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The Changing World of MSLs: Determining Value

By **John Mack**

It's a new era for pharmaceutical company interaction with physicians. New guidelines and regulations from various governmental and non-governmental regulatory bodies have come into play during the past few years. The second event defining this new era was the withdrawal of Vioxx from the market in 2004 and the subsequent re-emergence of the importance of physicians as "learned intermediaries."

More than ever, it is important to educate physicians about new drugs and to keep this education separate from the marketing function of the company yet aligned with commercial goals.

The May 2006, **Pharma Marketing Roundtable** discussion was devoted to exploring issues surrounding the new roles of medical science liaisons (MSLs) and key opinion leader physicians (KOLs) in physician education and product marketing. Roundtable participants included:

- **Walter Bartus**, Sr. Program manager, Xchange
- **Michael Bishop**, Exec. Dir., Bus. Dev., InterAct Communications, LLC
- **Jane Chin**, President, Medical Science Liaison Institute LLC (Guest)
- **Vincent DeChellis**, Independent Consultant, NHHS
- **Neil Gray**, Managing Director, Healthcare Trends & Strategies, LLC
- **John Mack**, Pharma Marketing News (moderator)
- **Robert Nauman**, Principal, BioPharma Advisors

Role of MSLs

John Mack: MSLs play a pivotal role interfacing between pharmaceutical companies and the KOLs who influence how medicine is routinely practiced. Today's MSL navigates between the unbiased, evidence-driven world of hands-on patient care and the business imperatives of the company.

Perhaps we can start the discussion by looking at how the role of the MSL is changing.

Jane Chin: In the past couple of years, the role of the MSL has changed because of compliance issues and how pharmaceutical companies are trying to address these issues. Until recently, marketing and sales influenced the MSL role and held considerable power over MSL activities and even objectives by controlling research and educational budgets. Current regulations, however, have changed this and created a firewall with marketing and sales on one side and medical affairs on the other.

Perhaps, however, the pendulum has swung too far. There is evidence that regulations may be preventing members of these groups from talking to one another. This, I believe, has been a cause of great frustration for sales and marketing and for many MSLs as well. Although MSLs appreciate a structure that will allow them to safeguard the ethics and legality of certain practices, the firewall may have a side effect of impacting the cross-functional teamwork necessary for the resolution of some problems.

Problems Adapting to Change

Jane: A big change has been the shift of funding for continuing medical (CME) and research grants from marketing to medical affairs. I am not sure that most pharmaceutical company medical affairs departments are equipped to handle funding allocation. Until recently, the medical affairs function supported goals usually established by the commercial side of the business. While medical affairs personnel should make funding decisions without commercial influence, they also are asked to allocate funding and administrate the process.

Rob Nauman: I would agree with most of what Jane said. However, I would add that the lack of communication/coordination between medical affairs and commercial functions regarding the management of KOLs in the industry today actually is solely attributable to changes in regulations. It's been an area long neglected by both sides of the organization. The lack of discipline and specific processes in place to manage multiple contacts that exist in the industry today is pretty significant. Obviously, the industry is reacting to regulations

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and this is a challenge, but it has also suffered from a lack of focus on this issue.

There is more pressure on medical affairs people today, especially if they are involved in the clinical trials side of the organization as well and are asked to deliver results with these relationships and bring new products to market. Their workload has increased tremendously without a corresponding increase in human and financial resources.

Fear of Metrics

Neil Gray: The MSL function, while enormously needed, is rapidly becoming commoditized in terms of job descriptions, performance metrics, and tools used to build relationships. Companies are not genuinely demonstrating that their MSLs are distinctive from one another

There is a wide variety of metrics that could be applied to MSLs to determine if they are "producing" for the organization or creating value from an accounting perspective. MSLs, however, vehemently resist attempts to measure their work performance or setting and achieving goals. This resistance to measurement on the commercial side is curious given that clinical research is no stranger to the concept of measurement.

Jane: To understand why MSLs are so reluctant to be measured you have to understand their mindset, part of which says that anything being measured is usually sales or marketing related. There is the default mentality that says "If you are measuring me, then you must see me as a sales representative."

Today you have a lot of people recruited from academia into the MSL ranks and they are a little too sensitive, I think, about being perceived as part of a commercial entity. On the one hand, they want to keep themselves "pure." On the other hand, they accept a 6-figure salary that is justified only by bridging commercial and scientific objectives.

Neil: I'm convinced that the really value-based MSLs of the future will have a blended sensitivity to science and commercialization. Today, the overwhelming majority of MSLs view science as their primary focus and wish to keep selling and commercialization at arms length.

There will be market forces that will catalyze the type of change I envision and some businesses will implement new qualitative-focused metrics to demonstrate the value of MSLs.

Jane: Neil, can you explain more what you mean by MSLs becoming a "commodity."

MSL as Commodity

Neil: Right now pharmaceutical companies are very focused on making sure that MSLs use scientific data as the tool to generate strong relationships with KOLs and to interest them in participating in research. Consequently, if you look at job descriptions for MSL or clinical specialist types of positions on the top 10 pharma companies' career websites and from recruiters seeking to place MSLs, they are remarkably similar (see box). On a scale of 1 to 10, where 10 means they are all alike, I think we are at 8 right now.

Where the MSL function is going, however, is not based solely on the dissemination of clinical information to the field and not only focused on KOL relationship building. This segment of the industry is rapidly moving to become the resource integrator for the pharma industry—the true pathway into all the data assets of the company

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Typical MSL Job Description

[As seen on the Pfizer Web site]

Imagine a career that touches the lives of people everywhere. Imagine an opportunity to reach beyond your area of expertise to make an impact on something greater than the bottom line. Imagine playing a key role in some of the most critical issues facing healthcare today. This is your career at Pfizer – a career unlike any other.

Job Duties: The Regional Medical Research Specialist is responsible for providing clinical and research support for the therapeutic area in the region. The RMRS role is to enhance medical communication between Pfizer and therapeutic experts and researchers, support clinical and outcomes research development, facilitate research site selection and study placement, and assist with the support of both Pfizer sponsored and investigator initiated research activities. The RMRS will establish relationships with clinical and research leaders in the region including academicians, clinical physicians, medical directors, directors of pharmacy and other health care professionals. The RMRS will contribute to site selection, investigator meetings, and medical advisory panel discussions in accord with the therapeutic strategy established by headquarters Medical. The RMRS will also facilitate communication between regional clinical and research leaders and headquarters Medical and contribute to the development of brand medical strategies.

Qualifications: Doctoral degree in clinical specialty (M.D., Ph.D. PharmD) with 5 - 15 years of experience, including 2 - 7 years of experience in clinical and/or health services research (preferably in the pharmaceutical industry). Therapeutic area knowledge and experience in therapeutic area of cardiovascular. Experience in clinical or health services research and 3 - 5 years of experience in clinical practice will be considered. The title of this position may change due to the capability level.

whether they are clinical or pharmacoeconomic in nature. I think we are going to see the more innovative and groundbreaking companies seeking to evolve the MSL function through that pathway.

Sales Force of the Future?

Rob: What you seem to be describing is a way back to the early days in the 70s and 80s when, for example, a Lilly representative had to be a health care professional and the industry put much more effort into training reps clinically. That's no longer the case. The main challenge that pharmaceutical companies are facing today is a result of their tremendous expansion in which a bunch of reps were put into the field who were not well trained clinically and who may not have the skill set necessary to convey complex medical content.

Neil: Although I am reluctant to admit it, I remember those days where you had to have a pharmacy degree to be a representative at Lilly. Sales rep training seems to be uneven across the industry these days. Some companies still invest a lot of time and effort in broad and deep training sessions for reps while others are satisfied with a one-day, fly in and fly out session somewhere in the middle of the country. Sometimes cycles come around again.

Jane: There are some in the industry that believe that MSLs are the sales force of the future. I think that is pushing the pendulum to the wrong side (see Box). I think better trained sales representatives should be the sales force of the future!

I get countless email messages from prospective MSLs who will make up the MSL force of the future. And invariably these people tell me that they want to leave the bench or clinical practice but they don't want to go into sales. Because of this mentality from the pool of potential MSLs, you see this pushback on metrics and the aversion to even learning about the commercialization side of the business.

Focus on the Message

Rob: The current perception is that an MSL can better convey relevant clinical information to practitioners than an equally-qualified and degreed (eg, PharmD) sales rep. However, whether we are talking about MSLs or sales reps, the important point for the industry to understand is that they are rapidly losing their ability to credibly convey their own medical information.

Let's not forget that the industry is basically limited to talking about what's in the approved labeling, which is carefully crafted for the approval process rather than for educating physicians about the product. Consequently, over the past few years, from a medical information perspective, the industry has painted itself into a corner with its inordinate focus on legal and regulatory challenges.

The MSL-KOL Relationship

Neil: The MSL function will be needed to deliver things other than clinical and scientific data. MSLs will need to integrate all the resources and assets and be the focal point for solving KOL problems that go far beyond what's new in phase I and phase II research and signing up KOLs for clinical trials.

KOLs have needs such as obligations and responsibil-ities to the societies and the academic institutions to which they belong. If the industry positions MSLs to focus exclusively on forming relationships with KOLs on the basis of dissemination of clinical data, it will miss the opportunity to differ-entiate one MSL from another. This lack of differ-entiation is one reason why the job of the MSL—especially access to KOLs—is becoming so challenging.

KOLs, with their other commit-ments (academic, societal, publishing) and their support staff, do not make it easy for MSLs to connect with them. Add-itionally, as the MSL function moves towards commoditization, numerous MSLs compete with one another for dwindling KOL time. How to create and strengthen MSL differen-tiation will be one of the more fundamental stra-tegies of the next several years.

Glorified Sales Reps?

"Medical science liaisons are not incentivized by sales goals, but current trends cause many to wonder if MSLs are supplanting today's representatives and becoming the 'sales force of the future,'" wrote Jane Chin in a Pharmaceutical Representative article. "While industry experts debate the sales force arms race," Chin said, "some companies have begun deploying MSLs to compensate for the effects of inadequate clinical training programs for representatives. ...many companies are now ramping up liaison teams and imposing reach-and-frequency requirements for MSLs. ...Blurring of thought leader 'segments' visited by sales reps and medical liaisons has led some MSLs to see their role as that of 'glorified sales representatives' and, worse, 'off-label sales representatives.'"

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Commentary

Give Docs What They Want

By **John Mack**

Abstracted from a post to Pharma Marketing Blog made on Monday, March 21, 2005
See http://pharmamkting.blogspot.com/2005/03/give-docs-what-they-want.html

Last week I attended a pharmaceutical industry conference focused on the problem of physician access or lack thereof by sales representatives. I heard a lot of advice from consultants as well as from physicians about how pharmaceutical companies need to change the number and kind of interactions between sales reps and physicians.

Physicians in a keynote panel at that meeting emphasized that they value a rep's product knowledge over the relationship with the rep. The panel moderator also cited a new, unpublished study that supported this preference (when asked "What do you like about sales reps?" respondents cited product knowledge first, relationship second, and samples third).

What the docs want are pharma representatives that keep them informed, protect them from prescribing the wrong drug, talk to them without regulatory constraints, and keep them stocked with samples. O yeah, they also wanted someone who talks like they do. In other words, they want another health professional and not a sales person at all! I've heard the same from other doctors at other industry meetings (see, for example, "A Crisis in Professional Detailing").

What if pharmaceutical companies actually listened to these physicians? Instead of talking about gaining "physician access" for sales reps, pharmaceutical companies might provide more access to the kind of representative physicians seem to want—the medical science liaison or MSL. Except let's drop the liaison part and just call them medical science representatives.

Today, MSLs play, at best, second fiddle to the sales reps. That situation should, IMHO, be turned on its head. The MSL should be the primary contact and call in the rep when the physician asks for samples. After all, sample delivery is the primary reason sales reps gain access to physicians anyway.

I think this idea could also save pharmaceutical companies money. A lot fewer MSLs would be needed than the current number of reps. Docs would be more eager to see MSLs and not make them wait in the office or turn them away. Less time would be spent on unproductive calls and each MSL could service many more docs than a sales rep. The sales rep's time would also be better managed because the docs would request their visit for the samples. At that time, the rep can still make the pitch without having to explain the value of the product—the MSL would have already done that.

Comments by Jane Chin:

Interesting commentary. While I agree with you that MSLs are currently more welcomed by physicians than compared with reps, I disagree that this model should take off. This is because MSLs serve a very different "client base" than sales reps do, and both are essential for the competitive advantage of a company. MSLs focus mostly on physicians who are involved in medical innovation and not necessarily high prescribers, while reps are able to target the community based specialists and primary care physicians who make decisions altogether differently than an academic-based research investigator makes decisions.

Would it be more efficient for a MSL to call on "everyone" including the primary care docs? Sure. Will this efficiency translate to effective use of the MSL's time and training? I'm not so sure. Would MSLs love to no longer play second fiddle to sales reps? Of course. But in order for this to happen, senior management would want to see MSL programs demonstrate more objective metrics. Some executives still believe in market share and sales dollars to measure MSL program ROI, albeit they would not admit so publicly, and MSLs themselves would not buy into this.

Since the industry is so heavily regulated by "perception," the perception that MSLs are separate and distinct from reps will be aggressively preserved by companies, at least at face value.

Vince DeChellis: There are only so many physicians that qualify as KOLs that a company can contract with legally without crossing the line into promotion. That's really going to limit the number of MSLs needed to support these relationships.

Jane: Technically, the KOLs working with MSLs should be distinct from those visited by sales representatives. With specialist representatives—who sometimes have medical qualifications similar to MSLs and would interact with a similar set of KOLs—you have to ask where the distinction is and how to segment the roles.

Vince: We shouldn't confuse the role of MSLs with the question regarding the evolution of sales in terms of the message, how it's delivered, and who is called on. We may be moving to more of a scientific and clinical approach to delivering sales messages, with less emphasis on the story and hype that goes with it, but with regard to the physicians targeted, the MSL deals with a completely different group of physicians.

Changing Influence Geometry

Neil: The influence geometry, relevant to KOLs, has also changed. Historically, it's been pretty much a triangular or pyramidic relationship with the thought leaders at the apex and their points of view permeating downhill to influence the national leaders who influence the regional leaders who influence the local leaders and so on (see Figure 1, pg. 6). With the advent of eLearning and e-mail this geometry of influence has changed to a circle (see Figure 2, pg. 6).

With the advent of electronic communications and information transfer, the new model of influence is not as much power based (and pyramid-like) as it was, but is now built upon knowledge, speed, and currency of information, which flows in a twinkling. It is easier now for local, regional, and national influencers to readily share information with global influencers and among themselves. Learning becomes much more circular (and faster) among groups. And that may very much affect MSL activities. In fact, it should begin to reshape their roles and goals.

Coordination and Culture

Neil: In a lot of instances, MSLs do not feel recognized, appreciated or understood by their own organization. That also is a consequence of the commodization I see happening. Pharma needs to address the internal cultural issues involved so that their organizations can better understand and appreciate the roles and goals of MSLs. Only then will this resource be used more fully.

Rob: As I see it, those companies without a good MSL culture also exhibit a total lack of discipline in how they manage their KOL relationships. "Loose and fast" is a term that characterizes this lack of discipline or well thought out approach. What's needed is a coordinated effort to manage the whole KOL effort rather than a fragmented approach. The chief compliance officer, who oversees all of the company's business compliance issues, may have a role to play here.

Vince: I would agree. Compliance officers are looking at where the liability is and are trying to shore up the loose requirements to more clearly define appropriate roles for MSLs versus sales reps. One needs to differentiate one from the other and make their respective roles clear within the organization. In my experience, the people responsible for MSLs were working within a silo that wasn't really aligned with the rest of the organization. They had their own perspective and they worked unencumbered from the rest of the organization.

Neil: Compliance with regulations and guidelines, however, may be responsible for isolating MSLs into the niche they are in. MSLs, more than ever, fear working too closely with sales and marketing precisely because of compliance issues. This further limits their roles in the organization.

Jane: Some MSLs actually welcome how much more siloed they are behind firewalls because they believe now they can disseminate clinical information appropriately.

Rob: I'm curious why that couldn't happen before. They've always had that ability to provide appropriate information, but now they are more worried than ever about it being tarnished or tainted in some way. I just don't get why they feel that way.

The Off-Label Promotion Factor

Jane: Perceptions may have changed due to the Neurontin and other off-label cases we've seen recently. Some medical affairs people may see themselves used by the company to make off-label sales.

MSL programs expanded in the 90s because there was a misconception that hiring doctorate-level MSLs makes their contact with clinicians automatically scientific exchange, not promotion. A lot of that misconception has cleared up, but MSLs worry that if they work closely with sales and marketing, they will be pressured to solicit and disseminate off-label information, which is essentially off-label promotion. Metrics on off-label and KOL prescribing is part of the pressure MSLs

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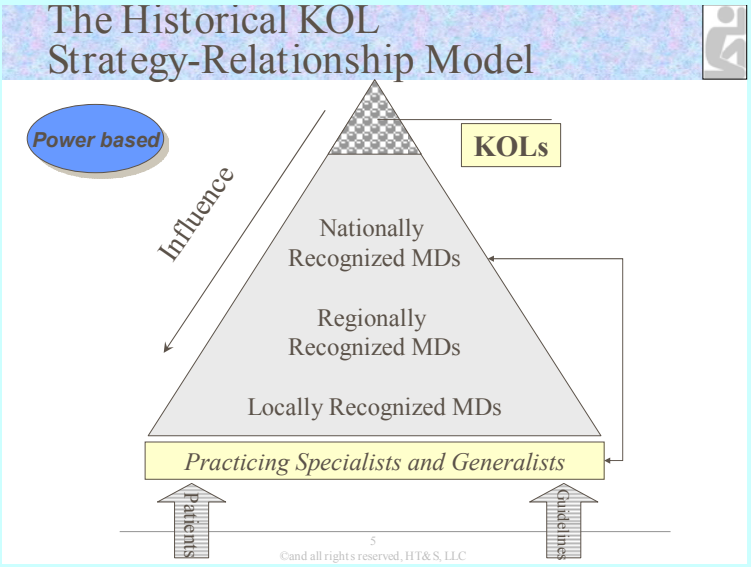

Figure 1: Changing KOL Influence Geometry. The classic Pyramid of Influence is a power-based model, in which most key opinion leaders sit atop the pyramid by dint of their organizational (sometimes academic) position and strength. They are usually perceived to be worldwide influencers who do the most research and writing, and in turn, influence national, regional, and local clinical leaders. In this model, their influence runs downhill and in many instances, it is still how MSLs perceive the KOLs with whom they need to cultivate relationships. Primary care physicians, patients, and clinical guidelines are bottom-up treatment influencers, but less so than the KOLs and their top-down influence.

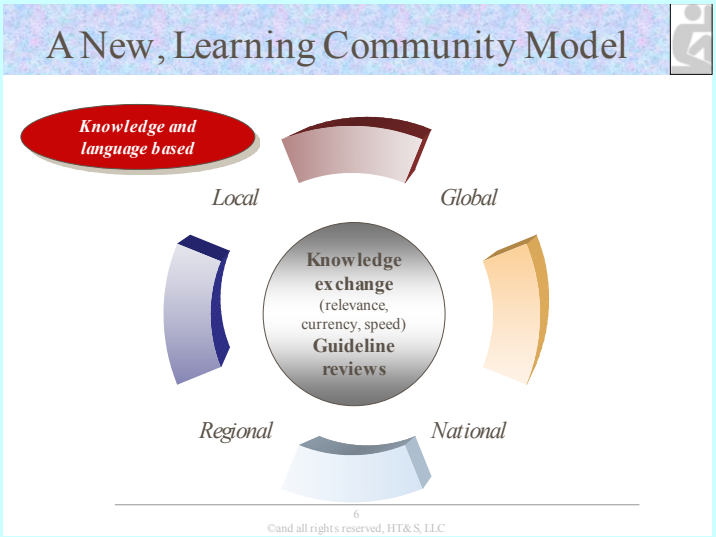

Figure 2: A New, Learning Community Model. With the advent of electronic communications and information transfer, the new model of influence is not as much power based (and pyramid-like) as it was, but is now built upon knowledge, speed, and currency of information, which flows in a twinkling. It is easier now for local, regional, and national influencers to readily share information with global influencers and among themselves. Learning becomes much more circular (and faster) among groups. And that may very much affect MSL activities. In fact, it should begin to reshape their roles and goals.)

feel and explains their wariness of performance metrics in general.

Rob: I personally am not aware of programs that are actually looking at those kinds of metrics.

Jane: There *are* programs, but no company is going to go public about it. There are consultants that advocate, for example, measuring KOL prescriptions as an indicator of MSL performance. Some companies look at overall prescriptions and compare territories with MSLs to those without. They are looking at total market share, which includes off-label prescriptions. When MSLs get wind of this, it confirms to them that they are being used as off-label promoters. I think, however, that their refusal to communicate at all with sales and marketing is being hyper-vigilant.

Vince: One hopes that most companies are not collecting that kind of data to measure MSL effectiveness. Many of the conservative, compliant companies I know would be shocked to learn of that practice. It's a recipe for trouble.

Rob: I was thinking of the satisfaction-type metrics for measuring MSL performance and value. This is not directly related to quantitative, revenue-related data.

Last Thoughts

Wally Bartus: I come at this from a different industry perspective. What I am hearing is the distaste from the technical side—ie, MSLs—about being anywhere near the sales function. I've seen this not just in pharma but in many other industries. There's a Dilbert comic out every other day about how engineers are as pure as the driven snow compared to salespeople. That's a common construct.

Metrics are key. The old Druckerism "You can't manage what you don't measure" flies in the face of MSLs' reluctance to be measured on any basis. If their performance cannot be measured even indirectly, what is their value to the organization? That is a core question upper management should be asking.

Neil: In business, the reality is that everyone gets measured somehow. In terms of MSLs, my research shows that managers look at the quality of relationships with KOLs, how many activities have they involved KOLs in, ease of access, etc. I must say, however, that the whole issue of measurement related to MSL performance is like wrestling with Jello.

Michael Bishop: I believe the organization status of MSLs should be viewed as staff positions and absolutely not related to sales functions! As a staff position there are many ways to measure their performance other than by increases in Rx volume or sales and certainly not by increases in off-label prescribing. You can look at the frequency and content of correspondence with KOLs, number of presentations/appointments and expansion of the KOLs on which they call, etc. to gauge their effectiveness.

Neil: I would suggest that going forward, MSL performance should be measured by how well and how often they connect their KOLs with other parts of the company to help KOLs solve problems whether these are clinical-based problems or business problems.

Vince: Given that a high value is placed on a physician's time, a key metric should be the time MSLs spend with their KOLs. If the MSL can connect KOLs with other components within the company that time spent with the KOL is as good a metric as any.

Rob: It's really about the customer. The industry has lost its way. At the end of the day, successful MSLs establish a customer-based relationship that is built on trust and value, which is based on providing relevant medical information. Marketers as well as senior executives of pharma companies today are so focused on building brands they have lost their way in terms of what the business is about—patients. You hear this also from the medical professionals who are filling the MSL roles in pharma. These people are very patient centric, they have grown up that way through their training.

Pharma Marketing News

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