

*The New*  
**REPUBLIC**

Published on *The New Republic* (<http://www.tnr.com>)

---

# Big (Brother) Pharma

How Drug Reps Know Which Doctors to Target

Jake Whitney August 29, 2006 | 12:00 am

For years Dr. Peter Klementowicz suspected that pharmaceutical sales representatives knew more about the prescriptions he was writing than they let on. Klementowicz, a cardiologist in Nashua, New Hampshire, would occasionally hear curious statements from drug reps, such as, “you’re one of my targets.” His suspicion peaked when a friend told him she overheard a group of reps at a local Panera Bread discussing ways to induce Klementowicz to prescribe their drugs. How did they know he wasn’t already prescribing their drugs? It wasn’t until last year, after Klementowicz’s wife stumbled upon a two-year-old newspaper article, that he learned what more and more doctors are also just discovering: Drug companies know almost everything about which physicians prescribe which drugs and how often.

Klementowicz’s case is unusual: His wife, Cindy Rosenwald, is a New Hampshire state representative. The revelation that drug reps knew about his prescribing habits prompted her bill—signed into law by Governor John Lynch this summer—that bans the sale for commercial use of prescription data throughout the state. Rosenwald’s bill was the first of its kind to become law, but several other states are considering regulating what they increasingly see as an onerous practice. And it’s not hard to see why.

For more than a decade, drug companies have been tracking physicians’ prescription records. It helps their bottom line immensely by allowing their sales reps to hound and ply physicians who, they believe, are underprescribing their drugs. But the practice is only just starting to receive widespread attention. In fact, a 2004 survey sponsored by the American Medical Association (AMA) found that about 25 percent of doctors were still unaware of the practice. And they’re not all happy about it, either. Some doctors see it as disruptive of their professional prerogatives. Others resent the violation of their privacy. But the real effects may be far worse than the physician outcry suggests. The real problem is financial: skyrocketing drug prices. Buying and selling prescription records is a lucrative business, and, perhaps as no other factor, it inflates the cost of drugs.

Pharmaceutical companies get prescription data in a few different ways. One is by buying the information from companies like IMS Health, which purchases and sorts records from pharmacies, hospitals, nursing homes, and insurance companies. This, itself, is a profitable business. Last year, IMS Health earned \$1.75 billion in revenue—\$848 million from “Sales Force Effectiveness” offerings. To help them understand pharmacies’ records, drug companies must also access an AMA database called the “Physician Masterfile.” This file is a detailed professional history of every physician in the United States, and it contains such unique identifiers as license and Drug Enforcement Agency numbers—which drug companies use to match doctors to prescription records, since not all records contain the doctor’s name (patient names are always excluded).

Proponents of the practice—including the AMA, the pharmaceutical industry, and data-mining companies—say prescription data is crucial for research purposes. (In an e-mailed statement, Ken Johnson, senior vice president of PhRMA, the pharmaceutical lobby, said that the data has been used in a study by the Centers for Disease Control and Prevention to “reduce unnecessary prescribing” of antibiotics.) The real explanation is that it’s quite good for the bottom line: It creates a cottage industry for middlemen like IMS Health and nets extra revenue at little cost for the

AMA. (The organization wouldn't say how much it made from the lease of its Masterfile, but, according to its annual report, the group earned \$44.5 million in 2005 from the sale of "Database Products.") But the real benefit is for drug companies, which collect the data because it allows them to target their marketing efforts on specific physicians with pinpoint accuracy (instead of only advertising in broad-penetration venues like medical journals and conferences).

A drug company's marketers can tell from the data not only how much of its drugs Dr. X is prescribing, but also whether Dr. X is a "high prescriber" in that drug class—which tells them if it should target Dr. X at all. Kathleen Slattery-Moschkau, a former rep who worked for Johnson & Johnson and Bristol-Myers Squibb, told me that the data was "sliced and diced" into various reports, such as the "Heavy Hitter List," which included the top physicians she should seek to "convert." "When I took Dr. Smith to dinner at that fancy restaurant," she says, "I could look at the following week's numbers to see if it had an impact. If not, I could try a different approach."

Jamie Reidy, a former Pfizer and Eli Lilly rep who skewered his erstwhile profession last year in *Hard Sell*, says prescription data "was our greatest tool in planning our approach to manipulating doctors." Reidy used prescriber reports to hone his sales tactics, which included befriending top physicians and wooing their office staffs. If the data showed that a particular doctor was a target physician, Reidy might treat the nursing staff to cocktails, where he'd make it clear that, if the doctor prescribed his drug over the competitors', "they'll be having regular happy hours." Slattery-Moschkau says that top prescribers are not only "targeted, wined, and dined," but also called upon repeatedly by different reps about the same drug. The idea is that each rep can bond with the doctor in a different way. "One might be a female who's kind of a looker, one might be a sports person who would bring [the doctor] to the game, one might be more analytical."

But tactics like these are expensive, and, while they may spike sales, the marketing expenditures also spike costs. The "extras" that reps give their top prescribers include expensive lunches and dinners, gift certificates, and fees for speaking at ostensibly educational events—all of this on top of the ubiquitous promotional trinkets that virtually all physicians receive, such as pens, notepads, mouse pads, tote bags, umbrellas, and stuffed animals. Faced with incentives like these, doctors often prescribe brand-name drugs where cheaper generics might have worked—and that is driving up insurance premiums and co-pays.

Skyrocketing prescription costs were a driving force behind Rosenwald's bill, and California, Arizona, Hawaii, and West Virginia have also considered restricting drug companies' access to the data. According to a spokesman for West Virginia's Office of the Pharmaceutical Advocate, although no legislation has yet been proposed, the state is "taking a look" at regulating the use of prescription data as a means for controlling drug costs. And, in California, negotiations over a bill like Rosenwald's have resulted in a unique program that will allow physicians to "opt out" of having their physician-specific data released to salespeople. But companies like IMS Health hope to discourage doctors from the opt-out with enticements of their own, such as educational newsletters, patient compliance reports, and data packages containing the prescribing information of physicians in their region and specialty.

The AMA has responded in two ways. First, it defends the practice as not only crucial to research, but also as a way for drug companies to actually reduce marketing costs. In a recent article for *Pharmaceutical Executive* magazine, the AMA's Robert Musacchio and IMS Health's Robert Hunkler argued that access to prescription data reduces drug costs by allowing "pharmaceutical promotion to be relevant and specific, making the whole process more cost-effective." While, on the surface, this argument seems to have merit, it fails to take into account the cost of the data itself on drug prices. And its implication that only certain physicians are targeted (while others are not) is false. Certainly—as reps like Reidy and Slattery-Moschkau explained—top prescribers are "targeted" more than lower-prescribing physicians. But this doesn't mean the latter are ignored by drug companies.

Second, the AMA has responded with its own "opt-out" program, known as the Prescribing Data Restriction Program (pdrp). Since July 1, the AMA has given physicians across the country the right to request that their physician-specific data be withheld from drug representatives. But critics of the AMA's opt-out, such as Rosenwald, say it is insufficient and fraught with holes—and, in light of the AMA's financial interest in the practice, it's just a self-policing measure intended to avoid more legislation. The authors of the *Pharmaceutical Executive* article even admit that avoiding more legislation is a goal: "If [the rules of the program] succeed, legislators will turn their attention elsewhere, and the industry can hang onto one of its most valuable data sources."

And there are other worries about the pdrp. For one, prescription data will continue to be made available to drug companies, including their marketing departments—just not reps and their direct supervisors—so drug firms will be on the honor system to keep the data from salespeople. This could give rise, as Rosenwald points out, to executives “winking” at reps or giving other tacit signals to go after targeted physicians. Another problem is that compliance will be measured strictly by physician complaints. This means, conceivably, that companies could continue to provide reps with the data; they would just need to better hide it from doctors. Finally, and most significantly, the pdrp does not offer any potential reduction in drug costs. Whether or not pharmaceutical companies adhere to pdrp rules, they will still spend millions on the records and the Masterfile, which, as always, will be reflected in higher drug prices. Clearly the pdrp is not the answer.

While prescription data can be beneficial for research purposes—like locating appropriate physicians for clinical trials—patients do not benefit from drug companies’ access to the data. As Slattery-Mosehkau told me, “prescriber reports are a perfect example that the industry’s direct-to-physician advertising has little or nothing to do with what is in the best interest of the patient. It’s all about market share and grabbing market share from our competitors.” Since the industry can’t be trusted to police itself, only bills like Rosenwald’s can make drug companies focus on research and development rather than conspiratorial Panera Bread bull sessions. And that’s just fine by Peter Klementowicz.

*Jake Whitney is a freelance writer in New York.*

**For more *TNR*, become a fan on Facebook and follow us on Twitter.**

---

**Source URL:** <http://www.tnr.com/article/84056/health-care-eli-lilly-pfizer-ama>