

## Getting to Yes: Corporate Power and the Creation of a Psychopharmaceutical Blockbuster

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Published online: 27 February 2009  
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**Abstract** In this paper, I analyze documentary evidence from a pharmaceutical company's strategic marketing campaign to expand the sale of an antipsychotic medication beyond its conventional market. I focus on the role of the managerial function known as channel marketing, the task of which is to minimize friction, achieve coordination and add value in the distribution of the company's products. However, the path to achieving these objectives is challenged because members of the marketing channel, or intermediaries, may not be contractual members of the channel; in fact they may have widely divergent goals or may even be hostile to the manufacturer's efforts at control. This can be construed to be the case for physicians and others who are in the pharmaceutical manufacturer's distribution channel but not of it. Their views and actions must somehow be brought into alignment with the manufacturer's goals. This paper seeks to show part of the process from the manufacturer's strategic standpoint, in which potential dissenters are incorporated into the pharmaceutical company distribution channel. The routinization of this incorporation results in the diminishment of psychiatry's professional autonomy by means of what is—paradoxically to them, but not to a student of marketing—a competitive threat. The paper concludes with a discussion of corporate power.

**Keywords** Pharmaceutical marketing · Corporate power

The greatest of human powers is that which is compounded of the powers of most men, united by consent, in one person, natural or civil, that has the use of all their powers depending on his will; such is the power of a Commonwealth.  
—Thomas Hobbes (1998:Chap. X)

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How, then, can a ‘channel captain’ implement the optimal channel design in the face of interdependence among channel partners, not all of whom have the incentive to cooperate in the performance of their designated channel flows? The answer lies in the possession and use of channel power.

—Coughlan and Stern (2001:259)

As the normative framework for how people interface with health-care services has shifted from that of patient to that of consumer, the agency of each member of the chain from pharmaceutical/insurer/health industry actors to health-care givers and then to individual recipients of service has been transformed. The debates surrounding this conversion for end users and providers are complex, and it is not my purpose to explore them in this article (see, e.g., Faunce 2007; Mol 2008). For the pharmaceutical industry, however, the consumer paradigm for health-care utilization authorizes an unambiguous call to action: consumers have unmet needs to be determined by (and sold to by) means of the tools of marketing. How marketers discover “unmet needs” that they subsequently “sell to” consumers is an intricate procedure that will be partly evinced in the case material below (see Applbaum (2003) and Healy (2008) for more inclusive discussions).

We can begin with a more basic challenge facing prescription pharmaceutical marketers, namely, “Who is the consumer?” This question is less straightforward than it might seem. Before one can reach the end user of a drug, one must penetrate a mesh of other choice-makers. These typically include prescribing physicians, hospitals, payers (insurers, Medicare/Medicaid, private prescription benefit providers, etc.), pharmacists and, in some cases, those who surround and influence the end user, such as case workers and family members. An article in the *Market Leader* explains:

The customer landscape for pharmaceutical companies is complex. Consider how medication is prescribed. Unlike most markets where consumers make their own brand choice and purchase decision, patients (end-consumers) pass their brand choice to a qualified healthcare professional, who diagnoses the condition and writes a prescription for a drug. The act of handing over the decision to external parties (co-dependent choice) is a defining characteristic of the pharmaceutical industry.... In the pharmaceutical industry, there is still further complexity. A doctor’s choice of medication depends not only on his or her knowledge of the range of available treatments, but also on prescription guidelines developed by the healthcare authorities. These guidelines shortlist recommended drugs suitable for treatment of conditions and are aimed at controlling the cost of healthcare. (Cleland et al. 2004:51)

As we will see, the above list of “codependent choice makers” are marketed to *as* consumers, with all that implies in terms of sales and marketing practices. However, insofar as all these are conduits to the end user, their roles must equally be described as intermediaries or, in marketing terms, “members of the distribution channel” for the product. If marketers typically seek to persuade consumers with communicational instruments such as brands, advertisements and sales pitches, distribution channel members are subject to the exercise of what marketing theorists call

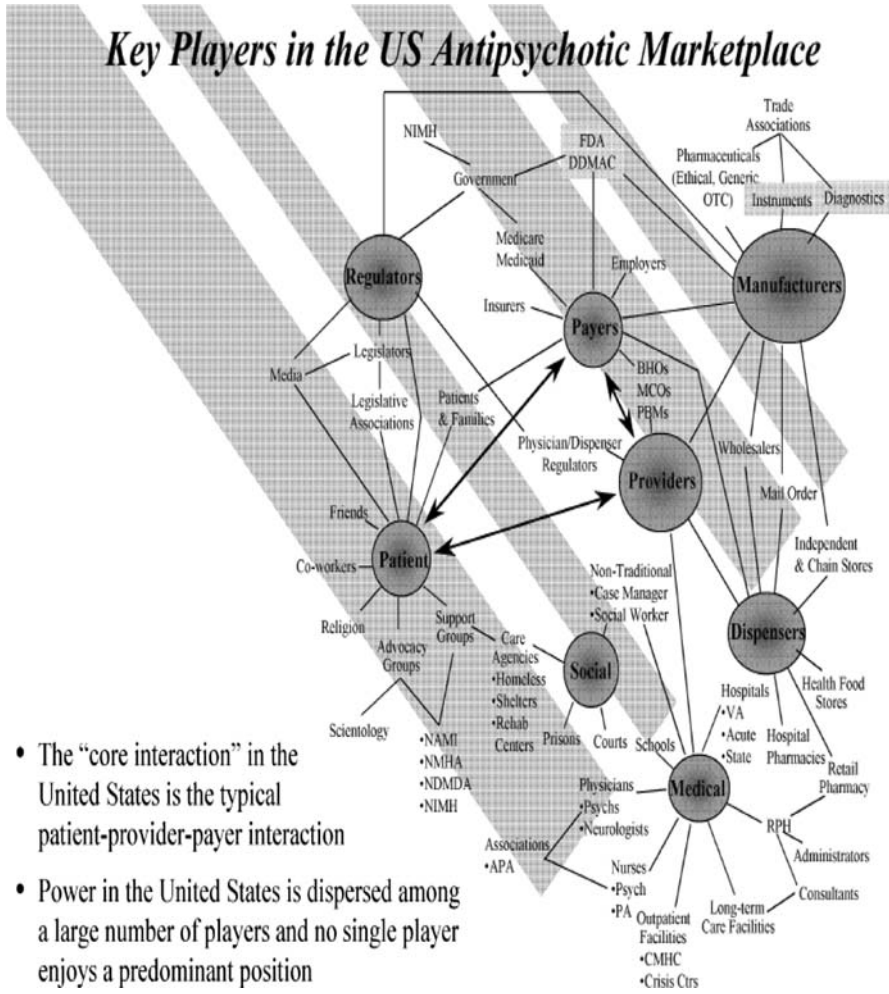
“channel power.” This power may be friendly, consisting of incentives and emoluments to trade. However, in the case of pharmaceutical channels, the power exercised is more often agonistic, even while it is never “hard” or threatening.

The inevitability of this logic can be understood from the context of pharmaceutical distribution itself. In most industries, distribution channel members are contractual partners in the trade. In the case of prescription pharmaceuticals, physicians, payers, etc., may be unavoidable members in the distribution channel between the manufacturer and the end user, but they are mostly not contractual members *of* the channel. Indeed, these actors may have widely divergent stakes and goals or may even be hostile to the manufacturer’s efforts at control. Each group of intermediaries has a compelling and distinct investment in organizing its activities in accordance with profession- or group-specific criteria. Management theorists refer to this situation of divergent purposes as “goal conflict.” The means to resolving goal conflict, as suggested in the second epigram above, may be the employment of power, persuasive or coercive, by the “channel captain,” which refers simply to the most dominant participant in the chain. The goal is channel coordination, as the same authors specify. “When the disparate members of the channel are brought together to advance the goals of the channel, rather than their own independent (and likely conflicting) goals, the channel is said to be coordinated.... Coordination is the end goal of the entire channel management process” (Coughlan and Stern 2001:261).

While textbook treatments of channel conflict typically stress the pecuniary interests of the various channel members, to be resolved either by financial threat by or mollification (“motivational programs”), the practical requirements of coordination often go much beyond economics. Coordination campaigns often entail bringing the moral and perceptual dimensions of the various actors into alignment. This may be particularly characteristic of international channel marketing because there one encounters what marketers call “cultural obstacles” (Applbaum 2000a). The example I bring here is mainly domestic in the United States, but is still ideal for demonstrating the procedure of seeking moral-cultural alignment so that passage can occur. The cultural obstacle, in this case, is the barrier dividing conventions in medical research and practice with marketing objectives.

In this sense, the combined consumers/intermediaries en route to the end user are, and are perceived to be, *gatekeepers*. The strategic goal becomes how to convert them from potential obstacles to compliant facilitators. The word gatekeeper calls to mind the prospect that it is not just doctors, hospital formulary-makers and insurers who are targets of marketing action, but regulatory agencies such as the FDA, treatment guideline commissions and patient advocacy groups such as NAMI (National Association for the Mentally Ill). Indeed, it is a matter of record that this is so (see, e.g., Healy 2006a), although it has only been in instances of manifest violation, when the strategic records of a marketing campaign are brought to light, that this dark interpretation has been brought to bear.

An advance peek from one of the cases discussed below illustrates the point about consumer/intermediary/gatekeeper. (This and the other Zyprexa-related documents cited in this paper were downloaded from public files made available during an extended lawsuit against Lilly (see Appendix). Figure 1 shows a network



**Fig. 1** Key players in the U.S. antipsychotic marketplace

map of “key players” in the U.S. antipsychotic market used by Eli Lilly & Co. in their marketing program for their antipsychotic medication, Zyprexa. The key players map identifies the people who are in or who influence the marketing channel for the drug. Each needs to be influenced and brought into conformity. A separate 74-page document is called the “key player play book.” The booklet details the segmentation and marketing program for each player, several of which are carried out by the substantial “business-government division” of the company.<sup>1</sup>

<sup>1</sup> Eli Lilly Document: “Key Player Playbook.” Available at: <http://www.furiouseasons.com/zyprexa%20documents/ZY100174816.pdf>. Accessed December 14, 2007.

The Zyprexa case is typical of contemporary pharmaceutical marketing. I therefore cast my analysis not in terms of violations, but in terms of normative marketing channel management and a cultural theory of corporate power. In the absence of a systematic investigation of pharmaceutical marketing initiatives along commercial and cultural dimensions, we will fail to comprehend contemporary market forces in health care.

There are few who would underestimate the pervasiveness of these forces—whether perceived as inimical or salubrious. The predominant role of pharmaceuticals in combination with the privatization of health-care policy is signaled by the term “pharmaceuticalization” (Biehl 2007), although the attempt to render that concept as a verb instead of a noun, or a transitive verb instead of an intransitive one, is less thought of. Appending the word “strategic” to pharmaceuticalization, or indeed to medicalization, suggests the direction of such an enterprise. *Strategic medicalization* would refer to that aspect of medicalization that occurs specifically as a result and by means of the strategic intent to expand the commercial sphere of pharmaceuticals and other medical products (see also Conrad 2005). On one level, this “intent” is unremarkable, for it is always in the nature of firms to broaden and deepen the commercial domain of their products. In the current environment, however, in which medicalization has been harnessed to some of the most powerful engines of capitalist commercialization and expansion in history, it behooves us to study more intensely the nature of this strategic intent.

There is another reason why regarding the case below and others like it as an instance of mere ethical or legal violation does not suffice. The making of a blockbuster drug entails a myriad of procedures, a virtual imponderabilia of complex assignments that could hardly be effected without billion-dollar budgets and coordinated strategy plans. However, even these would not suffice, for it cannot be by dint only of financial might and strategic intent that empires in the scale of tens of billions of dollars can so quickly materialize around a single pill. The gatekeeper entities identified in the “key players map” (Fig. 1) are immense and powerful. Even the propaganda arm of the mightiest drug company—even of the combined forces of the industry under the leadership of PhRMA<sup>2</sup>—cannot subdue all the field of players to its will. It is in this connection that I cited Hobbes above, to foreshadow my conclusion that, like the power of the Commonwealth that Hobbes described, corporate power succeeds because it is able to draw in the energy, willingness and participation of those who would be both the instruments and the victims of that power.

Thus I begin by focusing not on the weak or strong impact of marketing, so as to try to measure the power behind its strategies and tactics, but on how the context of its professional practice corresponds to a specific iteration of power. I propose to theorize marketing power as distinct from the coercive or oppositional power that informs most anthropological analyses. The term I use to describe corporate power comes from their own lexicon: synergistic power. Synergy is the means by which

<sup>2</sup> Pharmaceuticals Research and Manufacturers of America, an industry trade group whose mission it is “to conduct effective advocacy for public policies that encourage discovery of important new medicines for patients by pharmaceutical/biotechnology research companies” (<http://www.phrma.org/>), especially abroad (Applbaum 2006a).

firms seek to synthesize “a whole that multiplies the value of the parts” (Kanter 1989).<sup>3</sup>

To begin an investigation into synergistic power and how it functions, we may note the specific challenges facing the corporation for which this form of power evolved as a solution. The central conundrum of marketing in general is how to marry the industrial requirement to sell with the challenge of placing the product advantageously before the consumer. How does a corporation seek to orchestrate concord at the contact points between supply and demand when members of the marketing channel, or intermediaries, are not usually owned or directly controlled by the manufacturer?

This paper analyzes the strategies Eli Lilly & Co employed in its highly successful campaign to expand the sale of its antipsychotic medication, Zyprexa, beyond its conventional market and, in so doing, create a pharmaceutical blockbuster. I focus on the movement of an antipsychotic medication as it traverses several intermediaries in a distribution channel, with some emphasis on physicians, whose cooperation is necessary to the circulation of the drugs.

### How a Psychoactive Drug Goes to Market

Our case begins with the expiry of Eli Lilly & Co.’s patent for their best-selling drug Prozac (fluoxetine) in 2001. In the 1990s, Lilly’s SSRI (selective serotonin reuptake inhibitor) antidepressant had achieved distinction as the best-selling drug in history. By 2001, other companies had equaled and even surpassed Lilly’s success with Prozac. Their products—Paxil, Zoloft, Celexa and a couple of others—together grew and dominated a US\$9 billion SSRI market. All the SSRIs were but chemical variants on Prozac, distinguishable from it mainly by the marketing strategies that catapulted them into blockbusterhood rather than by their pharmacological properties or distinctive efficacy (Healy 2007). They were, in marketing lingo, “me-too products.” Because of the type of product and market, the entire posse of competitors relied more on marketing strategies for value creation/demonstration than on scientific product differentiation. Although their brand names were well known, by 2001 the drugs were, on one level, interchangeable; patients responded better to one or the other, but not based on brand. If anything specific was marketed to the public, it was the diseases rather than the branded drugs (Healy 2003; Parry 2003; Lane 2007). This contributed to their vulnerability to generic substitute at patent expiry.

<sup>3</sup> So as to avert possible confusion on this point, I use managers’ professional lexicon in the same way and for the same reason that ethnographers usually use “native” key terms and cultural categories: to cut close to the bone of the native’s view of the world. I regard synergy, for instance, to be a key strategic cultural term (strategic in that its influence is prescriptive and vectorial), and my purpose is simultaneously to explain and, in a sense, respect it as a motivating cultural idiom at the same time that I wish to leverage that understanding for purposes of “ironizing” or objectifying it as a folk category and element of the managerial theory of practice. This procedure is not exceptional except that, contrary to usual ethnographic practice, I am forced to use words that “we” share in common with them and that are not foreign field terms in no danger of being confused with our own everyday usage.

Prozac came first. As a result of a court proceeding initiated by Barr Laboratories, the patent expired two years earlier than Lilly had anticipated. Within two weeks of the introduction of generic versions of Prozac, Eli Lilly lost 73% of its market share (Tuttle et al. 2004). When I visited Lilly headquarters in Indianapolis several months later, in connection with a different line of research, all conversational roads led to the frightful prospects of life after Prozac. They were traumatized, and it was not entirely in jest that one manager told me that, at least in Indianapolis, Prozac sales were booming. In 2000, a quarter of the company's revenues rested on the one drug (down from one-third in 1997), and a replacement blockbuster that would be "better than Prozac" was not yet secure on the horizon.

Technically speaking, in the fall of 2001, this was not entirely accurate. Anticipating Prozac's decline, the company had already, in 1998, formed what was known as the New Antidepressant Team (NAT), under the direction of a psychiatrist and a marketing strategy expert. According to a business case reviewing Lilly's strategy, several possible successors to Prozac were considered. What seems to have characterized these deliberations more than earlier drug development forays was the oversight responsibility given to marketing managers. A new division was created at the company to oversee the "combined R&D and marketing endeavor." The business case cites the director of New Product Planning (NPP):

Though basic science will always be the engine of medical discovery, drugs often fail to achieve commercial success because their market potential had not been assessed properly or because specific indications critical to satisfying unmet patient needs were not built into the drug or were not tested for. That's where the New Product Planning division comes in. First and foremost, NPP seeks to uncover patient needs, either directly or through the eyes of physicians. It is also charged with understanding how well competitive offerings are perceived as satisfying the diverse set of patient needs. (Ofek 2007:11)

The question became not so much what kind of drug could be developed in the laboratory, but which compound already sitting on the shelf could be retested for symptoms, syndromes or disorders so as to fit a profitable niche in the psychopharmaceutical market. The low bar for efficacy over placebo or comparator agents set by the FDA (Healy 2007) would have encouraged this strategy as well. The drug development process itself had thus become not marketing *supported*, but marketing *driven*. The reallocation of priority to marketing at Eli Lilly & Co. corresponded with the shift that was taking place in the entire pharmaceutical industry, in which marketing and R&D were being strategically combined and spending on marketing activities outstripped spending on R&D (Barry 2000; Gagnon and Lexchin 2008).

### Marketing Lessons from Prozac

The single greatest marketing idea that helped bring Prozac its success was educating family or primary care physicians (PCPs) to the symptoms of depression and inspiring in them the confidence to bypass psychiatrists in writing prescriptions

for the antidepressant. The apparently low side-effect profile of Prozac, compared with the earlier generation of antidepressants, and its nonlethality in the event of overdose, helped allay PCPs' reluctance. In the language of marketing channels, PCPs were middlemen with far wider market access than psychiatrists, because there are many more of them and because patients generally reached psychiatrists by referral. Marketing copy on Prozac also began to create a distinction between major depressive disorder (MDD) and milder forms, which, they suggested, were particularly amenable to treatment with Prozac and which PCPs would be less apprehensive to treat.

A business case describes some of the prelaunch strategies for reaching the PCPs:

With the help of leading psychiatrists... [Lilly] established an extensive educational program (the 'Psychiatrists Experience Program') that started about a year prior to Prozac's launch.... Lilly hired leading psychiatrists to share their knowledge about Prozac at primary care conferences, symposia and medical meetings. (Eaton and Xu 2005)

This may have been the start of enlisting psychiatrists inside the firm and out for their marketing insight into peer prescribing attitudes and their power as opinion leaders. Other channel members Lilly convinced, with the help of psychiatrist experts in their employ, included insurers, who had to cover the cost of the drug, formulary committees at hospitals, the powerful patient advocacy group NAMI and the National Institute for Mental Health (NIMH), which distributed information about depression and its treatment to the public.<sup>4</sup>

Competitors' entry into the market coincided with relaxed FDA guidelines vis-à-vis direct-to-consumer advertising of pharmaceuticals. Lilly exploited the direct-to-consumer channel, taking their case directly to the public and thereby circumventing doctors as the first line of information about depression and its treatment. The public was taught that depression results from low serotonin in the brain, a condition straightforwardly rectified by a little green and white capsule (Lacasse and Leo 2005). By 1994, *Newsweek* could say, "Prozac has attained the familiarity of Kleenex and the social status of spring water" (Cowley 1994).

### No Pain, No Gain: The New Antidepressant Team and Cymbalta

When Prozac went off patent, duloxetine was one among several candidates for its replacement. Brand named Cymbalta, the drug was a serotonin and norepinephrine receptor inhibitor (SNRI) that had originally been developed for the major depression market. In 1993, it failed to prove efficacy at the doses tested and was not approved by the FDA. Five years later, when the NAT was casting about for

<sup>4</sup> It is important to interject here that I am not judging all marketing efforts as reprehensible or unwholesome. The campaign to sensitize PCPs to depression combined with what must be regarded as a salutary, if interested, antistigma program resulted in the treatment of millions of people who had previously suffered from a debilitating, underdiagnosed and sometimes fatal disease. However, it is crux to any understanding of the contemporary state of affairs that, while pharmaceutical companies may be in the business of creating medicines that cure sickness, when good business and good medicine find themselves in competition, as quite often occurs, business takes precedence (see Applbaum 2009).



possibilities, Cymbalta came under their radar for a different possible application than for depression, or rather, than for depression alone, since treatment of depression remained a requirement for their consideration.

A neuropharmacologist at the company had made note of suspected pain-relieving properties of duloxetine. One of the NAT members, and former brand manager for Prozac, reportedly connected this to a study he remembered seeing by a physician at nearby Indiana University linking depression and pain. Depressed patients often complained of physical pain. Physical pain and depression could be considered comorbid phenomena. Comorbidity refers to the simultaneous diagnosis of more than one disorder in an individual as, for instance, in the oft-diagnosed combination of major depression and panic disorder, or schizophrenia and dysthymic disorder. The marketing department followed up with a plan in which the “patient need to be met” that would provide competitive uniqueness (and drug approval) was the treatment of comorbid pain symptoms associated with depression.

The Cymbalta case demonstrates two marketing principles that are full-blown in the Zyprexa case, for which there is internal documentary evidence. The first principle is that doctors, as members of the distribution channel, need to have their requirements accounted for as surely as patients do. For Cymbalta, as for many pharmaceutical products, market research and segmentation showed doctors and patients to have nonidentical demands of the drugs. Since the medication could reach patients only by way of prescription, the doctor’s requirements had to be met first.

Market research determined that for physicians the avoidance of side effects was nearly three times as important as efficacy, and five times as important as the safety of the drugs (Ofek 2007). Patient needs were examined also, but “through the eyes of physicians.” In other words, patient segmentation meant involving physicians in a marketing-eye view of the target population. They were offered company-fabricated profiles of ideal typical patients who would be candidates for treatment with Cymbalta: “Functioning Fran,” “Addicted Denise,” “Complex Carl,” “Anxious Anne,” “Hurting Helen,” “Classic Carol” and “Nonresponding Nancy.” The typology was organized according to segment size, demographics (gender, age), treatment history and what is known to market researchers as psychographics. Thus Hurting Helen was “more likely to be overweight and female, somewhat difficult to treat, lower expectations on outcome, and consume more than average healthcare resources.” Complex Carl had “suspected poor compliance, and [was] more likely to have comorbid psychotic features, bipolar or borderline personality.” Later these character types, minus the segmentation key but featuring photographs of professional models wearing pained expressions, would be used in sales presentations to doctors.

When a consumer buys a desired product at an acceptable price, then all parties to the exchange are said to “win.” The procedures for stimulating consumer demand make up the art and science of marketing, and need no review for either blame or praise here. However, when one reads into the Cymbalta case, as we will also in the Zyprexa case materials, how physicians were being segmented *as consumers* en route to bringing them volitionally into the distribution channel, the nature of the company’s persuasion mechanism becomes newly apparent. We are

stimulated also to wondering how this might alter our general understanding of power relations between producers and consumers.

The second principle from the Cymbalta case is the manipulation of the prevalence of comorbidities to fit commercial requirements. Comorbidity is extremely common in psychiatry; in fact it is considered “the rule rather than the exception,” according to First (2005), who goes on to say, “It is important to understand that comorbidity in psychiatry does not imply the presence of multiple diseases or dysfunctions but rather reflects our current inability to apply Occam’s razor (i.e., a single diagnosis to account for all symptoms).”

Where the drug trade is concerned, comorbidity represents market opportunity. Why? Because if a drug can be marketed for a variety of disorders at the same time, it will sell to many more people. As the trade journal *Pharmaceutical Executive* recommends:

One of the most familiar, and favored, tactics in product lifecycle management is expanding the uses of the product.... Indication expansion is tried and tested in the psychotropic field, *where diagnostic distinctions can be blurred* and a drug initially promoted as an antidepressant may later find a niche in, for example, bipolar disorders. (Hisey 2004; emphasis added)

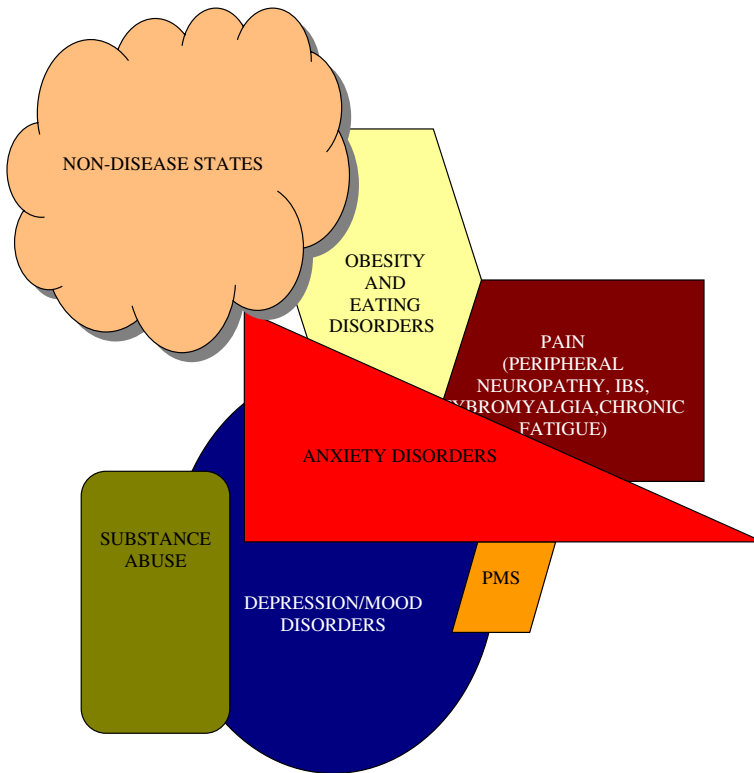
I believe that the author of the above sentence intended the verb “blurred” to be transitive. Table 1 is a list of indications approved for use by the FDA for the top three SSRIs.

Prescriptions for further indications or for populations not FDA approved, such as for irritable bowel syndrome or pediatric depression, are called “off-label” prescribing. This is legal activity for doctors, however, drug companies are not permitted to market for off-label use. As the Zyprexa documents demonstrate, they frequently do.

The only limiting factor is competition. The competitive field is conceived and divided according to therapeutic application as determined not mainly by the efficacy of the drug in question, but by brand positioning relative to the field of

**Table 1** Prozac, Zoloft and Paxil FDA-approved indications for use and date of approval

Indication	Year of approval
Major depression	1987
Dysthemia	1990
Geriatric depression	1991
Obsessive-compulsive disorder (OCD)	1994
Panic disorder	1995
Bulimia nervosa	1996
Social phobia	1999
Social anxiety disorder (SAD)	1999
Premenstrual dysphoric disorder (PMDD)	2000
Generalized anxiety disorder (GAD)	2001
Post-traumatic stress disorder (PTSD)	2001



**Fig. 2** Comorbidity competitive sphere

possibilities.<sup>5</sup> Marketers refer to this field as the “axis of competition.” For Cymbalta, the axis of competition was in effect far more important in determining what compound would be considered, what symptoms, syndromes and disorders it would be considered for (i.e., clinically tested) and even which evidence, such as that pertaining to side effects, would be released to public scrutiny once approval had been granted.

Figure 2 is a depiction of what can be called the “comorbidity competitive sphere” for Cymbalta. Diagrams like these were shown to me on several occasions when discussing related subjects with drug marketers. While comorbidity represents an opportunity for the psychopharmaceutical manufacturer, it is not an unfettered field. The other drug makers, who are offering products that are more alike than different from each other, are exploiting the same condition. Over time, it is not just competitors who crowd the field, but generic manufacturers of yesterday’s patented compounds. Thus, Prozac’s indications were for MDD, obsessive-compulsive

<sup>5</sup> This emphasis on brand positioning also does not contradict what I said earlier, that the drugs are nondifferentiated (“commodities,” in business lingo). Brand positioning here is a vehicle for seeking FDA approval for specific disorders. Also, branding pertains more to the early part of the drug life cycle.

disorder (OCD), bulimia nervosa (BN) and panic disorder (PD). Zoloft was approved for MDD, OCD, PD, post-traumatic stress disorder (PTSD), premenstrual dysphoric disorder (PMDD), and social anxiety disorder (SAD). If Cymbalta, which offered no superior efficacy as an antidepressant, were to become the next big blockbuster, it would have to find something new that it could offer. All the main depression and anxiety comorbidities were already spoken for by competitors. This was where the symptomology of pain came in.

The reader will observe in Fig. 2 the sphere marked off by a cloud figure and labeled “non-disease states.” I include this to show that the expansion of the entire market depends on the ability to reinterpret nonpathological experiences—everyday sadness, anxiety, shyness, restlessness, moodiness, moral disquiet, etc.—as pathological ones requiring medication. The term that has been given to this is disease mongering, and there is a substantial enough literature on it to require no summary here (Moynihan and Cassels 2005; Moynihan and Henry 2006). This conception of the competitive field is illustrated, for instance, by the Coca-Cola Company’s designation of water as one of their soft drink’s competitors for the average 64 fluid ounces per-day-per-human market. Once the competitive field is so envisaged, marketing can begin its work to claim its due from nature, calling the nonsoda portion of consumers’ diet an “unmet need.” The unmet need for Cymbalta—meaning the space on the axis of competition unfilled by any competitor’s product—was pain. The decision to market Cymbalta for this indication was made.<sup>6</sup>

### From Schizophrenia to Complicated Moods: The Evolution of Zyprexa

Zyprexa PCP Vision: Expand our market by redefining how primary care physicians identify, diagnose and treat complicated mood disorders (i.e., Bipolar Disorder).

—Eli Lilly Document<sup>7</sup>

The most profound contribution of biological psychiatry has unquestionably been the discovery of the first antipsychotic medication, chlorpromazine, in 1952 (Shorter 1997). Since that time antipsychotic agents have been the gold standard for the treatment of schizophrenia. Despite the history-altering effect of these medications, and the improvements made to them along one dimension or another, there has yet to be created an antipsychotic drug that cures people of the dreaded disease outright, or that manages the symptoms effectively for all sufferers or that comes without the cost of a long list of side effects, some of which are as disabling as the disease itself. Research into the long-term effects of the drugs has shown that their use is associated with diminished life span (Brown et al. 2000; Joukamaa et al. 2006). In

<sup>6</sup> Cymbalta is a US\$1.3 billion blockbuster. In 2006, the company spent \$157.1 million on Cymbalta advertising in its “Depression Hurts” campaign (John Russell. FDA Orders Lilly to Drop Cymbalta Promo Material. Indianapolis Star, October 3, 2007).

<sup>7</sup> Eli Lilly Document: “Managed Care-June 2002.” Available at: <http://www.furiouseasons.com/zyprexa%20documents/ZY200083405.pdf>. Accessed December 14, 2007.

short, antipsychotic medicines are among the most powerful and dangerous pharmacological agents in use. Like other technologies, with judicious application they can do much good, or if they are abused, they can cause much harm.

I open this section with this report because the medication I am about to describe, whose uses have been intentionally “blurred” so as to expand its application as widely as possible into the general population, is Zyprexa (generic olanzapine), an antipsychotic approved in 1996 for treating schizophrenia. The drug belongs to a next-generation class of antipsychotics called “atypicals,” which, it was hoped, would be more efficacious than their predecessors and would carry fewer side effects. The short version of the history of the new antipsychotics, according to the results of a \$42 million NIMH study involving more than 1400 research subjects, is that they turn out to be rather more typical than atypical. The hope of greater efficacy was not realized, and tolerability improved only slightly with some of the medicines. The side effects of all the medications remain severe (Lieberman et al. 2005).

Several of the atypical antipsychotic manufacturers, including Bristol-Myers Squibb, Pfizer, Janssen, AstraZeneca and Eli Lilly, have been brought up on charges for related violations in the past several years. As regards Eli Lilly and Zyprexa, many of the lawsuits have resulted from corporate cover-ups of the drug’s tendency to cause hyperglycemia, weight gain, hypercholesterolemia and other metabolic conditions that can lead to diabetes, stroke and heart disease. Thus far, the company has settled with 28,500 individuals, for an ongoing tally of \$1.2 billion (Berenson 2007). Another category of suit successfully brought against Lilly (and other companies) has been for promoting off-label use of the drug (i.e., for conditions or populations other than those for which the drug is approved). Finally, states are suing Lilly in connection with using illegal influence to obtain status for Zyprexa on state hospital formularies. Several workers unions are suing Lilly for its funding of the patient advocacy group NAMI to lobby state and federal governments to increase spending on Zyprexa.<sup>8</sup>

The number of smoking cannons uncovered across the industry suggests not isolated instances of corruption, but a systemically embedded set of practices attributable to the adoption of a marketing-driven protocol for developing and purveying the drugs. Among the evidentiary documents used in the Zyprexa litigations are dozens that reveal the marketing process in naked detail. For want of space, I select only a few key practices, with the aim of abstracting some general principles of practice.

### Disease State Prioritization

Shortly after Zyprexa was approved for use in schizophrenia in 1997, a strategy document was prepared at Lilly to consider future priorities for the drug. The “strategic intent” was declared as follows: “Zyprexa will be the world’s number

<sup>8</sup> See: <http://www.psychsearch.net/documents/tmap/sheet.pdf>. Accessed November 27, 2008. See also: <http://www.psychsearch.net/lawsuits.html>. Accessed November 27, 2007.

one neuroscience pharmaceutical in history.”<sup>9</sup> The document material warned, “The ability of Eli Lilly to remain independent [i.e., and not be bought out by another company in a consolidating industry] and emerge as the fastest growing pharma company of the decade depends solely on our ability to achieve *world class commercialization of Zyprexa*” (original emphasis). This early plan was dominated by the goal to “prioritize disease state opportunities to pursue new indications based on prevalence of the disorder, unmet medical need and probability of technical success (market opportunity).” This disease state focus would maximize the product life cycle value because, with each new approved indication, the drug’s patent would be extended.

In one exhibit, priority disease states were sorted into four columns. The first, labeled “highest priority,” listed bipolar disorder, dementia with psychosis, depression with psychotic features, dysthymia, personality disorder with treatment associated psychosis, schizoaffective, schizophrenia and unipolar depression. Column two, labeled “second priority,” listed substance-related disorders, anxiety disorders, borderline/schizotypal personality disorders, aggression, anorexia, delirium with psychotic features, psychotic disorders of low prevalence and schizophreniform. The origin of these diagnostic terms is the DSM-IV.

The first step for expanding the use of Zyprexa was to obtain scientific evidence. In a slide entitled, “Venture Team: Generate the New Data Required to Grow,” various trial protocols and their descriptions were listed. The basic idea was to test the efficacy of Zyprexa against any condition of psychosis, but also to test it for the vaguely contiguous illness domains of dementia, autism and Parkinson’s disease. The trial-everything approach to drug discovery is meant to capitalize on comorbidities. The mechanism of action for virtually every aspect of these drugs is poorly understood: in which case, the best product strategy is to throw as much mud as possible at the wall and see what sticks.

The use of Zyprexa for bipolar disorder was the first and most successful exploit of the disease-state expansion strategy. Unlike schizophrenia, which has an invariable incidence of about 1% in the population, diagnoses of bipolar disorder, newly renamed from manic-depression, were growing by leaps and bounds, in no small way because of the disease promotion activities of Lilly and its peers. Between the early 1980s and the mid-1990s, the diagnosis of bipolar disorder increased more than 50-fold. This coincided with the emergence of a suborder of diagnoses that included bipolar II, cyclothymia and bipolar disorder NOS (not otherwise specified). These diagnoses differed from the earlier manic-depression (now bipolar I) in that previously a diagnosis involved an episode of hospitalization for mania. The new bipolar disorder is mainly “community based,” in David Healy’s term (2006b), and may be evolving still into a “spectrum disorder [that] can be recognized in as much as 50% of the population” (Cookson 2003). The expansion of bipolar diagnoses into the pediatric population—an increase of 4000% between 1994 and 2002 (Moreno et al. 2007), accounting for even infant

<sup>9</sup> Eli Lilly Document: “Zyprexa Product Team: Four Column Summary.” Available at: <http://www.furiousseasons.com/zyprexa%20documents/ZY200270343.pdf>. Accessed December 14, 2007.

diagnoses—has added yet another layer of profitability to the annual US\$18 billion and 10.9% growth market for atypical antipsychotics.

While the majority of initial testing for Zyprexa and its competitors-in-arms in the treatment of bipolar disorder used subject populations with acute mania (i.e., bipolar I subjects) to gain approval, the real target population appears to have been the rapidly growing segment under the new diagnoses. This became evident through the promotional strategies used in primary care settings, where acute mania is not generally seen, and in the staged approval-seeking process for use of Zyprexa not as a short-term medicine for acute (i.e., psychotic) episodes of mania, but as a prophylactic for all bipolar disorder.

The strategy to wield influence over the primary care setting is doubly germane because it can be seen as a marketing channel strategy that fulfills both strategic criteria of the discipline. First, it facilitates movement of product through the channel and widens distribution access. Second, it adds value during the distribution, not in the usual manner, with service add-ons, but by contributing to the growing diagnostic base of the disorder. As the company would have learned from the Prozac experience, and is generally understood by health-care researchers, the more medical care there is, the more demand grows to meet it. PCPs are a key site for inciting the process further.

#### Donna: A Case Study in Sales-Force Power

A slide in the 1997 Strategic Intent reads:

Our Challenge:

- PCPs have not been trained to recognize this patient ... some afraid of the “B” [bipolar] word.
- PCPs have traditionally not treated this patient.
  - Lack of comfort with the disease state.
  - Lack of comfort with the meds due primarily to safety concerns.

We can change their paradigm....

The sales force accounts for a large portion of marketing efforts in the pharmaceutical industry. In the United States in 2002, there were an estimated 90,000 drug reps (MRs; this once stood for “marketing representative” but changed in the 1990s, starting with Lilly, I have been told, to “medical representative”)—an increase from 30,000 in 1994—for some 630,000 physicians. Implementation of much of the channel marketing strategy is in their hands. The company sales-force documents that stand out are entitled “Zyprexa Primary Care Sales Force Resource Guide”<sup>10</sup> and “Zyprexa Frequent Areas of Concern or FAOC.”<sup>11</sup>

<sup>10</sup> Eli Lilly Document: “Zyprexa Sales Force Resource Guide.” Available at: <http://www.furiousseasons.com/zyprexa%20documents/ZY200061996.pdf>. See also: <http://www.furiousseasons.com/zyprexa%20documents/ZY200189276.pdf>. Accessed December 14, 2007.

<sup>11</sup> Eli Lilly Document: “Zyprexa Frequent Areas of Concern, or FAOC.” Available at: <http://www.furiousseasons.com/zyprexa%20documents/ZY200083622.pdf>. Accessed December 14, 2007.

The Resource Guide, dated June 2002, at which point Zyprexa had been approved for short-term use in acute bipolar mania, opens with

Welcome, Primary Care sales force, to the ZYPREXA Limitless Team.... ZYPREXA was originally launched to the primary care audience by the Sigma sales force in November 2000.... ZYPREXA will continue to revolutionize the way complicated mood disorders are treated by primary care physicians. Just as Prozac revolutionized the treatment of depression in the late 1980s and throughout the 90s, so too will ZYPREXA forever change the way primary care physicians view and treat bipolar disorder. Did you know ... the prevalence of bipolar disorder was once thought to be between 1 and 2%. More recent studies have indicated it may be as high as 6%. But when you look at patients who are already being treated or diagnosed with depressive disorders, as many as 30% may actually be bipolar.

Inspirational bravado aside, one of the company's key strategies is revealed in the last sentence. In the pharmaceutical industry the bottom line of all value is the patent. Patents are the geese that lay golden eggs. They are the equivalent of brands in other consumer products. Take away the name Coca-Cola, and the company is worth the real estate it sits on. For the pharmaceutical industry the patent is what counts most—only, instead of its being invested in a single named drug, such as Cymbalta or Zyprexa, the value rolls from one patent-protected entity to the next. When the patent for a popular drug expires, the product becomes what in commercial lingo is called a commodity—an object without a name, equivalent to any copy, and priced low accordingly. “Commoditization” is the mortal enemy of marketing (Applbaum 2000b).

Of the strategies a company can employ to retain value in the transition, the most secure one is to transfer the consumers themselves into the product loyalty sphere of the next patented drug. With SSRI antidepressants coming off patent, Lilly might have determined that one way to retain at least a percentage of those customers was to transfer the consumers either to Cymbalta or to Zyprexa, both of which remained under patent protection. While there is no explicit strategic statement to this effect, in the context of the phenomenal new industry-sponsored research attention being given to bipolar disorder, the notion gained currency that those patients who were receiving no benefit from SSRIs were in this position not because SSRIs are imperfect drugs, but because of an erroneous diagnosis. They were not unipolar after all, but bipolar: “...When you look at patients who are already being treated or diagnosed with depressive disorders, as many as 30% may actually be bipolar.” The solution was to put them on Zyprexa.<sup>12</sup>

I described in relation to Cymbalta the requirement the drug company faced vis-a-vis their primary customers, physicians. Moving product through the physician's hands into the end user's medicine cabinet requires blurring physicians' status as

<sup>12</sup> The same process may be at work in the case of the vastly overdiagnosed ADHD (attention deficit/hyperactivity disorder). A growing percentage of all those millions of children who are failing to show improvement on a class of drugs quickly falling from patent are being diagnosed with pediatric bipolar disorder (Healy and Le Noury 2007).



experts with their status as channel members and consumers. They are consumers insofar as they themselves have to be convinced about the usefulness and safety of the drugs. Drug reps are trained to exude knowledgeability and confidence about the medications, and they are trained to be able to respond to doubts by marshalling scientific and epidemiological data on drug effects that doctors themselves do not have the time to investigate. At the same time, drug reps collect and feed back to headquarters information from the field about common physician concerns regarding the drugs and, also, what patient experiences are like. This information becomes the basis for the next round of sales-force training (Oldani 2006).

For example, a common “area of concern” for PCPs in the use of antipsychotics was the presentation of extrapyramidal symptoms (EPSs). EPSs include a long list of horrible side effects such as Parkinsonism, akathisia (distressing body restlessness) and a potentially fatal alteration of breathing and heart rate (neuroleptic malignant syndrome). The most common and feared—because it is sometimes irreversible—side effect is tardive dyskinesia (TD), involuntary movement of the mouth, lips and tongue. More than 60% of patients taking conventional antipsychotics face one or more EPS. The atypical antipsychotics have had a better track record with these particular side effects, but PCPs were familiar with these first and were understandably concerned about encountering them in their general practice. Here is a sample sell tactic:

*[MD]:* I am concerned about EPS/TD.

**Cushion:** I understand your concern regarding EPS/TD.

**Clarify:** Can you clarify your concern regarding EPS?

**Address AOC** [area of concern] (go to Favorable Safety page):

**EPS:** Zyprexa has a low risk of EPS, and in a study using the most exacting measurements, the Simpson Angus Scale, Zyprexa’s rate of EPS was comparable to placebo across all dose ranges (page 6)....

**TD:** Zyprexa has a minimal risk for Tardive Dyskinesia (TD). In a clinical trial vs. Haldol, the incidence of TD was .52% with Zyprexa vs. 7.45% with Haldol over a 1-year period

**Check for Agreement:** How do you feel about this safety data?

**Get Back to Selling.**

Similar sales scripts were written to allay physicians’ concerns over sedation, weight gain and diabetes, common side effects of the atypicals. The scripted responses for side effects common to the atypicals would naturally be more evasive because the real data are damning. The diabetes area-of-concern script ends with the following admonishment: “Confidence and correct tone is very important. We cannot dismiss this objection as a non-issue but rather we need to understand their concerns and address them appropriately.” A separate document on “physician orientation” offers different sales strategies to different doctors, depending on whether he or she is a “certainty seeker,” “independent skeptic,” “holistic

experimenter,” “referrer” or “cautious practitioner.”<sup>13</sup> Elsewhere in the documents this typology is called “neuroscience segmentation,” and the categories of Dr. “High Flyer” and Dr. “Rule Bounds” are explained for their tendencies in prescribing (early or late adopter, high- or low-dose prescriber) and in their receptiveness to the sales message from the rep.<sup>14</sup>

Pharmaceutical companies are shrewd not to overestimate the sophistication of the average doctor. Lilly based their bipolar sales pitch on hypothetical patient profiles, perhaps harking back to Freud’s case studies—Anna O., Dora, Little Hans, etc. Figure 3 reports the case of Michael, a moody man in his 30s whose symptoms have grown worse on antidepressants. “Your goals of therapy for Michael may include stabilizing his mood while reducing his agitation.”<sup>15</sup> The most commonly referred-to patient profile, however, and Zyprexa’s sweet spot patient, is Donna.

Donna is a single mom in her mid-30s, appearing in your office in drab clothing and seeming somewhat ill at ease. Her chief complaint is, “I feel so anxious and irritable lately.” Today, she says she’s been sleeping more than usual and has trouble concentrating at work and home. However, several appointments earlier, she was talkative, elated, and reported little need for sleep. You have treated her with various medications including antidepressants with little success.

After the usual sales rigmarole of awarding the physician due respect by listening to his answers to open-ended questions, you reassure him, “You will be able to assure Donna that ZYPREXA is safe and that it will help to relieve the symptoms she is struggling with.” Once this is apparently taken in, the salesman is encouraged to “cash in your chips”:

Doctor, today you agreed that ZYPREXA’s reliability can help you meet your therapeutic needs for your patients with complicated mood symptoms because ... (recap the doctor’s statements in regards to ZYPREXA’s efficacy). Based on your confidence in ZYPREXA’s efficacy and safety, will you try ZYPREXA in a patient like Donna?

Samples, education materials for patients, diagnostic tools for future cases and, of course, gift tokens (or much more) are provided (Oldani 2004; Elliott 2006; Fugh-Berman and Ahari 2007). Here’s how the claim to scientific legitimacy is backed up.

### Share of Voice and the Goal of Maintenance Status

In March 2000, Zyprexa was approved for short-term use in acute bipolar mania. That same month, the rollout for projects “Clinical Management of the Bipolar

<sup>13</sup> Eli Lilly Document: “Global Value Committee Review of Zyprexa.” Available at: <http://www.furiousseasons.com/zyprexa%20documents/ZY200227498.pdf>. Accessed December 14, 2007.

<sup>14</sup> Eli Lilly Document: “Cross Brand Segmentation: An Introduction to Selling Through Advanced Customer Knowledge.” Available at: <http://www.furiousseasons.com/zyprexa%20documents/ZY200085380.pdf>. Accessed December 14, 2007.

<sup>15</sup> Eli Lilly Document: “Zyprexa Primary Care Q3 Implementation.” Available at: <http://www.furiousseasons.com/zyprexa%20documents/ZY100520636.pdf>. Accessed December 14, 2007.

## Michael Spread

This is Michael. Michael is a professional in his mid 30s. He's highly functional, but his wife says that he's always been prone to mood swings, and lately, things have gotten worse.

You rule out substance abuse and possible organic causes, and you're left with a complicated mood disturbance. The last time you saw Michael, he seemed down, unmotivated, detached. You prescribed an antidepressant. Now, 2 months later, he appears "wired," irritable, and anxious, and he hasn't been sleeping much.

His wife is very concerned, not only about Michael's health, but also his recent spending habits and erratic behavior.

Michael says he won't "see a psychiatrist." In fact, he denies that there's anything wrong with him. Simply switching antidepressants may not alleviate his symptoms. Your goals of therapy for Michael may include stabilizing his mood while reducing his agitation.

ZYPREXA, unlike mood stabilizers such as Depakote or lithium, does not carry any black-box or bolded warnings in its package insert. There is no routine blood monitoring required with ZYPREXA, and its cardiovascular safety is proven. ZYPREXA enables you to prescribe with confidence and without hassles. The most common side effect is somnolence, which is dose-dependent, and for a patient like Michael, a calming effect may be desirable.

Doctor, ZYPREXA works. In this head-to-head study versus Depakote, the most widely used mood stabilizer, ZYPREXA was **equivalent or superior in all symptoms** of bipolar disorder. Even if you don't use Depakote, notice how effective ZYPREXA was in treating elevated mood and irritability, and in improving sleep. Would you agree Michael could benefit from a trial of ZYPREXA? Dosing for a patient

**Fig. 3** Patient profile: Michael

Spectrum for the New Millennium" and "Restoring Balance: Long-Term Mood Stabilization in the Bipolar Patient" were propounded in a number of strategic documents. To be provided in coming months were catered psychiatric conferences and continuing medical education "satellite symposiums" led by big-name psychiatrists for an audience of 6,000 MDs and 8,000 treatment team members from 1000 facilities; 15 bipolar dinner meetings, with 150 to 400 MDs per dinner; distribution of sell sheets to 30,000 MDs and 95,000 pharmacists; 30 regional psychosis/bipolar weekend symposia; and so on. These policy sheets were followed by others entitled "Use of antipsychotics in geriatric populations" and "The

## 2.0 Charter

### 2.1 In Scope -funded (content approved by PMC):

- **Olanzapine compound support**

- Hyperglycemia, weight gain, CIB, Annual Report, Alerts, other safety responses as necessary to address customer/regulatory inquiries, (e.g., triglycerides, cholesterol, etc.)

- **Support the schizophrenia and bipolar franchises worldwide**

- New studies, publications, presentations, rapid response to worldwide regulatory questions, rapid response to customer, affiliate, and promotional inquiries/challenges.
- Bipolar depression (Q4/03) and maintenance (Q2/04) indications (i.e., mood stabilization)
- Increased physician support for presentations at conferences and to key customers.
- ZydysIVelotab (launched 4/00), rapid-acting IM (RAIM) (7/01), long-acting (depot) injectable (Q2/05), granules for Japan (Q2/02).
- Meet FDAMA pediatric requirements for additional exclusivity
- Redefining expectations of efficacy through existing databases and novel studies.

- **Support initiatives to maximize olanzapine's commercial value**

- Establish share of voice (SOV) leadership with psychiatrists as a corporate priority
- Continuous review of pricing strategy versus Ziprasidone~sperdal/Seroquel/Depakote
- Market research to define our future - where we will compete and where we will not
- Marketing plan maintenance and message evolution
- Optimal use of novel communication/promotion opportunities (e.g., E-commerce)

### Support the use of olanzapine in patients with Alzheimer's disease

- Widespread publication/presentation of existing data
- Pursuit of a psychosis in Alzheimer's claim in the US and EU (registration decision 7/01)
- Behavioral disturbances in elderly patients (EUI type I) (registration decision 7/01)

### 2.2 Currently Out of Scope - requesting funding:

- Obtain efficacy and safety data above 20mg for patients needing enhanced efficacy
- Borderline personality disorder, post-traumatic stress disorder, and emesis subject to unique headcount requirements for dedicated subteams

**Fig. 4** 2001 integrated product plan (abridged)

interface of neuropsychiatric disorders in the elderly,” to be similarly supported by faculty presentations and other direct-to-physician (DTP) initiatives to “build the Zyprexa ‘New Opportunities’ LTC [long-term care] business.”<sup>16</sup>

The Integrated Product Plan for 2001 similarly promoted uses of the drug not or not yet approved, suggesting violation of the no-off-label marketing rules. Note the initiatives on the 2001 plan (Fig. 4).<sup>17</sup> I have highlighted some key lines in yellow. The first goal under “Support initiatives to maximize olanzapine’s [Zyprexa] commercial value,” reads: “Establish share of voice (SOV) leadership with psychiatrists as a corporate priority.” This is particularly pertinent to our discussion. “Share of voice” is a concept that will enable the corporation to accomplish two

<sup>16</sup> Eli Lilly Document: “Zyprexa Launch March 2000.” Available at: <http://www.furiousseasons.com/zyprexa%20documents/ZY201448094.pdf>. Accessed December 14, 2007.

<sup>17</sup> Eli Lilly Document: “2001 Integrated Plan Zyprexa Product Team.” Available at: <http://www.furiousseasons.com/zyprexa%20documents/ZY200061996.pdf>. Accessed December 14, 2007.

objectives necessary to removing friction and uncertainty from the distribution channel.

The first objective is straightforwardly to compete with psychiatrists over whose expert voice will be heard by the public when the subject of bipolar disorder is raised. The ways in which this can be accomplished are by advertising directly to the public, by successfully transferring prescription responsibilities to PCPs, who receive most of their education about Zyprexa from MRs, and by creating an infrastructure of shadow experts, scientists and psychiatrists in the company's employ who will drown out the voices of independent investigators. This last strategy is accomplished through funding and publicizing researches—often ghost-written by the company—that support company interests, sponsoring journal supplements that will publish these findings exclusively, and so on (Antonuccio et al. 2003; Healy 2006c; Moffatt and Elliott 2007; Sismondo 2007).

These activities effectively pitch medical scientific and commercial expertise into direct competition, thereby enabling the blurring and eventual conversion of the former into the latter. This is the ultimate objective, because it coordinates and integrates the distribution channel along solidly commercial lines. The independent, noncommercial goals and ideas of psychiatrists and psychiatric researchers continually threaten to obstruct the distribution channel with what, I have noted earlier, is known to channel marketers as “goal conflict.” Establishing superior share of voice—a term bearing familial resemblance to the consumer product marketing concepts of market share and “share of mind,” which refers to the space inside the consumer's head that one strives to have devoted to one's product—is a competitive project (Applbaum 2003)—only here, the competition is not with other atypical antipsychotics, but with the opinions of non-company-aligned scientific persons and entities. The battlefields for share of voice might include, for example, academic journal space, doctor's office brochures, NAMI endorsements, government guidelines for treatment, media reports and scientific programming at psychiatry conferences. All of this is merely spadework to prepare the persuasion of numerous other channel members such as regulators, payers, social agencies, patient friends and family, etc., and before “ask your doctor” and other direct-to-consumer campaigns are introduced.

The procedure is repeated for each new possible off-label indication, and is reproduced in some localized version in every accessible foreign market, so that profits can have a global base (see Fig. 5).<sup>18</sup>

### Marketing Channels and Synergistic Power: Conclusion

In the epigram, I cited a marketing channels expert to the effect that the “channel captain” has at its disposal something called “channel power” to apply to wayward members of the channel. I have not yet explained the nature and scope of what sort of power it is that can achieve the goal of channel coordination. Here I refer again to

<sup>18</sup> Available at: [http://www.sptimes.com/2007/11/18/Worldandnation/Dementia\\_relief\\_\\_with.shtml](http://www.sptimes.com/2007/11/18/Worldandnation/Dementia_relief__with.shtml)  
Accessed December 1, 2007.

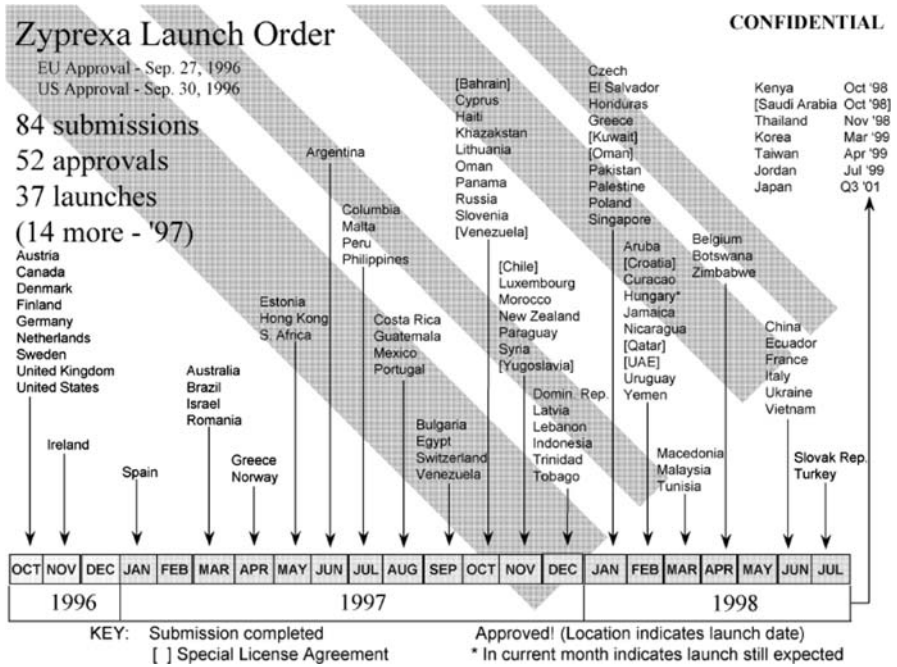


Fig. 5 Zyprexa global rollout

synergistic power as the key to how independent and potentially reluctant channel members are brought willingly into the channel so the smooth flow of product can be maintained. Synergistic power relies on consensus building across interest or institutional barriers. A term often used in business to describe this process as a strategic proposition is “getting to yes.” *Getting to Yes* is the title of a perennially best-selling management how-to book written by a lawyer, a psychologist and a one-time anthropology graduate student (Fisher et al. 1991). The book is hugely acclaimed, as is its most famous expression: a “win-win situation.” Win-win is when both sides of a negotiation believe that they are benefiting, and even getting the better of their opponent. Nobody loses. In this case, it is not consensus that is being built, but eagerness on the part of all concerned to participate or to “get onboard and move forward.”

The contemporary firm is increasingly decentralized, “networked” and virtual (Castels 1996; Aneesh 2006). It confronts, in both its internal and its external environment, a host of disintegrating forces. In marketing channels, fragmentation can result from the diversification of customer bases associated with global aspiration and the proliferation of information technologies that bring about new options for distribution available both to the firm and to its competitors. The functional fragmentation of the channel accentuates the perceived need to assert control over one’s product and operations. Traditionally, the preeminent mechanism for maintaining control of external partners was vertical integration (Dannhaeuser

1989; Applbaum 2005). This meant that the manufacturer itself either undertook the work of external distributors (such as sales negotiation, merchandising, offering credit, breaking bulk and providing after sales service) or exerted control over intermediaries through partial ownership and like arrangements.

The context for distribution today is more complicated. Among the concepts in channel marketing that have been developed to meet this circumstance are “horizontal networks” and “hybridity.” Hybrid channels are considered “a channel structure in which the supplier and its partners share in the execution of the channel functions.... In essence the channel system works together” (Rangan 1994). The premier textbook on the subject concludes with a chapter entitled “Vertical Integration in Distribution,” which states that “more often than not the manufacturer should *not* vertically integrate a downstream flow because doing so is typically inefficient” (Coughlan et al. 2006:333). The aspiration to control has not been discarded: “In theory, the integrated entity is better off” (p. 336). Practically, however, this is often not possible. A compromise, in either the contractual terms or the style of engagement with channel members, is necessary. The watchwords for the new channel order are “trust,” “relational governance” and “consumer interactivity.” These new marketing channel watchwords are all getting-to-yes expressions.

The application of getting to yes as a managerial cultural process lies in the way managers are able to create the consciousness for everyone in a channel that they are on the same team and are absorbed in achieving the same ends. Initially one finds a range of views regarding any subject, such as contradictory epidemiological opinion about the prevalence of a disorder or the cost-effectiveness of a proposed solution. Getting to yes does not rely on everyone having the same point of view, only on their reaching the understanding that they are all pursuing allied goals and participating in the same universe of meaning. The agonistic consensus that the pharmaceutical industry systematically orchestrates through “collaborative competitorship” (Hamel et al. 2002) results in the ability to pull all those disparate strings so that it looks like there is a consensus firming up from multiple locations, and hence it is not manipulated, cannot *possibly* be manipulated. One of the reasons the manipulation is obscure to us is that it seems as if they are not supervising the process at every step, because their hands are off the process so much of the time—And how, anyway, could they control the entire system?

I offer as the final illustration an abstracted sketch of the rise of the mega-blockbuster SSRIs. In the 1990s everyone in mental health care could relate to the tragic reality of individuals who, untreated for depression, ended up committing suicide. There is no doubt that this occurred commonly, and continues to. It was natural for all concerned to strive for a future in which this would never occur.

The two-part solution offered by the drug companies, who were already the de facto channel captains for mental health care, was as follows. First, an antidepressant pill to cure depression and prevent suicidal outcomes to the disease was created or designated. At this point, the question of whether the drugs were to be approved on the basis of murky, marginal, bogus or, for that matter, sterling efficacy was immaterial to the company—one should not be particular about the distinction; it is just business (Hart 2005). Second, following this, working in parallel but also in

concert with each other, the companies endeavored to disseminate the pill as widely as possible, with the irreproachable aim of ushering in a future in which afflicted but potentially undiagnosed individuals would no longer slip through the cracks. The language of prevention, which by that point had gained ground in other areas of medicine, helped harness the public shoulder to the wheel. Professional consensus affirming that the industry's wildest dreams were also the public's was not so much argued as kindled by some of the marketing methods outlined above: combined marketing and R&D divisions created and publicized research to demonstrate the efficacy of the drug; obtained academic "key opinion leader" (KOL) endorsements for professional audiences (people whose careers and pocketbooks improved simultaneously); aired celebrity spokespeople and advertising to educate the lay public about the disease; lavishly funded antistigma campaigns; promoted among family doctors the use of abridged depression questionnaires and educated, and thus empowered, these doctors (and eventually their non-MD assistants) to look for telltale signs of depression and treat it; enrolled (in some cases, also bankrolled) the support of patient advocacy groups and solicited testimonials from among them; generated certified guidelines formulated and endorsed by psychiatrists in the employ of industry, to be adopted by hospital formularies and public insurance programs; took a lead role in determining the curriculum and scientific programs at continuing medical education programs and professional congresses; designed Web sites with diagnostic self-tests encouraging consumers along the path from self-diagnosis to the request for medication at the doctor's office—a request most often honored; dispatched the MR brigades; and so on (e.g., Antonuccio et al. 2003; Healy 2003, 2004, 2006a; Applbaum 2004, 2006b; Medawar and Hardon 2004; Moynihan 2004; Conrad 2005). The result was a phenomenal increase in the diagnosis of conditions for which a prescription of an SSRI ensued. Between 1994 and 2002, there were some 6 million to 8 million new prescriptions *per year* in the United States for Prozac, Zoloft and Paxil alone (Healy and Aldred 2005).

The entire process may begin with a pill that actually does decisively ameliorate suffering, or it may begin with a pill that beats placebo only by a hair. It may begin with a pill that was approved not by reason of efficacy, but because its clinical trials were manipulated to show a lower side effect profile than its competitor or its generic predecessor—exactly the history of Zyprexa's first approval (Healy 2006b). By the time the entire marketing edifice has been built and the profits from billions of dollars in annual sales are surging into company coffers, the original questions of how or how well the pill actually works (Kirsch and Sapirstein 1998; Moncrieff and Cohen 2006), whether it creates dependency, causes mania (Breggin 2003), or triggers suicide more often than it prevents it (Beasley et al. 1991; Medawar and Hardon 2004)—none of which have been put to bed—no longer matter. The highly abstracted initial idea that brought all the channel members "onboard"—the shared commitment to reduce suffering—has receded beyond the horizon.

Getting to yes is the means whereby pharmaceutical corporations fuse the divergent positions of market intermediaries under the banner of a more abstract, univocal and often ethical purpose, drawing even on the energy of those intermediaries to construct a singly directed force propelling them toward company objectives. Getting to yes means avoiding conflict, bringing everyone to agreement,



to the feeling that they are all pursuing the same goal. It does not, however—as in the distribution channel literature cited above, or even as regards the firm’s interactions with consumers—eliminate power from the equation. It merely *conceals* the exercise of power. The truth of this concealment of power is more difficult to fathom vis-à-vis the health-care channel, which is filled with devoted, educated individuals who pledge the public good and would seem to have enough self-determination and awareness not to be duped or to be persuaded of things that are either untrue or inimical to their constituents, their ethical charter or their own professional autonomy.<sup>19</sup>

The ability to conceal the exercise of power is one essential characteristic of the marketing-led organization; after all, they are the experts in packaging and public relations. However, the source of their greatest power comes rather from their intense single-mindedness of purpose and from their ability to take the same social and informational complexity that stymies the state and to put it to their purpose. For the state, which is their nearest true adversary, implementation of the democratic process means opening field to conflicted participation, power-sharing, complex voicings and multiply organized social actors. The state’s goals are compromised because of the ways citizens compete over limited resources and life chances. In a rights-based environment, the state expends much of its energy toward adjudication of competing goals.

The corporation, by contrast, is able to devote its state-sized resources single-mindedly and efficiently. To consumers it offers a slice of the good life, undivided by particular positionality. Even people with less personal agency, such as children, the elderly or the severely mentally ill, can be bounteous consumers of pharmaceutical products—so long as the people around them who will approve, prescribe and pay for the medicines are adequately incorporated into the channel. The dreams of perfect health and self-realization through the exercise of free choice in the market, of modern style and progress, are not difficult to sell. In a consumer society, as I pointed out earlier, it seems hard to justify a hegemonic theory of power. This seems to be particularly so for the leading proponents of Cultural Anthropology today, for whom

<sup>19</sup> Many key opinion leader physicians (KOLs) are comforted in their work as representatives of industry in the belief that, since they do not endorse only one company’s products, they are not acting in a biased fashion. The existence of several apparently competing pharmaceutical companies serves as a guarantee to them that the race to a cure is genuine and balanced. It is a widely held view in a society that sees itself as market-based that competition implies that a system of checks and balances functions as a bulwark against monopolistic power. This 19th-century trust-busting view of competition, which conforms to an implicit ethical equilibrium model, distracts us from the collaborative nature of contemporary corporate competition. “Collaborate with Your Competitors—and Win,” the title of a *Harvard Business Review* article in 1989, announced the age of “strategic alliances” (Hamel et al. 2002), which has come to form only one visible dimension of the ways in which competition not only does not weaken monopolistic coalition-building, but functions to strengthen it. The presence of industry trade groups such as PhRMA should alert us to the fact that a sort of segmentary opposition—“an organization of predatory expansion” (Sahlins 1961)—is at work here. Or, for the nonanthropologist, let us say that the formation of marketing channel alliances over time signifies competitive, rather than vertical, integration and, in many regards, is indistinguishable from it. The last to know are all the psychiatrists who take money from the industry in the benighted or self-serving belief that, since they are not taking from any single company, they are not being corrupted. All the while, they are bringing their entire profession inexorably to yes, which is a form of extinction. (This is another sense in which the drugs may be causing rather than preventing suicide.)

the agency of individuals has come to be conflated with their identity as consumers. In this scheme, handing too much determinative agency to corporations is not easily countenanced.<sup>20</sup> A rudderless raft of complicated, stylish theories has thus been devised to prove that corporations are unable, hard as they may try, to deny agency to the consumer. One can outdo these too-subtle arguments: we willingly buy the goods, we subscribe to the ideology of prosperity through stuff and some of us even become shareholders or get MBAs and, thereby, become two parts more the corporation ourselves. In the end, at least in the industrialized world, Toys R not Them, but Us.

Or so it would seem, if all we had to say was, “We are all consumers now.” The consumers-have-the-power model rests on the idea that commodities are just ordinary things that people can use to construct whatever identities they choose. How does it differ when we discover that the pharmaceutical company treats physicians as consumers who are to be drawn into the channel unwittingly, even while it stands to cause them to violate their professional oath? What might we learn about the power exercised toward consumers in general when the statement “We are all consumers now” is indistinguishable from “We are all members of the distribution channel now”?

The motivational logic of marketing channels is not really as it seems, perhaps even from the above discussion: that a product is created at place A and you have to get it to place F, convincing B, C, D and E along the way to sanction or improve the flow. Channels themselves are the new objects of control. In marketing channels one finds all manner of bits and shreds of life that do not fly the company logo: laws, knowledge, organizations, infrastructure, disease categories, physicians, lifestyles, social relations and even common language. We fail to notice this vast net of semiownership because we continue to be caught up in the idea that commodities are solid, isolated entities, identities (consider all the people who say not, “I have bipolar disorder,” but, “I am bipolar” [Martin 2007]) that can or have been isolated and forged far away from corporate boardrooms.

Pharmaceutical manufacturers, like other marketing-driven enterprises, have realized that it is less in the product, the brand or even the patent where their fortunes lie, but in the stream, the marketing channel. Once you control the channel, you can insert any product you like into it, no matter how useless or dangerous. The trick is to cut a large swathe and to run it through other institutions without their

<sup>20</sup> I Do not mean to suggest that corporate power is omnipotent, or that informal outlets for economic engagement or interpretive action are weak agencies. However, in their pragmatic intercourse with consumers—in which physicians and their patients become indistinguishable except by the technique with which they are engaged—pharmaceutical corporations are *somehow* managing to incorporate their opposer’s positions and to make it seem like everyone is running in the same direction. The *somehow* is what I am calling—not entirely as an objectivist proposition, since it is their own term—synergistic power.

I believe that health care is a special case. Not because marketers operate according to a unique scheme in that field—quite the opposite—but because health care is the ultimate arena in the struggle between human need and corporate power. “What drives suffering?” Farmer (2003) asks. He advocates the notion of structural violence to explain what drives suffering in public health in the developing world. I think he is utterly correct. Let us call what I am identifying in this paper “corporate structural violence,” and let us analyze it as a social process, with all the good intentions gone awry included.

noticing that they have become victims of compulsory purchase (eminent domain). This is a structural (and structurally violent) facet of pharmaceuticalization that calls for our investigation.

Why do we misrecognize this system? Because contestation over subjectivities within a common goal frame leaves us unable to see where the corporations are coming from or where their aims and ours might conflict. “GE. We bring good things to life.” For the corporation, the less visibility the better. The point is less an escape from detection—since that does not seem to carry any consequences anyway—than it is an aspiration to synergistic power. The master of synergistic power does not sell to the channel outright. Instead, through manipulating partial truths and through capturing majority shares of heart, mind and voice, the disappearing synergist creates the context in which many social actors can move in a single direction even when they have competing interests. It is social process itself that is being pushed down the channel, while corporations collect only tolls.

Corporations, in their superior capacity to manage complexity, will be remembered as the champions of our age. Like all forms of power, corporate power is culturally constituted. Its mode of communication—commercialization and, well we might add, pharmaceuticalization and strategic medicalization—is contagious to other domains, perhaps as Durkheim (1995) reported of the tendency of the sacred in religious society. The contagious effect of corporate power is hardly limited to markets and marketplaces. It extends as concretely into politics, into the habits and worldviews of people—consumers, now, who conform as much to commodity-differentiated lifestyles as to cultures—and, in the case of pharmaceuticals, into the veinal and neural pathways of humanity, increasingly through channels forged globally. Until we have revealed both theoretically and ethnographically how corporate power feels like truth instead of like force, we will neither comprehend it nor stand to harness its mighty power for the good of humanity.

**Acknowledgements** A version of this paper was presented in January 2008 at the London School of Economics. Ingrid Jordt contributed many ideas to the paper. My medical anthropology colleagues at UWM, Paul Brodwin, Michael Oldani and Ben Campbell, read and commented on the earlier version, as did Thomas Malaby and Andreas Glaeser. My colleagues and teachers, Sidney Mintz, Keith Hart, Arthur Kleinman and David Healy, also read the paper and offered valuable reflections. I wish to thank all of the above for their generous input while absolving them of answerability for my forceful positions.

### **Appendix: A View from the Bridge: Methods for Analyzing the Mind of Capitalist Agency**

In this paper I am not drawing on fieldwork among pharmaceutical company managers, but on records that were obtained by subpoena from Eli Lilly & Co. during a suit against them in Alaska in 2006. Three hundred fifty-eight documents, which include marketing plans, sales training manuals, scientific reports and a host of internal correspondence, were given to *The New York Times* by one of the plaintiff’s attorneys. A *Times* reporter published several articles using the documents (Berenson 2006) and then leaked them to the public. The documents are, following an unsuccessful attempt by Lilly to repatriate them, legally in the

public domain and available for download from the Internet (see Footnote 1). It is not principally my interest to use the documents to embellish on the company's violations, which have by now been widely reported on in connection with an avalanche of suits against the company. My aim is rather to illustrate the ways in which the marketing practices exposed in the documents are not exceptions to, but indicative of, the competitive structure and normative, everyday practices in this industry, and of marketing in general. They may, if anything, reflect a systematization and normalization of corruption.

The unusual data source invites remark with regard to the questions of both what sort of data is adequate to securing insight into corporate activity and how anthropologists might go about conducting research into transnational corporations in the first place. Corporations are extraordinary ethnographic sites and subjects. Many are as vast and influential as nation-state bureaucracies. In addition to their size, their reach and the complexity of their interface with the world, they are animated by managerial expertise each of several areas of which is a discipline larger than anthropology. Yet the elite business world and the specialized professions that cross-cut it may be counterintuitively more secluded and stable for anthropological "ironization" (Marcus 1998) than are many of the places anthropologists continue to seek out hoping to find boundedness and authenticity.

While corporations take pains to remain unnoticed and inaccessible to the public, and membership in their society is highly restricted, their attachment to secrecy may be inversely proportional to the actual accessibility of their information. Most large corporations are publicly owned. Future business plans, patent applications, financial projections, market research and the like are kept safe from competitors; after the fact, much of this material becomes available for inspection. Particularly in regulated industries such as the pharmaceutical industry, there is public access at some point even to past strategic and strategic-scientific data (the hyphenated term will explain itself below). Individual companies are linked in an informational and often cooperative, rather than competitive, web to other companies in their industry. Investor analysts, management consultants, business-school case writers and innumerable others who make their living as experts openly report their insights into corporate activities in trade journals, how-to books and similar venues. Conferences, workshops and trade shows can be rich veins of information. Managerial personnel with indistinguishable résumés circulate like ball players among the leading firms, pollinating each other with standard notions billed as the latest innovation, all of which generates a suite of models and street wisdoms that managers apply to solve the problems of their work, and in which the anthropologist can find cultural coherence. It is from this store of primary data that I construct the case presented here.

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