative at Company X giving the average

representative an extreme advantage in the marketplace. The pharmaceutical industry continues to perfect the culture of winning (i.e., generating millions of new “scripts”), but at what cost? The anthropologist Hugh Gusterson (1997:727-8), in response to Nader’s (1997) discussion of “Controlling Processes,” has asked “what other issues might profit from a similar analysis” of controlling processes used by corporations that draw upon (and profit) from “the authority of science” (and medicine). There is perhaps no better candidate for examining controlling processes at work within the corporation, as well as at work in “the field” through the practices of sales representatives, than the multinational pharmaceutical industry, which uses the authority of science and medicine to expand the market share of products and gain incredible profits in return. The issue at stake remains furthering our understanding of the activities, motivations, and ideological underpinnings of pharmaceutical corporations as they continue to influence medical care. Gusterson directs our attention to pharmaceutical executives who claim that one third of the world’s population may be taking psychiatric medication within two decades (Harper’s Index 1997). What I have attempted to show above is that these executives can only make such a claim with a full understanding of the complex machinery in place that can generate millions of prescriptions of their respective pharmaceutical products. The industry fully understands the extent of its power—which includes a population of salespersons now numbering close to 70,000 in the United States, one for every eleven doctors (Kirkpatrick 2000), and armed with a variety of resources including sophisticated information technology. The task remains for a critical medical ethnography to fully grasp and further articulate the dynamic nature of pharmaceutical power.

Conclusion

The daily activities of representatives are just a small slice of the hegemonic pie that is the multinational pharmaceutical industry. The industry, like other institutions of power and control, continues to present a formidable task for ethnographers interested in “representing the complexities of personal experience without losing sight of connections” (Nader 1997:711). To date, the most comprehensive anthropological review regarding pharmaceuticals in general remains “The Anthropology of Pharmaceuticals: A Biographical Approach” (van der Geest, et al. 1996). The authors take a novel and useful approach by creating a genealogy or a “life cycle” of a drug including: production (research and development), marketing, prescription, distribution, purchasing, consumption, and efficacy. As the authors note, “each phase has its own particular context, actors, and transactions and is characterized by different sets of values and ideas” (153). The authors specifically focus on the fact that sales representatives have attracted very little attention from anthropologists. Part of this reason could be the previous models used for studying pharmaceutical-related questions. For example, Kleinman (1980) realized a trend in medical anthropology was to focus on the “folk” and the “popular” sectors of healthcare versus focusing “primarily on the transaction of pharmaceuticals within

professional settings" (van der Geest, et al. 1996:155). Ethnographies looking at pharmaceutical "transactions" within the professional setting (i.e., health clinics, hospitals, and pharmacies) have predominantly taken place outside the United States (e.g. Sachs 1989, Sachs and Tomson 1994, van der Geest 1982, Waddington and Enyimayew 1989/1990). This "conspicuous gap" concerning American pharmaceutical rep-doctor interactions in the literature comes with an ironic twist. Although anthropologists have just begun to intensely study pharmaceutical sales(persons), the industry itself has not failed to study *us* the consequences of which are quite disturbing. By referring to anthropological studies that show how non-Western peoples cherish vitamins, blood tonics, anti-diarrhea medicines, and hormonal preparations, the industry has been able to claim an "openness" to local variations in cultural concepts of health, illness, and medicine. In short, the "anthropological perspective is congenial to market research" (van der Geest 1996:158). From a biomedical and critical anthropological perspective, pharmaceuticals may seem "overused," and certain drugs may seem dubious, useless, or even dangerous, yet thanks to the ethnographic work of anthropologists (and their emphasis on pharmaceutical relativism), the industry can claim it is only providing for all of humankind what people welcome as useful and effective medications for their own culturally specific treatments and "cures." The pharmaceutical industry and sales and marketing in particular, are quite adept at this type of "spin selling." Every *objection* (by physicians, patients and the general public) can be turned around and become a *positive* "thing," something to be valued and sold. In fact, this logic permeates every level of the industry, right down into the depths of everyday verbal exchanges between doctors and reps.

To even begin to understand the logic of the pharmaceutical industry, we must begin to conceptualize *the* critical (and everyday) site for pharmaceutical transactions—doctor-drug rep exchanges.³⁹ This paper has used my personal experiences as a "detail man" at Company X for a touchstone of both auto-ethnographic exploration and pharmaceutical power analysis. The sales practices of drug reps can no longer be mentioned only in passing (see Ferguson 1981, Nichter 1983 and Wolffers 1991, in van der Geest et al. 1996:158 for mention of reps outside of the United States). They must become *central* to both a critically engaged ethnographic project concerned with pharmaceutical sales, marketing, and promotion, and to anthropological questions concerned with fully understanding and conceptualizing the pharmaceutical industry.

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Notes

¹ The company name, product names, and individual names have been changed for a variety of reasons, including protection of individuals through anonymity and personal liability.

² Detail man is a phrase derived from the “detail” which is a central part of a pharmaceutical salesperson’s selling activity. The detail is the sales pitch (i.e. “Doctor, our antibiotic has a broader spectrum of activity, is only once-a-day, and costs half the price of our competition.”) The pitch is verbal, however, almost all representatives carry a “detail book,” which includes company advertisements, clinical reprints of product efficacy and safety, and cost information. The detail book was seen by my managers as a way of stressing particular selling points. The information that is included or not included in the detail book is of central importance to this paper.

³ The package insert (“PI”) is included with pharmaceutical products sold to pharmacies or included in products given free to doctors. The “complete” package insert contains the FDA approved list of indications for a product, side effects, drug interactions, dispensing instructions, and other information related to the particular drug. Tanouye (1997) in the Wall Street Journal provides both insight into the dollars behind off-label promotions for pharmaceutical companies and the tactics used by companies to ensure off-label prescription writing by doctors. In her example, Rhone-Poulenc Rorer’s (RPR) drug Lovenox in 1996 did \$151 million in sales, 60 percent of which was from off-label use. (FDA indicated for preventing blood clots in hip, knee, and abdominal surgery, the drug is used freely by doctors for patients post-stroke or during heart operations when installing stents to keep arteries open.) Legally, doctors can write for any product for any use. However, it is against FDA policy for companies to promote their drugs for “unapproved” use. According to this investigation, RPR encouraged representative to have doctors recommend off-label prescriptions. Tanouye also discusses how four “former and current” employees of RPR were suing the company for coercing them to promote products off-label and that they were harassed when they protested. In my example that follows, I describe how I freely participated in off-label promotion of Company X products, and after I finally protested against this type of activity, how I was ignored and later “let go.”

⁴ For example, a rep might request for a doctor a medical department letter explaining off-label uses for a Company X product – a good way to expand market share through official corporate channels. Representatives could then ask the doctor for a copy and then make more copies and hand these out to other doctors. This was a short cut and a way to increase “noise level” on a particular product for uses outside of the FDA approved package insert.

⁵ Throughout this paper, I employ the term “representatives” which is often abbreviated as “reps” or “sales reps.”

⁶ The stakes are particularly high in the SSRI antidepressant market. During my employment with Paxil, Prozac, and Company X's own SSRI were dominating the market (each product today is over \$1 billion dollars in sales). Companies had begun to co-market their products (i.e., 2 or 3 representatives for each company would call on the same doctor). What became key to expanding market share was getting new indications. Paxil, for example, was gaining on Company X's SSRI and received its obsessive compulsive disorder (OCD) indication first. Rumors in the field centered around how the FDA was punishing Company X for its unethical activities in the field (i.e., promoting off-label) by "holding up" approval of any other indications. In other words, we needed to publicly clean up our act – "zero-tolerance" thereby became born as official Company X policy.

⁷ Quota is a term to describe yearly increases the company would give for a particular product. For example, in 1997 a representative may sell one million dollars of a product. The next year the quota may be one million plus an additional ten percent, or \$100,000.00, equaling \$1,100,000 in total sales. For 1998, the rep must beat the previous year plus the new quota. The goal is always to finish over quota. At Company X all bonus dollar payouts at the end of the year were contingent on making your yearly quota for each product sold (my portfolio ranged from three products to five).

⁸ I have recently explored other examples of spin selling (e.g., Oldani 2001) and would like to stress that the "spin" is now part of our everyday language and thought. The spin simply means taking a negative thing and spinning it into a positive thing, something beneficial for both parties involved. (Neil Rackham's 1996 book, *The S.P.I.N. Selling Fieldbook: Practical Tools, Methods, Exercises, and Resources* was discussed at several POA meetings.) Doctors might object to an antidepressant I sold by saying it "causes too much nausea." I would spin this and retort: "This may be true in some patients, but you can tell these patients it's a sign *the drug is working* and the nausea will fade over time." I could also remind the doctor that if a patient tried to overdose on our drug it would cause so much nausea that the patient would vomit – a nice built-in safety mechanism.(Oldani 2001:34, n.38).

⁹ "Guerrilla marketing" is a movement that originated in mid-1990s from a series of popular books regarding sales techniques (Levinson and Rubin 1994 and Levinson et al. 1995). The books stressed things such as "noise level" (i.e. the more times someone sees the name of a product the more likely they will remember to use it) as a marketing strategy. My district used "bulk mail" (hundreds of advertising pieces sent weekly to doctors in a sales territory) as a strategy to increase noise level for products.

¹⁰ Occasionally, the regional manager (RM), the DM's immediate supervisor, would be on hand at these POA meetings. On more than one occasion I can recall the regional manager telling us that he was going to "act like I didn't see (or hear) that" and let the district manager continue on with his presentation. In this specific case the DM (previously a RM himself) had actually hired the then current regional manager.

¹¹ As representatives, we were all aware of particular doctors who published favorable articles pertaining to our products. These usually appeared in "throwaway journals" (non-peer reviewed). These doctors would often be on the Company X "speaking tour," and we would bring them around our territories for dinner programs, grand rounds and continuing medical education (CME) programs. We had to be careful because most physicians could easily spot a

“company whore.” However, many of Company X’s product supporters were very clever and adept at selling our products without giving a blatant advertisement.

¹² A group of pulmonologists over lunch showed me a video from another pharmaceutical manufacturer that they all found hilarious. This was a company training video (that was probably not supposed to be handed out to physicians) that comically illustrated the relationship between the doctor and the rep in terms of knowledge and information. It begins with a representative trying to sell the doctor a particular antibiotic and the representative mispronounces the names of bacteria. The video then went on to show the representative going through a sort of medical jargon training Olympics. The video concluded with the representative giving a flawless presentation packed full of medical terminology, all of which was correctly pronounced. The problem was that now the physician could not understand the rep!

¹³ We were told during our meetings and training sessions that prior to Prozac (the first SSRI), family practice doctors appeared reluctant to talk about “depression” with their patients. One of the most common treatment options at that time was to use a TCA (a tricyclic antidepressant) for treating depression. The TCAs have a sedating effect so they could be talked about as sleep aids, avoiding the stigmatizing language of depression and mental illness. The TCAs are also toxic at higher doses and patients can ingest a fatal overdose. With Prozac and the SSRIs, serious (i.e., fatal) side effects were no longer an issue. In terms of efficacy, SSRIs work no better than TCAs; they simply are *easy* to use, especially for family practice. Within several years everyone was talking about depression and we had helped to broker both the everyday use of mental illness terms and the generation of billions of dollars in prescription medication. I do not want to claim that reps were solely responsible for destigmatizing depression. However, while pharmaceutical corporations spent millions of dollars on advertising “depression awareness” to the general public and helped to focus government attention on mental health, on a daily basis thousands of representatives were not only talking about depression, but handing out boxes of educational material, and stocking millions of dollars worth of free samples in clinics.

¹⁴ The “no see” doctor is the physician who refuses to engage any type of interaction with the pharmaceutical industry. They were a major challenge for representatives and required relentless pursuit. Success in seeing a no-see doctor was recognized as a great achievement by management.

¹⁵ “Blockbuster” is used by Wall Street investors to describe drugs that normally exceed a billion dollars in sales during the first full-year of sales and marketing.

¹⁶ Simple math explains this incredible growth. If you had 1000 shares of Company X stock that was purchased for 50 dollars a share, this would equal a cost of \$50,000. Company X began to split stock when it reached a price of roughly 150 a share. Your total now is \$150,000 - a nice profit. However, a two-for-one split means you now have 2,000 shares at \$75.00 a share (still \$150,000). Yet, the stock continues to grow to \$150 a share once again. You now have (2,000 shares x \$150) \$300,000 worth of stock. Another two-for-one and growth to \$150 per share would equal (\$4,000 x \$150) \$600,000, and so on. Company X provided this kind of growth to stockholders (many of whom were employees thanks to a stock

option program where the initial buying price is actually lower than the current market price) over a relatively short period of time, roughly 10 years – the decade of the 1990s.

¹⁷ As a Senior Institutional Healthcare Representative, I was seen as a leader and mentor to many district members. My manager often asked me to give presentations regarding my own strategies and to provide information for other district members. One of my last presentations included an elaborate "cut-and-paste" visual aid and dosage card for Company X's antifungal, which was all clearly against official policies as defined here. Most reps were eager to use the material, some had reservations. Nevertheless, I was compensated with "bonus points" which I could use to buy merchandise with at the end of the year.

¹⁸ My previous year was mediocre in terms of my quota so my last year I would have lower quotas to make. I discouraged my hospital pharmacies from buying any product in the last several months of the previous year. Because I was a hospital representative I had large volume hospital accounts and dealt directly with pharmacy purchasers. "Saint Lucratives" had a purchaser that would do *quid pro quo* transactions. He would buy huge amounts of product and in return I would provide the pharmacy grants, gifts for fund raisers, dinners, lunches, etc. In this particular year he requested a \$6000 pharmacy paperwork-processing machine and in return would buy over \$300,000 in one product. I would be well over quota and maximize bonus payout. The only way I could do this was to "write off" this money in the form of dinner programs at \$500 each. "OK" was given from my manager, and I informed all my co-promoting Company X colleagues as to what was going on. Our district would finish "number one" (largely impart from this transaction), and a co-promoting colleague was promoted during the next year to a district manager. I never saw the bonus money from the increase in sales due to my demotion.

¹⁹ Cruise control is a term to describe a territory over quota on all products and increasing in sales each month.

²⁰ Pharmaceutical companies are very much aware that prescribing "habits" begin during resident training. Many times, for example, a staff surgeon will dictate which antibiotics will be used by surgical residents throughout the residency, thus forming a prescribing habit for residents that is hard for pharmaceutical reps to break. Staff surgeons are extremely hard to meet with and rarely change their own habits. If you had a staff doctor that loved your product you were lucky – reinforcing this with the residents was easy.

²¹ My colleague and this psychiatrist were very close. At the time they probably had a 20-year relationship of eating, drinking, and golfing together. This rep was very protective of the institution as well (he had called on it off and on for 25 years). We had actually agreed that this doctor was "off-limits" for my daily sales calls. The problem was that this rep was not promoting our drugs at the institution. He was more concerned with talking to his "old friends," usually about arcane issues. So I used the mail to get around this - to do some *selling*. He later denied having anything to do with my demotion at Company.

²² My manager had only been on the job a few months when a manager from another division at Company X turned in a "cut-and-paste" flyer that he had received from a concerned physician. My manager had created and used this piece while still working as a sales rep. She was promoted in large part do to her outstanding "numbers" for Company X's antifungal. One

way she had exceeded quota was to do weekly mailings to physicians providing information for the use of our antifungal for fungal toe nail infections – a growing market for oral antifungals. She engaged in questionable tactics of pulling different efficacy rates from different sources and comparing them together on the same page. Our product clearly looked superior. As a manager she gave us this one page summary and we all began to hand it out. In fact, the day we spoke on the phone regarding her investigation, I had just handed the flyer out to a group of dermatologists. I had to run back to the clinic and collect all the paper evidence and throw it away. Nothing ever happened to my manager.

²³ Today, I find it somewhat humorous that on the plane ride to New York City I had a panic attack – with the classic symptoms of increased heart rate, nausea, and sweating. This is slightly ironic considering I was being punished for promoting Company X's SSRI off-label, which included copying medical department information discussing the use of our SSRI for the treatment of panic disorder.

²⁴ Probably the only thing to save me from being fired was my number one ranking amongst Institutional Healthcare Representatives in the Midwest region. The "Goal Achievement Report" (GAR) had only been release with my number ranking the week before my demotion. I was having a "great year" and it saved me. As a trainee you have no territory (you help other reps in their own) and no quota. You receive full pay, but no chance for bonus. Its sort of a liminal state where you await a new territory, or you simply can decide if you want to stay on with the company.

²⁵ I later received cards and notes from colleagues. A note stated: "thanks for taking one for the team." And a personal card was signed: "this could have happened to any of us."

²⁶ The paper that resulted from this research methods class has informed certain aspects of this current paper. However, my original project (Oldani 1997) was covert in nature. I took notes after meetings, recorded voice mail transmissions, interviewed my district members informally, and asked questions in a way to get salespersons to talk about ethics and cheating. In addition to this, I analyzed how the company advertised both inside the corporation to its employees and outside to the consumers (patients and doctors). My information gathering and analysis had a dual purpose. Aside from a research project, I was trying to collect information for my lawyers for a legal suit that never materialized. After the project was completed however, my instructor and I decided against pursuing this type of covert social science research. There was no informed consent from Company X or my colleagues, and with full disclosure to informants and human subjects a basic tenant of research for the American Anthropological Association, we felt this research, if possible, should go in another direction. My current efforts have moved more towards auto-ethnography, which does limit the perspective to a "mono-view," but considering the circumstances this method seems most appropriate at this time.

²⁷ My replacement and I have stayed in contact. In 2000 he accepted a "buyout" from Company X (after a merger with another pharmaceutical company created an excess of salespersons in the same territory) and went back to school with the hopes of being a teacher. He decided however to try pharmaceuticals again, explaining to me through email exchanges that perhaps it was Company X that was strange. He was quickly hired by the competition but

only lasted two months. He commented to me: "they all are the same" (in terms of promoting products).

²⁸ Recall that the original "cut-and-paste" material sent to the FDA was not of my creation and that Company was losing ground in the race for FDA approval of new indications for their SSRI to the competition. My belief is that Company X needed to give the FDA a name and the proof of taking severe disciplinary action against a senior representative (who was ranked number one) in order to appease FDA investigators and thereby eliminate any further setbacks regarding future SSRI indications. However, without access to internal Company X documents, it's impossible to prove.

²⁹ Representatives still found a way to use medical department letters at the local level that broke company policy.

³⁰ My interest in pharmaceutical sales practices is an on going project (see Oldani 2001), and I continue to maintain relationships with informants that are both past and current employees of Company X, as well as with representatives of other pharmaceutical corporations. What I have found comes as little surprise: reps like to talk about their work, their activities, especially anonymously. What has begun to stand out during my conversations with informants is that many representatives maintain a "love-hate" relationship with their job and with the image of themselves regarding their actions and behaviors. The experienced representatives also realize that to be "effective" requires a complete understanding of the social nature of sales. An informant recently discussed a retirement party for a senior representative that she attended along with many physicians that the new retiree had called on over the years. During the event, a local psychiatrist (who was a product spokesperson for the company) made a toast in which he told the audience that "Stan, was the best drug rep he had ever met because he never mentioned a product by name" during their years of interaction. The doctor told the audience that Stan realized "it's all social." This comment opens a wide field for interpretation. The simple fact that doctors were present at the retirement event demonstrates the family-like relationships that can develop over long-term interaction and/or the creation of an atmosphere where doctors and representatives work for the same company. The doctor's statement is also ambiguous if he is a Company X speaker: he and Stan no doubt talked about products and stipends often. Yet, he chose to tell a room full of other representatives and doctors how to be good salespersons.

³¹ A large part of the doctor-rep interaction is based on gift exchanges (see Wazana 2000 and Oldani 2001) and one could say the act of gift giving has become institutionalized within the industry. Gifting occurs at various levels on an everyday basis from the plastic pen with a product name on it (that ideally writes a "script") to the expensive dinner with tickets to the opera.

³² "Best" in the eyes of the corporation, meant being consistently ranked high on the company's "Goal Achievement Report" (GAR). Your "ranking" was directly related to *exceeding* quota on a regular basis. The representatives who finished consistently in the top five to ten percent of the divisional field force were rewarded with prizes, trips, and status recognition (i.e., internal company publications with quota numbers and photographs).

³³ The President and CEO of Company X at the time of my departure had began as a pharmaceutical rep with the company and had moved his way up over some thirty plus years to the top position.

³⁴ The rep that becomes manager provides an instance to examine the second dimension of trickster behavior within Company X. The first dimension discussed above is trickster as external boundary crosser between the market and medicine. The second dimension is the internal boundary crosser within the corporation itself. My second manager was never comfortable with his position of power and ultimately moved back into the field.

³⁵ I have managed to keep tract of Doctor D since leaving Company X. Currently, he is on Company X's "National Speaker's Bureau" and has continued to move up the academic ladder as well and is the chairperson of a large geriatric psychiatry program. He also is the lead investigator on several clinical trials involving Company X's psychotropic medications as well as other pharmaceutical manufacturer's products.

³⁶ The medical establishment is concerned with the increasing influence of the pharmaceutical industry towards their profession. Pharmaceutical company product has been examined in a series of articles in the *Journal of the American Medical Association (JAMA)*. Tenery (2000: 391-393) in his "Commentary" raises several important issues regarding whether a patient's best interest will come into conflict with industry's focus on the bottom line. He realizes that funding for continuing medical education CME has become so financially intertwined with the pharmaceutical industry that he calls for a special task force to focus on conflicts of interest with the charge of developing industry-wide standards of conduct. He is basing his comments largely on the results of Wazana's (2000) review article, "Physicians and the Pharmaceutical Industry: Is a Gift Ever Just a Gift?" in the same issue. Her comprehensive review and analysis provide several startling statistics which call for further investigation from both the medical community and from medical anthropologists. For instance the mere fact that more than \$11 billion dollars is spent each year by pharmaceutical companies in promotion and marketing is underscored by the \$5 billion portion of that money that goes directly to the activities of sales representatives and their externally oriented activities.

³⁷ During POA meetings and both through electronic mail and voice messages, we discussed the "numbers" at length (Oldani 1997:11-14). This concerned personal rep rankings per product within the district and at the regional as well as the national level. Percents of quota (e.g., "Mike Oldani: 190% for Product P and ranked #1 in the midwest") were posted on the walls of meetings, exalting the winning reps and humiliating the losers. The goals were always clear: "vice presidents club" or "circle of excellence" for individual reps and "number one" ranking for the district. The year I was demoted we finished number one as a district and we all were given a four-day all-expenses-paid-trip to Vail, Colorado, with a guest as our reward (I was allowed to vacation ahead of the rest of the district, avoiding confrontations and awkward situations with my district manager and some of my district members.). On a daily basis my last manager was adept at sending little "reminders" to her reps concerning our collective efforts. Postcards quoting Vince Lombardi's perspectives on winning were her favorite.

³⁸ Before 1995 all sales were tracked through zip code sales. Company X could buy sales data from wholesalers regarding what they had distributed to pharmacies and hospitals within a specific zip code. In rural territories this was a good way to track business because most prescriptions were filled in the same zip code or in a zip code in a nearby town that was still in your territory. In bigger metropolitan areas this method proved problematic because several territories were close together and reps were "losing scripts" to other reps (i.e., doctor X's prescription was filled in a colleague's zip code). Script tracking theoretically would track all prescriptions that a doctor wrote, even if the territory was part of Alabama and the patient traveled to Texas on vacation and filled the script there – the rep received credit. All this information was apparently bought through various third parties, such as pharmacy benefit management (PBMs) companies. There seemed to be a lot of room for error (and a lot of mathematical formulas), but reps for the most part believed managers when they said that the "system works."

³⁹ The logic of the pharmaceutical industry is what Nader (1997:722) would describe as "cultural hegemonies at home." This paper was in part motivated by the "shortage" of ethnographic analyses of home-grown, U.S.-based, ethnography as described by Nader. It is quite clear that anthropologists may never gain access into the pharmaceutical corporation; however, as I have mentioned above, reps like to take risks (like revealing company secrets) and they love to talk.

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