

## Sales Management: The Lesser of Two Evils

Physicians fear that prescription-data restrictions might force sales reps to mine for personal info

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Is the American Medical Association's (AMA) Prescribing Data Restriction Program (PDRP) the answer to physicians' privacy concerns, or will it just hamper the relationship between rep and doc? Observant LLC recently gauged reactions to the PDRP and doctors' expectancies of how this initiative affects physicians' practices and their relationships with pharmaceutical representatives. The findings suggest that the initiative may have paradoxical negative implications for physicians.

### Michael Feehan



The PDRP was introduced in July 2006 to address physicians' level of discomfort with the amount of personal prescribing information available to pharmaceutical representatives. The broad objectives of the PDRP aim to keep prescribing data out of the

hands of sales reps who have direct contact with physicians. This voluntary program restricts physician-level prescribing data from being shared with representatives and their direct managers. However, it does allow prescribing data to be shared at the corporate level for marketing and segmentation purposes.

### Neil Bergquist



In-depth discussions with 44 physicians suggest that enthusiasm for the PDRP is muted, as only slightly more than half indicated any likelihood of enrolling in the program. Those who do intend to enroll largely plan to adopt a wait-and-see attitude with respect to the potential

impact on their practice. The research indicates that the PDRP may ultimately fall short on several metrics of concern.

### The High Cost of Information

Despite the fact that many doctors prefer not to share their prescribing data with pharmaceutical companies, there is a sense of resignation that this data provision is a necessary evil of practicing medicine in a capitalist paradigm. However, physicians are particularly sensitive to personal information being recorded and shared among pharma sales reps.

Personal information can include conversations between the physician and the representative regarding vacation plans, recent car purchases, or children's birthdays. Information disclosed in these kinds of one-to-one interactions is generally viewed as private. Doctors are often surprised and offended by the notion that this information might be stored and shared among reps.

In the study, physicians were shown three scenarios outlining possible cumulative levels of prescribing and interaction data that pharmaceutical representatives may have available to them. These scenarios reflected industry approaches and were not based on any one client company's practice. The first scenario, depicting the most conservative level of information—including total-level monthly prescribing data, or month-to-month change in the prescribing of a rep's product—drew discomfort from the physicians. Some doctors said that even at this level, "reps have too much information available to them."

This discomfort was exacerbated when respondents were shown scenarios illustrating even more personal and specific information that could be gathered and shared amongst reps. The second scenario indicated that reps had access to total-level data for competitor products and their change month-to-month over the past year, as well as functional notes on the rep's laptop of the rep's interactions with the physician and his staff, accessible to other sales reps.

The third scenario, which elicited the greatest level of discomfort, listed dose-level monthly prescribing data for that rep's product and competitor products, detailed graphs and charts illustrating month-to-month change for all products, and personal notes on the quality of the rep/physician interaction, along with the doctor's personal details. Physicians were instructed to assume these notes—as well as prescribing data and functional/personal notes from other reps who have visited the physician—were reviewed by the rep before entering the office.

### No Free Lunch

Although the sharing of personal information is not the purview of the PDRP, some physicians believe that these types of tactics will become more prevalent if the AMA were to restrict prescribing data to reps. For many, this is of equal or greater concern than rep access to their prescribing data per se.

Many physicians also presume that restricting their data will undermine the value of the relationship they have with their reps. The ability to deliver commodities, such as samples, lunches for staff, and new product information, may be hampered if reps are not equipped with prescribing data to guide their efforts.

More than three quarters of physicians note—sometimes grudgingly—that having prescribing data available to reps does allow reps to better understand which samples provide the most value and which samples simply take up valuable space in the drug closet. In the absence of prescribing data, sampling may become less targeted to a physician's practice, and the doctor will have to spend more time educating reps about what they may or may not need in terms of samples.

One physician noted, "This is a business, and if reps don't know what I'm prescribing, they won't know what to bring to me unless I tell them."

### A Bad Rep(utation)

In the absence of readily available prescribing data, some physicians feel that reps may spend more time mining the data they need from physicians directly, and this may ultimately take more time from the physician's schedule. Some doctors

believe that sales reps may become more aggressive and spend more time with staff members and front-desk gatekeepers to obtain general prescribing information. One in four doctors interviewed fear the number and frequency of details would increase under the PDRP in order to obtain more information.

As one physician noted, "It would be counterproductive to take away my prescribing data from a rep only to have him spend more time digging for my personal information." If this were to happen, physicians indicate that their practices may introduce even more restrictive measures to limit rep access.

### Guard the Guards

A final major concern among physicians that weakens the intent to enroll in the program is uncertainty around enforcement. Many feel that PDRP will be limited by a lack of enforcement in the event that a pharmaceutical company "breaks the rules." These physicians are concerned that the program may lack teeth and that pharmaceutical companies will have little incentive to comply. As one doctor said, "I'm not convinced that companies will actually abide by this. I don't think the AMA could even give them a slap on the wrist."

Ultimately, physicians want the best elements of the physician/representative relationship: appropriate sampling to suit their practices, information about new products, and new data for existing products. They want this information without the sense that they may be compromising their personal privacy.

While the practice of recording physician-interaction information may be here to stay and is a valuable resource for reps, pharmaceutical companies need to be sensitive to these concerns and act responsibly in the absence of prescribing data at the representative and district-manager level. Any actions by reps to skirt the system to gain access to prescribing data (and worse, personal data) are likely to add fuel to the fire and further erode perceptions of pharmaceutical manufacturers as trusted partners in the delivery of optimal healthcare.