Letter to Congress:

As a former drug representative for Eli Lilly, I spent 20 months increasing the market share of my company's drugs. I was recruited fresh from college with an eager desire to employ my degree in molecular biology and biochemistry. Shortly after my hiring, it became clearly apparent that a drug sale had much more to do with establishing personal relationships than it did with understanding the latest science. However, any doubts I held regarding the effectiveness of such methods were dispelled by the results of my persuasiveness and the financial rewards I received for my efforts. The latter also helped me rationalize the many ethically dubious situations I routinely encountered in my work. Upon my departure from the industry, I began working for the public's health. Seven years later, as a result of my experiences and education I am more convinced than ever that the goals of the pharmaceutical industry often stand in direct conflict with the practice of ethical and responsible medicine. Nothing in my recent research causes me to believe that my experiences were anything but typical of the training and practice of the majority of drug reps plying their trade today.

The Role of Drug Reps

"There's a big bucket of money sitting in every [doctor's] office." – Michael Zubillaga, Astra Zeneca Regional Sales Director, Oncology

Ostensibly, the drug rep provides a valuable service to the practicing clinician. Their role is explained by the industry as a means to provide valuable education to physicians and to supply all-important samples, especially to those patients who normally can't afford to pay for their own medications. I am convinced that these justifications are nothing more than a distraction from the actual purpose of pharmaceutical sales representatives: to sell. To sell pharmaceuticals means convincing doctors to prescribe your product more than your competitors despite what might be the more suitable drug for the patient. It means swaying doctors to use your product in instances where they may not think to despite what might be medically acceptable usage. It means persuading doctors to use your drug when a non-medication therapy would be a better alternative. This means rewarding physicians with gifts and attention for their allegiance to your product and company despite what might be ethically appropriate. This means to sell, as one would any other marketed product.

But, of course there are clear and obvious reasons why the laws and expectations regulating the sales of medications are fundamentally different than those relating to the sales of most other marketed products. Drugs are selected by proxy, on behalf of the patient by doctors. Doctors rely on objective scientific evidence to guide their prescribing choices. Despite this, we drug reps, untrained in medicine, market our own products as the ideal choice. Our intent as sales reps is to provide a skewed perspective; one where our product is presented in the best possible light while we shine a spotlight on the shortcoming of our competitors' products. The end effect is a skewed understanding of the pharmacology, poor prescribing practices, and compromised medical professionalism. Crucial to this process is the persuasiveness, enthusiasm and charisma necessary to overcome the natural misgivings of physicians.

Recruitment

"I would think, essentially, that cheerleaders make good sales people." – Ms. Cassie Napier, TAP pharmaceutical drug representative

The majority of drug reps entering the work force today are young and attractive. The ranks of reps are replete with sexual icons: former cheerleaders, ex-military, models, athletes. Of

course, as a sales job, the reps must be eloquent and convincing. Depending on the population, certain ethnicities are preferred either to make the rep distinct among other reps or to provide them with a cultural advantage in connecting with their clients. Noticeably lacking among most new reps is any significant scientific understanding. My personal case illustrates this point rather vividly: In my training class for Eli Lilly's elite neuroscience division, selling two products that constituted over 50% of the company's profits at the time, none of my 21 classmates nor our two trainers had any college level scientific education. In fact, that first day of training, I taught my class and my instructors the very basic but crucial process by which two nerve cells communicate with one another. It is very likely that the majority of my class couldn't explain the difference between a neuron and a neutron prior to sales school. While it's certainly a bonus to have a scientifically educated representative, it is far from a primary recruitment criterion. Youth is a much higher criterion for the sales position. Youth is equated with attractiveness and enthusiasm but also younger reps are more likely to believe unequivocally in their products superiority against competitors. This combination of charisma and zealotry makes the rep a compelling personality.

Training

"It is difficult to get a man to understand something when his job depends on not understanding it." – Upton Sinclair

Training varies significantly from company to company and product to product however, certain commonalities exist. Most reps are taught a modicum of science pertinent to their product. They learn the basics of the disease their product is intended to treat but still lack a significant scientific education to place their knowledge into context. Essential to their "scientific education" is learning how to discuss critical talking points about drugs in their product's class. Reps memorize facts and statistics to support market-tested positive perceptions of their products. Reps also memorize negative facts and statistics about their competitors. Hours a day are spent learning how to weave the perceived benefits of their product into a concise, seemingly un-rehearsed message. The ability to deliver the message is further refined by learning how to handle common objections. A typical tactic is to rebut the negative medical experience of the concerned physician with positive data from the company that addresses their concern. *"Doctor, that may be **you're experience** but the **data,** drawn from a much larger population, suggests otherwise …"* An equally typical tactic is to rebut the negative data a concerned physician may have with positive anecdotes of their colleagues' experiences and how their vicarious understanding should outweigh the concerns that the data may cause. *"Sure, doctor, **the paper** may suggest that the side-effect commonly occurs, but how often have **you** seen it with your **patients**?"* The use of these tactics is not mutually exclusive. Rebuttals are seen as merely tools in the toolbox: whatever will fix the problem and get the conversation back on track towards selling.

Sales representative trainers are almost always veteran sales representatives and consequently, much of the training they offer is implicit in the anecdotes they give. This informal training parallels the standard training offered by the industry and in many ways compliments it. It is tacitly accepted by management and perceived as the "real" training by many veteran sale representatives. Among the more dubious "unofficial" lessons a new rep learns are: how to manipulate an expense report to exceed the spending limit for important clients, how to use free samples to leverage sales, how to use friendship to foster an implied "quid pro quo" relationship, the importance of sexual tension, and how to maneuver yourself to becoming a necessity to an office or clinic. This handing down of tried and true techniques is common whenever a senior sales person is in close working company with a fresh recruit.

Some medical learning certainly occurs after training during the routine course of the job - doctors love to teach and it is our role as reps to ingratiate ourselves to our clients - however, given that most reps switch jobs or careers after only 2 years, it's difficult to believe they have mastered enough medicine to consistently provide a source of reliable scientific information for their physicians. Incidentally, the short tenure of drug reps seems linked to the duration of zealotry a rep holds for their product. Once the rep begins to question the notion that the product is no longer the overwhelmingly clear choice, enthusiasm diminishes and the process of sales becomes more complex. These reps are easily replaced by other, younger, less questioning recruits.

A standard test given towards the end of a sales rep's training is a mock sales call on an actual paid doctor, hired to play the role of the objecting client. While the scenario is often contrived and the dialogue scripted, a camera records the encounter to provide an observer's perspective of the reps efforts. These videos are evaluated by the entire training class and scrutiny comes in a variety of forms: uncomfortable body language, a missed opportunity to personally connect with the client, a deviation from the market-tested sales pitch, a failure to criticize a competitor's product, or most egregiously, failure to be assertive in "asking for the business" - a concept so crucial to sales, even pharmaceutical sales, that it warrants its own acronym AFTB. Every sales training about which I have heard or read puts AFTB as the most important part of any sales encounter. Sales reps are taught to convert social or medical capital into an increase in market share by "asking for the business." However, the way that you curry that capital is as varied as the diversity of your clients' personalities. A very common if informal part of training is learning to classify your clients' personalities into categories defined by psychological test such as Myers-Briggs. Once recognized, reps are expected to tailor their approach to best achieve a response from the clients. Doctors who are intellectuals (these typically constitute the minority of a rep's clientele for a variety of reasons) are offered the latest scientific articles or receive polite requests to "teach" the drug rep about the science of his or her product. Doctors who are extroverted are lavished with personal attention. Small friendly dinners are common for these doctors and most likely many personal details are exchanged between the rep and the physician to build an intimacy that can later be leveraged to increase market share. Doctors who are more intuitive can be approached indirectly. By establishing a friendly relationship with a core group of physicians trusted by the intuitive doctor, one can rely on anecdotes from or personal intervention by the core to establish a relationship with the target.

<u>Pairing</u>

"If you do it right, it can be the most rewarding selling situation because of the synergy that multiple reps can bring to a situation. One rep might get along better with a certain person in the office, another rep may say something to the customer a little differently, and that might be just enough to turn the doctor around. It gives us more chances to be successful." – Anonymous Sales Manager – Pharmacuetical Representative Online Magazine, September 1st 2006, <u>Two Sides of the Team</u>

Drug reps themselves are given long and complex psychological exams to assess their personalities. One reason is to provide better management and career direction for the rep but another reason is to provide rough guidelines on the personalities the with which drug rep is compatible. However, the amount of thought invested in determining what personalities mesh best goes deeper than an expensive, exhaustive mental evaluation. Drug reps are often paired. These pairs are responsible for the same group of clients, however the pairing often occurs with the intent to increase the likelihood that a client will have something in common with one of the

reps. While female reps are more common than male reps (to cater to the disproportionate number of male heterosexual physicians), males and females are mixed whenever possible to provide a gender appeal to all clients in a territory. Quite simply put: some doctors prefer the company of men and some the company of women. The pairing often also takes into account the interests of the reps. Once a fertile common ground is found between the client and one of the reps (referred to as the "lead" rep), the pair dedicate their resources to enhancing that relationship. The reps don't both need to be "good friends" with the client. It is in fact, preferable that one of them becomes the doctor's "best friend." To achieve this, reps have occasionally played "Good Cop, Bad Cop," intentionally sacrificing the relationship of the lesser rep to enhance the relationship of the lead rep.

Tools of the Trade

"There is something called the momentum effect, which means that if a rep leaves a sample with a doctor today, that will influence that physician to prescribe the drug in the future. There will be a lingering effect: The doctor will be thinking about prescribing that rep's drug next week, and the week after, and so forth, based on what was delivered to him today." – Patrick Burns, Pharma Executive Online, June 2005, A sample plan: one of the industry's most important promotional tools is also one of its least understood.

Drug reps have a variety of weapons at their disposal in the campaign to increase market share. Regardless of the rep's choice, every decision is, on some level, weighed in a cost benefit analysis and calculated to boost sales in the long run. Tactical and strategic decisions are weighed in the minds of drug reps as they consider what assets to dedicate to their targets and what return is expected on the investment.

Some doctors are susceptible to congenial meals with friends. Others expect an abundance of free samples. Some prefer to be elevated to the ranks of official paid speakers. Some enjoy a box of doughnuts and coffee for their staff. And some will be satisfied with pleasant small talk. The expected yields are just as varied. A meal may involve colleagues beleaguering their friend to use more of the host rep's product. Extra samples may be left behind contingent on being given to new patients as opposed to sustaining therapy (and thus "cannibalizing" sales). Invitations to join the speaker circuit are rescinded when doctors fail to show their loyalty by prescribing more of the sponsor's product ... or if speakers fail to convince their audiences to use more of the sponsor's product. Routinely providing meals and cultivating friendships are among the most effective ways of influencing a physician's prescribing habits without addressing the science. The quid pro quo in all of these scenarios is tacit and never directly stated. However, clients learn fast that these gifts come with strings attached.

Samples

"Although samples are the single largest marketing expense for the drug industry, they pay handsome dividends: doctors who accept samples of a drug are far more likely to prescribe that drug later on." – Carl Elliot, The Atlantic, The Drug Pushers, April 2006

Among the gifts with which drug reps ply their clients, samples are the most routinely used to defend the need for pharmaceutical sales representatives. Doctors claim to use the samples to help indigent patients. While this may be the case, it is difficult to believe that the legions of reps with exorbitant salaries and expense budgets are the most effective means of disseminating bottles containing only 14 pills each. Pharmaceutical companies are not charities, and the delivery of samples is merely another means to promote business ... again at the expense

of the public and potentially at the expense of the patient. Drug reps are taught to use samples in myriad ways. As a gift, samples win the gratitude of doctors, who in turn win the gratitude of their patients when they offer a week's supply of free medications. Unfortunately, few patients with chronic diseases immediately realize that this "free gift" is for a drug that they will be taking for a long, long time. Compounding this tragedy is that for many drugs a generic alternative is available that is cheaper and usually just as effective, but once a medication has been started, doctors are reluctant to change their prescription. Reps cleverly limit the number of samples they allocates to each clinic or office to make their return in 2 weeks a necessity. Reps are also instructed to parley "extra" samples left on the physicians desk as a gift to be used exclusively for new patients. In essence, the rep is using tactics similar to those employed by illegal narcotics dealers: the first drug is free and then you're hooked and you have to pay. Doctors who continue to insist that samples help sustain the therapies of poor patients need only be informed that drug reps do not visit every doctor in their territory - they only visit the ones that are most likely to give them a good return on their investments of time, money, food, gifts, samples and friendship.

Prescriber Data

"Physician behavior drives today's pharmaceutical marketing tactics, and sales representatives are often tasked with 'changing physician behavior.'" – Jane Y. Chin Pharmaceutical Representative Online Magazine, October 1st 2006, Get Educated

Helping drug reps triage which clients to see, prescriber data identifies which doctors in a given region write the most scripts (i.e., prescriptions). The data scores physicians on a scale of 1 to 10, with 10 being the greatest writers and 1 indicating a writer of very few prescriptions. 10-ranked physicians are known by all the drug reps in a territory. They are given the most attention and the most lavish gifts. Doctors who are 5-ranked, on the other hand, rarely see the drug reps. They may be invited periodically to a dinner but rarely receive the perks of their higher-prescribing colleagues. The argument for the use of these data is to allow drug reps to determine which physicians most crucially need their "scientific expertise." Sadly, this approach focuses on a strict minority - leaving the smaller but much more common practices, which treat the majority of patients in a given territory, with little opportunity to draw from the reps "expertise." It defies logic to believe that a well-paid, gift-bearing, charismatic, twenty-four year old, liberal arts college graduate is the most efficient vehicle to disseminate up-to-the minute scientific information to doctors.

In addition to the information that gauges a physician's market value, the data also catalog what products a physician is prescribing. This information helps determine how reps will tailor their sales pitch to appropriately juxtapose the rep's product against the physicians preferred choice. Most physicians prefer not to share their prescribing practices with drug reps. When the data are available the physician's attempt at privacy becomes moot. In fact drug reps are trained to study their target's prescribing patterns to best consider what sales pitches will work. Oftentimes, the juxtaposition is subtly made without mentioning the physician's preferred drug and arousing his or her suspicion.

Personal Client Information

"When you're out to dinner with a doctor, the physician is eating with a friend. You are eating with a client." – Anonymous Sales Rep Trainer

The most troubling aspect of pharmaceutical sales is systematic befriending of our

clients. In addition to the psychological profiling mentioned above, drug reps are taught to constantly be on the lookout for personal effects that will help us connect to our doctors. When entering an office for the first time, we nonchalantly survey it for clues to ingratiate ourselves with our client. Similarly, conversations are intentionally steered into the realm of personal details such as religion, family, or hobbies to acquire similar information. As a matter of training, we collect this data subtly. In the course of a conversation with clients, we may glean facts about their prescribing preferences, the dates of their children's birthdays, where they were born, or what music they enjoy. Training encourages us to commit these details to memory just long enough to return to our cars and instantly type up a "call report" listing the details of our conversation. On a daily basis, we connect our computers to a central database that uploads the information we've acquired, allowing us to share it with our partner drug reps and company marketers. Subsequently, drug reps interweave pieces of conversation specifically tailored to appeal to their client drawn from personal information that wasn't necessarily shared with them. For example, Dr. Jones will be nothing but grateful when I supply him with a cake celebrating his children's birthday when, in fact, he told my partner (and not me) the birthdates several months prior in a personal conversation.

The prescriber data and personal client information make our laptops the single most important tool in our arsenal after our personalities. Reps take their laptops to the field and examine them prior to every client visit to help them develop an appropriate plan of attack. While reps see only an average of 8-10 physicians in a normal 8 hour work day (a seemingly small number considering that a single office may hold 4 important clients or that an effective sales exchange can occur in less than 2 minutes), they spend a considerable amount of time studying their computers for strategy purposes. This laptop-stored information is arguably the best kept secret of drug-repping - most doctors are completely unaware of the existence of these files on them. For our part, we drug reps are instructed never to enter an office with our laptops, to avoid showing physicians their profiles, and if ever confronted about the existence of such information, to downplay its importance to our work. From my lectures and in conversations with physicians, I have yet to find an audience where a significant portion of the physician audience hasn't been surprised by the existence of such information. From my research and conversations with drug reps, I have yet to find a company that openly discloses its client information to their clients.

Thought Leaders

A rarely used but powerful tool to create changes in prescribing habits is the lure of coveted company-sponsored speaking engagements. Drug reps scour their territory to find potential speakers who can persuade their peers to increase their usage of a particular product. Characteristics that we look for in our speakers include the following:

1. Charisma – the speaker must have the ability to capture his/her audience's attention
2. Credibility – the doctor must be respected by his/her peers
3. Convincing – the doctor must adequately address concerns about the product so as to ultimately increase sales.
4. Constancy – with respect to his/her prescribing of the company's product.

When the client is first recruited, he or she is given local speaking engagements. Evidence of effectiveness is monitored and, depending of the degree of their success, the doctor may be informally promoted to speaking engagements in a wider area and given larger honoraria. In

effect the physician speaker becomes a second arm of a marketing strategy that relies on "synergy." Adding to this complementation in sales, doctors are often supplied with presentations crafted by the marketing department to emphasize the specific advantages of our products that will yield the greatest sales benefits – not surprisingly, they are often very similar to what the reps are scripted to speak of. While physicians are generally reluctant to become mouthpieces of industry marketing in such an overt fashion, most accede to these conditions. Such rationalizations can be attributed to a variety of reasons: no one will know that it presentation was company made, the doctor still believes that they remain wholly objective, and failure to meet company expectations can result in a cancellation of the talk (even the day of the expected event.)

While most doctors are genuine in their belief in the products about which they speak, the relationship exists for the profit of the sponsoring company. For example, should a doctor have a change in mindset about the product, fail to convincingly address an audience's objections about the product, refuse to use the slides created by the company or simply fail to write enough prescriptions for the sponsor's product, then the sponsor is free to cancel the relationship. While a common and acceptable business practice, this behavior risks creating a coercive relationship with speakers who wish to speak (and get paid) more than they wish to teach. Again, we must ask ourselves, how much marketing at the expense of distorting the balance of objective information is permissible?

Gifts

"Not accepting a gift is one thing, but restricting sales reps' ability to give healthcare professionals valuable information about their drugs would be a big mistake."- Scott Lassman, PhRMA's senior assistant general counsel Pharmaceutical Representative Online Magazine, November 1st 2006, Gifts That Keep on Giving

Aside from the above tactics and tools, drug reps are armed with a wide assortment of gifts and deep pockets to further influence physician prescribing. Whether pens, pads, clip boards, or anatomical models, companies take great pains to make their gifts vibrantly colored and clearly logo'ed. The strategy behind these gifts is to draw attention to the pharmaceutical products and to serve as reminders of the company's generosity. These reminders generate a conscious or subconscious desire to return the "favor." Referred to as "reciprocity" (a well known term in psychology and marketing), this desire is cultivated by drug reps with whom doctors have a social bond.

While PhRMA, the leading pharmaceutical industry association, has set out guidelines to remedy conflicts of interest, the effort is largely cosmetic. Of course, it is necessary to point out that not all drug companies are represented by PhRMA. Without enforcement measures, these guidelines are merely wishful thinking that the fox will change its nature and actually guard the henhouse. Furthermore, the notion that permissible gifts are those that "benefit the practice of medicine" does nothing to change the nature of how these gifts still sway physicians. The gifts still come from reps who work for companies that have obligations to shareholders – with a goal that is not based on scientific evidence, the patient's well-being, or public health but on company profit. Also, the total amount of spending on these gifts hasn't been reduced by the PhRMA guidelines. For example, in the past, as a rep, I would spend a $100 on a golf club for a physician allowing him/her to spend $100 on a medical textbook. Today, I buy the book and he/she buys the golf club. It is still a gift, still a perk, and still $100.

Sales Representative Culture

"I want you out there every day selling Neurontin. Neurontin is more profitable than Accupril so we need to focus on Neurontin. Pain management, now that's money. We don't want to share these patients with everybody, we want them on Neurontin only. We want their whole drug budget--not a quarter, not half--the whole thing. We can't wait for them to ask, we need to get out there and tell them up front. Holding their hand and whispering in their ear: 'Neurontin for pain, Neurontin for everything.' I don't want to see a single patient coming off Neurontin before they've been up to at least 4,800 milligrams a day. I don't want to hear that safety crap, either. Have you tried Neurontin? Every one of you should take one just to see there's nothing. It's a great drug!" - John Ford, senior marketing executive for Parke-Davis

More often than not, what is deemed acceptable or necessary behavior for the job is also passed down between representatives. Sadly, while many companies have strict guidelines on what is acceptable and unacceptable behavior, the incentives and pressures to perform encourage many reps not only to work harder but to bend the rules when necessary to achieve their goals. Most managers are willing to look the other way in the case of a well performing salesperson. When ethical infringements become public knowledge and a punishment is handed down, most reps acknowledge the bizarre working environment that superficially demands a strict adherence to ethical standards while rewarding unethical behavior. The recent news is replete with examples of questionable behavior but a particularly telling quote from an Astra Zeneca regional sales director best conveys the spirit of pharmaceutical sales: “There’s a big bucket of money sitting in every [doctor’s] office.” Drug reps are not given promotions on how many doctors they educate, nor how many patients are cured, nor are they given bonuses for the number of indigent patients that receive necessary medications. They are rewarded for increasing their market share and they are encouraged to be creative in achieving that goal. No industry is made up of saints; however, when the problem extends beyond a few errant reps such as the off-label marketing of Neurontin, or the suppression of negative data on Vioxx, or the denial of Oxycontin’s addictive properties, it becomes an issue of incompatible goals and responsibilities. The industry cannot be expected to temper its obligation to shareholders to better serve the public’s health and the medical establishment without some form of effective external regulation.

Why I Left

“I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.” – Modern Day Medical Oath

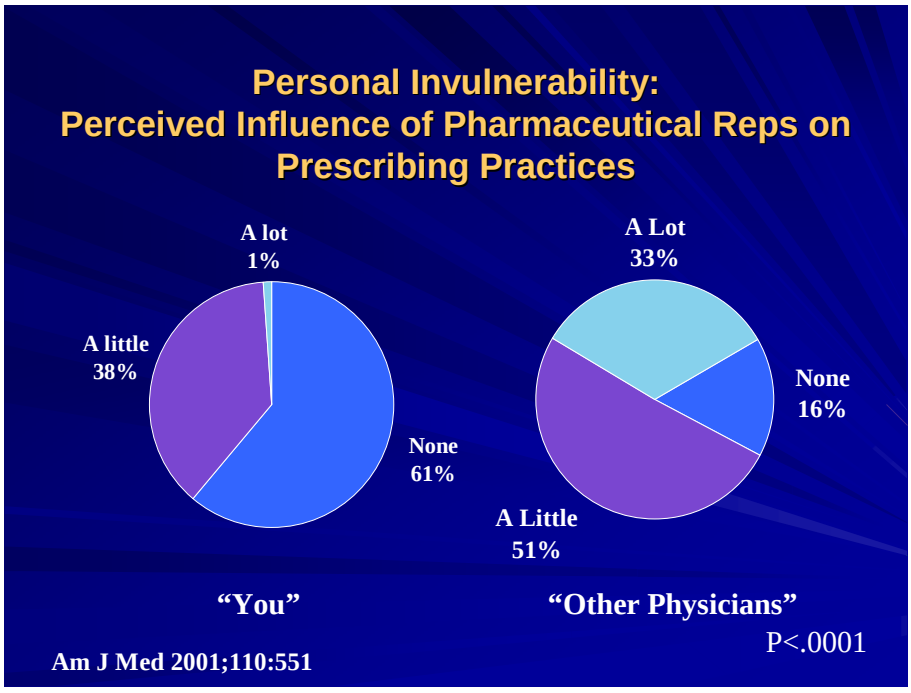
As a drug representative, I found myself in constant conflict with the values imprinted upon me by my family of medical practitioners – the doctor is in service to the patient above all other concerns. I was troubled that I could walk into an office filled with waiting patients but know that I would be seen first by the doctor by virtue of our friendship. I was bothered to know that doctors who denied my products’ medical effectiveness would prescribe copious amounts of it after a friendly (but expensive) dinner in Manhattan. I was angered that the exorbitant expense budgets used for meals and gifts could instead be used to help the many patients who couldn’t afford our products. It made me wonder, what I would think of my doctor if he prescribed me a medication that was made by the company that bought him dinner the night before. There is nothing wrong with profit but there is something wrong when that profit comes at the expense of medical professionalism, broken trust between physicians and patients and the public’s health.

Addendum: The Data

***cognitive dissonance**, noun: psychological conflict resulting from simultaneously held incongruous beliefs and attitudes (as a fondness for smoking and a belief that it is harmful)*

Much in the same vein as I have been taught at Eli Lilly, I have presented my case in this memo with an appeal to the emotions as the primary basis for my argument. This would cause the casual thinker that there is very little data to actually support such a perspective. Nothing can be further from the truth. The overwhelming body of peer-reviewed, academic articles makes a clear case for how marketing has negative effects for the medical community, physician behavior and the public. And while I am confident in my academic credentials, there are more qualified researchers who have quantifiably evaluated the industry's impact beyond the marketplace. Here are two compelling pieces of evidence that measurably relate the story of marketing.

This graph is from an article written by Dr. Michael Steinmann from the University of California, San Francisco. A common refrain from physicians when asked how vulnerable they are to marketing is "I am too smart to be influenced." When the question asks them to judge their peers, the result is strikingly reversed - "I can't believe how much of that pharma propaganda my colleagues swallow?!" A simple point that is worthy of repetition is that reps have multiple sophisticated mechanisms to evaluate the effectiveness of their sales efforts. They are shrewd in their cost-benefit assessments and will unlikely retain a professional relationship with a client that fails to benefit their business to some extent. If a rep is in common contact with a physician, they are invariably an asset to the rep's business and the doctor is likely unaware of the influence marketing holds on their prescribing practices. It exposes a critical illusion that drug reps do their utmost to cultivate: "Marketing can't possibly sway you doctor. You have several years of training and education far in advance of my own. How can I possibly influence you?" The result is a level of cognitive dissonance so pervasive and profound as to cause a physician to rationalize unethical behavior. Sadly, it is a reminder of the anecdote statistic that 90% of physicians believe they graduated in the top half of their medical school class.



This second graph provides an interesting insight on how “medical education” has impact on a large scale. The red line represents the average use of a particular medication at several similar hospitals. The yellow line represents the prescription of 20 physicians at the hospital of interest. The green arrow shows the when the product was introduced to the hospitals formulary. You’ll notice that prescriptions at this institution were similar to the control group. However, at the blue arrow point, all 20 physicians received an all-expense paid invitation to a medical conference pertaining to the medication in question. Incidentally, this conference was held in a location renown for its contributions to higher learning - the Caribbean. Immediately following the acceptance to the invitation, one detects a marked rise in written prescriptions. Generally speaking, most physicians innocently want to accrue greater experience with the product they will soon be lectured on. From a marketing perspective, this is an expected phenomenon. The precipitous drop in prescriptions denoted by the red arrow does not represent any dissatisfaction with the product or a limit in supply. Instead, it is reflective of the physician’s inability to continue prescribing while ostensibly learning in the Caribbean. However, any losses in prescription are made up for with great enthusiasm upon returning from their medical conference and far exceed the average at similar medical centers. When one considers the duration of medication associated with each prescription (years to a lifetime) one can surmise that any expenditures accumulated from the trip are paid for by the subsequent month’s prescriptions. And while there in nothing inherently wrong with providing “medical education” or profit, the fact that 19 of the 20 physicians in this particular study felt that they were not influenced by such an experience and found their prescribing to be normative belies marketing’s ability to transform the prescribing culture of an entire community with scarcely little awareness of its members. Given the objectives of the sales force to both expand the market and expand market share, it is small wonder that these practices have raised alarms for bio-ethicists, physicians, health policy experts and public health researchers alike.