

Branded Time

The prices of brand-name, or branded, medicines in Colombia often exceed what people in the US pay for them (Fajardo 2015), and the price differences between brand-names and generics are among the most significant in Latin America.¹ Yet the overpricing of branded drugs in Colombia is not what kept physicians up at night; the chronic scarcity of generics did.²

Dr. Masa helps me illustrate this point. As I explained earlier, he is a senior oncologist who mostly treats patients enrolled in EPSs for the poor or unemployed. In addition, he works part-time at several hospitals in Cali, alternating between the oncology wards at HUV and other smaller medical facilities owned by EPSs.³

Dr. Masa explained, “They [patients] are struggling to get generic anti-cancer drugs, the same medications that the Santos administration has pledged to make widely available for all. And, this is, of course, a serious problem! You see, generics are the kind of drugs we [physicians] are encouraged to prescribe. These drugs are covered by health care plans and included in the national formulary, largely because they are far less expensive than their branded counterparts. But these are often scarce. So let me be blunt. Sometimes [the problem] is because drugs are expensive, other times because they are affordable [Unas veces es porque las drogas son caras, otras veces porque son baratas]. What kind of game are we playing? [¿A que estamos jugando?].”

Dr. Masa and his fellow oncologists are often caught between affordable anti-cancer generics—which seem to promise so much for a politics of universal health care “precisely because they circulate beyond or outside the patent” (Hayden 2007, 475)—and newer and expensive branded drugs that promise a life without cancer or, at the very least, a life with manageable cancer.⁴

In 2012, Dr. Masa and colleagues at the National Institute of Cancer (Instituto Nacional de Cancerología) filed a petition at the Ministry of Health. They demanded the national government guarantee the supply of “essential” anti-cancer drugs—typically generics. In the doctors’ view, the scarcity of these drugs reflects undue government attention to the interests of the multinational pharmaceuticals.

Dr. Masa explained further: “Increasing the supply of anti-cancer generics should not be this difficult. We are not requesting something that hasn’t been invented. The drugs are already there. Most of them have been around for more than fifty years and are inexpensive—trust me. The problem is that pharmaceuticals prefer to import branded drugs, which may cost up to several thousand dollars per chemo cycle, instead of going through the hassle of locally producing cheaper, albeit essential, equivalent generics.”

Bringing this solution to fruition, however, seemed unlikely. “Our patients do not have the time to wait for public health policy transformations. We need immediate actions, even if these are temporary,” he said.

During his twenty-five years at HUV, Dr. Masa had learned that the time it takes the state to design and implement new policies follows a different rhythm from the one it takes tumors to grow. He knows that waiting patiently for scarce generics, dealing with EPS bureaucracy, and signing petitions won’t be translated into better prognoses or longer life expectancy for patients.

“Something else has to be done in the meantime,” Dr. Masa said, gesturing to communicate a sense of urgency. “We must carry on and keep doing our job with whatever is readily available, even if that means prescribing branded medications not typically covered by the health care system. It is preferable to do something rather than nothing. Here is where pharmaceutical representatives become instrumental.”

In this chapter I focus on brand-name chemotherapeutic samples, understood as promotional tools used by pharmaceutical companies to increase demand for “drugs with high profit margins” (Alagha and Fugh-Berman 2022, 2). I discuss how the informal relationships between Dr. Masa and pharma reps may transform branded chemotherapeutic samples into technologies of care that reduce treatment uncertainty for low-income patients; that is, samples turn into stopgaps that save patients’ time, at least temporarily, while a permanent supply of the same branded medications is secured via tutelas.

To explore how branded drugs are transformed into stopgaps, I bridge three ethnographic events that unfolded independently. The first event, “Generic Disbelief,” involves a prostate cancer patient who is puzzled by Dr. Masa’s decision to switch a generic chemo drug for its branded equivalent. The second, “Sample Care,” describes my encounters with pharmaceutical reps at HUV and conceptualizes branded samples as technologies of care, which have the potential to save patients’ time. The third event, “Socio-Chemistry,” unfolds at an upscale restaurant in south Cali, where Dr. Masa met with a pharma rep and secured one branded

drug sample for one of his patients who suffers from stomach cancer. My hope is that bringing these events together provides a clearer picture of how senior oncologists like Dr. Masa seek to manage the complex relations between generic scarcity and branded overabundance in this country.

GENERIC DISBELIEF

Horacio, seventy-two, is an Afro-Colombian who was diagnosed with stage IV prostate cancer. He is originally from Buenaventura, a port city on the Pacific coast, but moved to Cali in his mid-twenties to work in the sugarcane fields and then as a *bultero* at a factory that produces soy-based food for farm animals.⁵ Like many other cancer patients I met at HUV, Horacio's diagnosis came when his symptoms were unbearable. According to his medical history, nagging urinary pain took him to a general practitioner and eventually to a urologist. A digital exam was conducted. Upon completion, blood tests were ordered to check his PSA levels. A biopsy was performed, followed by imaging exams, which confirmed the diagnosis: prostate cancer with bladder metastasis. Horacio was finally referred to Dr. Masa at HUV, who recommended a chemotherapy regime to prolong his life.

For several months the conversations I had with Horacio transpired at the oncology wards and were infused with the typical anxiety experienced by cancer patients who are grappling with the temporal and existential questions associated with their disease. On this occasion, however, I had been invited to his home. He lives in a two-story house located at a busy intersection in east Cali, where the noise of buses, trucks, and motorcycles makes conversation difficult. While seated at the kitchen table, he opened a plastic folder and pulled out a crumpled piece of paper. Holding it with both hands, he sought to unfold it—being careful not to tear it apart in the process. The piece of paper had the HUV seal printed on a corner and cursive handwriting, which was difficult to understand. The more he tried to read it, the more frustrated he became.

But a few words immediately stood out: *abiraterone 500 mg*. This is the name of a generic chemotherapy medication, which is usually in tablet form and works by decreasing testosterone levels in the body.⁶ It is considered a relatively inexpensive drug compared to other oncology medications on the market.⁷ Because of its proven efficacy and safety record over several decades, standard oncology knowledge considers it an essential medication for the treatment of metastatic prostate cancer and other malignancies (NCCN 2020).

Horacio placed the abiraterone prescription on the table and immediately reached back to his folder. He pulled out a second prescription and read it out loud: "abiraterone, once again." Then he showed me a third prescription. "Enzalutamide," Horacio said, while placing all three documents side by side on the kitchen table.⁸ "Do you see? Generics all the way. Dr. Masa has consistently prescribed

generic drugs since I got my diagnosis,” he uttered in exasperation, as if trying to prove an obvious yet elusive point.

Horacio reached into the folder one last time, tossing around several forms, old prescriptions, and multiple copies of his clinical history. Anticipating the potential mess, his wife stepped in and offered to help, but Horacio declined by making a jerking motion with his hand. She shrugged and left the room.

“Here’s my latest prescription,” he said happily.

Horacio grabbed the piece of paper and handed it to me. “Camilo, please read it out loud,” he asked with impatience. I could not wait any longer to learn what was written in this prescription. Suspense was building.

Holding it with my hands, I proceeded: “Here it says . . . Zytiga.”

“That’s a brand-name, right?” Horacio asked.

I nodded.

I remembered physicians writing drug brand-names in capital letters on most prescription forms. Next to them, or underneath, generic names were usually included. In Horacio’s case, Dr. Masa had written *abiraterone* in parenthesis.

But Horacio was not convinced about my silent gesture of assurance. He kept insisting, “Are you completely sure it is a brand-name?”

I reached for my cellphone and googled Zytiga. Most results came back in English. I paused for a moment and typed “Zytiga español” into the search engine. I clicked on the first link at the top of the results page, which took me to the official Spanish version of the US National Institute of Health (NIH) website. I handed my device to Horacio.

“I told you!” Horacio said. He raised his arms, palms facing up. “I have never been prescribed a branded drug. Do you get why I am surprised? If my EPS has already put up a lot of obstacles to provide cheap generics, just imagine what they would do when I request a brand-name medication! [Laughing loudly.] I just don’t get it. If they [EPSs] don’t want to give us the cheap ones, why would they provide us with the expensive ones? [Si no nos quieren dar las baratas, ¿por qué nos van a dar las caras?]”

In total, Dr. Masa had written for two abiraterone prescriptions and one enzalutamide prescription over the past three months (one for each month) only to find out these generics were scarce in Horacio’s EPS’s pharmacy network.⁹ Frustrated by this situation, the physician switched Horacio’s prescription to Zytiga, a branded equivalent that happened to be widely available during my fieldwork. Horacio, however, thought the physician’s choice seemed like a long shot. I didn’t blame him. “What was Dr. Masa thinking?” Horacio kept asking, visibly disconcerted.

While it often comes as a surprise for many patients like Horacio, switching from generics to branded drugs is a rather common practice in Colombian medicine—especially when generics are scarce. For Horacio’s EPS, however, the Zytiga request was seen as an unjustified expense for a patient like him (low-income,

in his seventies, and suffering from a metastatic cancer). Dr. Masa was asked to reconsider his prescription choice.

In the physician's view, the EPS's request was rather feckless. According to him, "Zytiga is what Horacio needed at that moment. Had I followed his EPS's request, I would have needed to tweak considerably the original chemo protocol, which means resorting to second- or third-line therapeutics that may present far more risks for him. Do you get what I am trying to say? Patients are supposed to access the most efficacious and safe medications included in the national formulary, but when financial criteria are added to the health care equation, it becomes okay to prescribe drugs that aren't. That's when we all get caught up in absurd and senseless debates, which look like a *'diálogo de sordos'* [dialogue of the deaf], where the parties involved are unable to listen to each other and work together for the sake of helping patients."

Dr. Masa suddenly went silent for a few seconds, as if trying to come up with a simpler explanation for a disconcerting problem. He cleared his throat and made an unexpected reference to Mexican popular culture. "This situation reminds me of Cantinflas's famous phrase, *'Ni lo uno ni lo otro, sino todo lo contrario'* [Neither this nor that but quite the opposite]. Do you know what I am talking about?" he asked me.

While trying to explain how the Colombian government seeks to maintain the balance between the financial sustainability of the health care system and the right to health (or between limited resources and unlimited needs), Dr. Masa had drawn inspiration from Mario Moreno, known as "Cantinflas," an accomplished Mexican comedian who is seen as a popular icon throughout Latin America. According to the literary theorist Ilan Stavans (1995), Cantinflas was the master of *mal gusto* (bad taste), which he used as a great equalizer; ridiculing the seemingly insurmountable distance between social groups. For the Mexican philosopher Carlos Monsiváis, what is applauded about Cantinflas is "his non-sense (*incoherencia*) that is the sense (*coherencia*) of the masses, the aggression that is ignorant of the ruling class" (cited in Stavans 1995, 31).

When growing up in Colombia during the 1980s and 1990s, I remember watching several Cantinflas films. In most of these movies, he played the role of an astute mumbler who exasperated his interlocutors by engaging in confusing dialogues in which there is much talk, but nothing is said. As Stavans (1995) has noted, Cantinflas has the ability to conjugate verbs erroneously, coming up with new adjectives and adverbs while failing to complete his sentences.

Cantinflas's confusing prose has allowed Dr. Masa to highlight how "*Ni lo uno ni lo otro, sino todo lo contrario*" has come to define the paradoxes unleashed by the creation of the national drug formulary, known as Plan Obligatorio de Salud (POS), or Mandatory Health Plan. This formulary was created in 1994 to "guide drug selection, registration and procurement by the government" (Homedes and Ugalde 2005, 64). It was initially conceived as a list of "explicitly predetermined"

medical technologies (known as POS drugs), which means only drugs included in the formulary would be covered by EPSs. Drugs not listed in the formulary are considered experimental, cosmetic, or too expensive (known as No-POS), and EPSs are under no obligation to provide them.

When it was first introduced, the formulary was divided into two different lists of medical technologies; one list sought to guide drug selection for patients enrolled in the contributive regime for workers;¹⁰ the other list was intended for the poor and unemployed population, often enrolled in the subsidized regime. Although both lists were composed largely of generics, patients enrolled in the subsidized regime had fewer therapeutic options compared to their “wealthier” counterparts.¹¹

Criticized for reproducing socioeconomic inequalities, the two lists were combined into a unique, standardized formulary for all patients by President Santos in 2012. It later became known as Plan de Beneficios de Salud (PBS), or Health Benefits Plan. In this new version of the drug formulary, individuals enrolled in the health insurance regime for the poor and unemployed became eligible for the same health services offered in the insurance regime for workers.

While pivotal, this integration was not enough to counteract rampant inequities in access to drugs or reconcile disagreements about the provision of high-cost medications and the financial sustainability of the health care system (Defensoria del Pueblo 2013; Andia 2018; Prada et al. 2018). The record numbers of *tutelas* filed to access medical services—including No-POS drugs—attest to the ineffectiveness of these policies, which has transformed Colombia into a country with a high rate of health care litigation.¹²

The *tutela* has become an invaluable tool for Colombians to protect their fundamental rights. But it has a bizarre catch: when judges rule that EPSs must provide claimants with No-POS drugs (typically branded), insurers pass on their financial responsibility to the state through *recobro*, or reimbursement. As explained in chapter 2, *recobro* allows EPSs to request a reimbursement claim from a central public fund known as FOSYGA (today Adres), which decides the amount to be reimbursed according to rules established by the government (Andia and Lamprea 2019; Abadía-Barrero 2022). Hence, instead of penalizing EPSs for delaying access to prescribed medications and threatening patients’ right to health, *tutelas* provoke quite the opposite effect, as Cantinflas would have put it. As such, *tutela* writs shield EPSs from the high costs associated with the provision of branded No-POS drugs.

Two decades of *tutela* litigation over drugs have resulted in a substantial increase in public expense for health care services and drugs, the majority of which correspond to branded No-POS meds. Between 2003 and 2009, according to the sociologist Tatiana Andia (2018), the annual growth in No-POS drugs’ reimbursement value was 68 percent and reached around US\$1.3 billion in 2010. During 2012 and 2015, following her, the total pharmaceutical expense increased 23 percent. In the context of chemotherapeutic drugs, the cost of branded No-POS

drugs has continued to increase too, especially due to the arrival of new and more expensive oncology drugs—which are in patent exclusivity.

Tutelas, after all, transform generics into branded drugs. This transformative potential may have a direct effect on the thriving market in brand-name drugs, many of which are still in patent. From Yervoy, Herceptin, and Zelboraf to Avastin and Taxotere, the list of branded chemotherapeutic drugs being requested through tutelas was astounding.¹³ Even more puzzling is the fact that many of these drugs were being sold at exorbitant prices (Homedes and Ugalde 2005; Fajardo 2015; Prada et al. 2018).¹⁴ According to studies conducted by Econometría (see Cuevas 2012), local journalists (Quevedo 2013; Semana 2021), and Health Action International (HAI 2008), patients in Colombia (via their EPSs) have been paying for drugs that are up to 240 percent more expensive than most people pay in the Global North.

According to Prada and colleagues (2018), part of the reason that Colombia has tended to have high drug prices boils down to the lack of clear and effective pharmaceutical regulatory frameworks.¹⁵ Consider the two price control mechanisms implemented by Santos between 2010 and 2015:¹⁶ the creation of “price caps on No-POS drugs to be reimbursed by the government,” on the one hand, and “the introduction of an External Price Referencing (EPR) system for selected groups,” on the other (Prada et al. 2018, 2).¹⁷ Neither of these mechanisms, however, decreased overall No-POS expenditure.¹⁸ On the contrary, Prada and colleagues commented, these measures likely induced an excess of demand or an excessive increase in units sold during 2012–15.¹⁹

In addition to pricing controls, the Santos administration sought to lower health expenditures and counteract inequity by including in the formulary some of the most frequently reimbursed No-POS drugs,²⁰ most of which were high-cost medications for cancer. As part of this effort, in 2015 the Constitutional Court promulgated Ley 1751 (Ley Estatutaria de Salud),²¹ which transformed the POS formulary from a list of explicitly predetermined technologies into a benefits plan with a list of exclusions, also known as *lista negativa*, or negative list (Andia 2018). In a negative list, every drug or treatment that is not explicitly excluded (e.g., cosmetic or experimental medications) is understood to be included in the formulary.

Despite the new drug additions to the formulary, the number of No-POS drug reimbursement requests has not been reduced.²² Patients have continued filing tutelas to access branded medications that either have generic bioequivalents on the market or are considered “too expensive” by EPSs. In 2018, for instance, there were nearly 207,000 tutelas requesting access to medical services, including many branded drugs (Defensoría del Pueblo 2019).

These examples show that regulatory frameworks enacted to guarantee access to medicines may have contributed to reproducing generic scarcity vis-à-vis the abundance of branded cancer drugs. It is no wonder that Dr. Masa had turned to Cantinflas’s confusing prose to explain the bizarre dynamics that characterize the

chemotherapy drug market in Colombia. While Cantinflas's "neither this nor that" could be used to describe the challenges faced by patients as they seek access to generic or branded medications, "quite the opposite" refers to the reimbursement scheme that tends to free EPSs from No-POS (typically branded) drug expenses. This is the mechanism that allows insurers to transfer their financial responsibility back to the state—commonly understood as the opposite of the market under standard neoliberal frameworks.²³

In the remainder of this chapter I discuss how physicians navigate these Cantinflasque conditions by tapping into their informal relationships with the pharmaceutical industry. These relationships, I contend, have the potential to make branded (No-POS) drug samples possible for individuals like Horacio, saving them time while tutelas are filed to access the same branded drugs temporarily provided as samples.

SAMPLE CARE

Social science researchers have written extensively on the growing entanglement between pharmaceutical companies and the day-to-day practice of medicine (Dumit 2012; Biehl and Petryna 2013; Sunder Rajan 2017). From the US to Brazil and from Colombia to India, industry gifts (pads, pens, logo bags, etc.), luxurious invitations to international congresses, and the "free" lunch have become ordinary practices (Sismondo 2018).

In this section I write about pharmaceutical reps who frequently hung out at HUV.²⁴ The discussion that ensues builds on my encounters with sales reps at the Resident's Seminar Room. This is a multipurpose space that features a large sofa, two microwaves, a sink, a rectangular table with eight chairs, lockers, and a restroom. It is a learning space for junior clinicians, who keep their belongings in this room, socialize during their breaks, attend meetings with faculty advisers, and eat and sleep during extended shifts. It also a decompressing spot for sales reps, who would stop in to answer emails, make phone calls, take power naps, and give out pharmaceutical samples and lunch boxes.²⁵

Most of my interactions with sales reps occurred through physicians, like Dr. Jesus. He is a second-year oncology resident, originally from the city of Pasto, in the southern department of Nariño close to the Ecuadorian border. After graduating from high school, Dr. Jesus came to Cali for medical school.

Like many other junior clinicians, Dr. Jesus had come to see pharmaceutical representatives as an integral part of hospital life. "Reps are everywhere. That's why they are also called *visitadores médicos* [medical visitors]. They visit us wherever we [physicians] are, reminding us about their products. And they are always easy to spot. They look like *ekelos*," he commented jokingly.

The *ekelo* is a being associated with prosperity and abundance in the southern Andean world (specifically Peru and Bolivia). It is usually represented as a mestizo



FIGURE 3. Ekeko at a street stand. Credit: juhauski72, <https://commons.wikimedia.org/w/index.php?curid=69915694>.

male figurine wearing the clothing of Indigenous Aymara and Quechua people. While ekekos are usually represented as benign and generous beings, their good intentions cannot be taken for granted. They are demanding entities who must be kept happy with regular supplies of alcohol, cigarettes, and all kinds of miniature gifts (food, appliances, university degrees, flight tickets, currency). In return, these beings watch over the household, ensuring that the miniature gifts they receive will show up in people's lives. As both trader and trickster, as Sandra Rozental (2019) has written, the ekeko "grants access to commodities—the magic of capital itself—in exchange for offerings." Therefore, it is crucial to build good relationships with them.

Like ekekos, pharma reps who visit the HUV are associated with material abundance. These full-size humans grant access to medicines and carry a "payload" too.

Reps I came across would often be pulling one or two wheeled suitcases full of pharmaceutical products, with additional bags on their shoulders. From medical literature, lunch boxes, and nutrition supplements to souvenirs (e.g., Ensure, Avastin mouse pads, and pens), pharma reps always have something for everyone.

When visiting physicians at noontime, reps would usually bring unmarked polystyrene boxes filled with *corrientazo* lunch combos. The word *corrientazo* comes from *corriente*, which means “standard,” “ordinary,” or “regular.” In the Colombian culinary context, *corrientazo* usually refers to regular or generic food—*comida casera* (household/comfort food)—that is sold at diners. Among physicians, it was often perceived as being of lower quality. A typical *corrientazo* lunch box at HUV would contain Colombian staples like white rice, pasta, plantains, and potatoes (often a little bit of each). It would also include proteins like beef or chicken and a combination of fresh vegetables like lettuce, cabbage, carrots, and tomatoes.

Corrientazo lunch is not intended for everyone. Pharma reps at HUV would usually distribute the lunches to chief nurses and receptionists to help them cultivate rapport, which “translates into more time with physicians” (Sismondo 2018, 142). Medical students and anthropologists like me would also qualify (if we showed up at the Residents’ Room at the right time). When reps focus their attention on “higher value” targets, like residents, they distribute a different kind of lunch: brand-name boxes. These are boxes marked with the logos and names of fast-food restaurants perceived by my interlocutors as having higher quality, such as El Corral or Charlie’s Roastbeef—two iconic chain restaurants in Colombia that pride themselves on serving “gourmet” fast food: hamburgers, sandwiches, and french fries.

In addition to knowing who gets a branded or a generic lunch, *visitadores médicos* usually have strong social skills and outgoing personalities. And they are always impeccably dressed. While at HUV, male reps would wear suits, ties, and polished shoes; women would wear dresses or skirts and heels. They would typically be equipped with scripts carefully tailored to match doctors’ personalities and neutralize any of their potential evasive moves. Often reps would strategically roam around bathroom areas or exit doors as they anticipated doctors’ lunchtime or coffee breaks. The boldest ones knew how to sneak into doctors’ offices and give out samples between consultations.

While eating my lunch at the Residents’ Room, I would often hear these salespeople using the phrase, “mis doctores estrella [my top doctors].” When I asked Dr. Jesus about this phrase, he explained that pharmaceutical companies keep lists of doctors and rank them according to the volume of drugs they prescribe. These lists are typically organized by neighborhoods and assigned to individual representatives. Each list is called a “caseload” and may typically range from ten to thirty physicians. “A rep who works with oncology drug portfolios, for instance, may get assigned around ten physicians to work with, while another’s caseload may be thirty general practitioners,” the physician explained.

Regardless of how many doctors they manage to visit each day and the drug portfolio they seek to expand, pharma salespeople rarely seem to improvise. According to Dr. Jesus, “They don’t just show up at a medical office expecting to come across a good prescriber, someone who would patiently listen to them for fifteen to twenty minutes.” In fact, he told me, reps do research in advance about the prescription potential of each of the physicians they visit, as well as a host of other details that might help connect with them. “Ellos nos hacen seguimiento [They follow us],” Dr. Jesus noted. “They collect data about drugs’ sales and learn who their top prescribers are—who tends to prescribe what and which doctors need special incentives from the industry.”²⁶

Even though stricter ethical regulations have been put in place recently that prohibit pharmaceutical companies from sponsoring doctors and giving them sumptuous gifts to encourage the prescription of certain drugs (AFIDRO 2019, 2022), it is still up to individual doctors to draw the fuzzy line between what is sumptuous and economical, ethical and unethical.²⁷

Among the residents I met at HUV, Dr. Jesus is probably one of the most pragmatic when it comes to drawing these lines and engaging with the pharma industry. “We cannot close our eyes and pretend the [pharma] industry has no influence whatsoever on our job. We depend on it,” Dr. Jesus said. “Do you think most doctors in Colombia, who often work more than ten hours daily, would have the time to go home every night, spend quality time with partners and kids, and read the latest ten articles on oncology research, treatments, and new drugs? Reps provide us with a valuable service, sharing data on drug development, so we get a sense of what’s happening in the latest research and we can make informed decisions.”²⁸

Dr. Jesus paused briefly and then added a clarification: “Of course, there are pharmaceuticals whose ethical boundaries are questionable. For instance, I know colleagues who had been invited to deliver talks at medical congresses. Prior to their presentations, pharma reps have reached out to them and asked to see their slides. There are other instances when reps ask us to talk about their drugs and use the brand-names at congresses. These cases, I believe, are utterly unacceptable, unethical. But, you know, there are doctors who don’t mind, and are happy engaging in ethically questionable practices. Because these doctors have not set clear ethical boundaries from the beginning, they later find themselves too infatuated with of the lures of the industry.”

Dr. Jesus concluded, “It is important to know who you are as a physician. Be friendly enough with reps. You never know when you will need them. Just be aware of your own boundaries, don’t be too friendly to the point that your medical autonomy and decision making get seriously compromised.”

For him, setting personal limits from the beginning is crucial. Yet these boundaries need to be flexible enough to adapt to the unique conditions of the anti-cancer drug market in Colombia.

“The pharma industry can also be a positive force,” Dr. Jesus explained. “Think about drug samples. These are not only marketing tools used to increase sales of drugs. Samples may also be great for patients. But it is important to know how to harness their potential.”

Supporters of drug samples argue that they may allow trials before purchase (Alexander, Zhang, and Basu 2008), provide patients with immediate access to treatments instead of enduring delays filling prescriptions and submitting drug requests to EPSs, and may even give doctors a chance to gain experience with new drugs (Alikhan et al. 2010; Tran 2014).

While it may be tempting to argue that drug samples help low-income patients, critics argue that these single dosages are rarely first-line medications, are not recommended by clinical protocols, and are not always effective or less expensive than generic alternatives (Evans and Brown 2012; Brown 2021). In addition, the use of samples may have an effect on the drugs’ costs. In countries like the US, for instance, drug samples have proven to raise the cost of health care, “as companies recoup marketing costs through higher prices and increased sales volume” (Chimonas and Kassirer 2009, 2).²⁹ In the case of Colombia, the widespread use of tutelas and the distribution of drug samples, it could be argued, also play a role in reproducing generic scarcity and transforming this country into one of the most profitable markets for branded medications (see Andia 2013).

My conceptualization of drug samples draws inspiration from Rima Praspaliauskienė’s *Enveloped Lives* (2016). In her ethnography conducted at hospitals in Lithuania, she writes about patients who frequently give doctors little white envelopes with money, which are informal payments to ensure surgeries or treatments go well. Envelopes like these, she explains, may even serve to transform rude and grumpy doctors into caring individuals. As a complex patient-doctor transaction, “enveloped” care “exceeds the notion of the gift and/or the bribe while also being included in them” (584). Its reality is not limited to an economic rationality. Hence, rather than a gift or a bribe, Praspaliauskienė conceptualizes these little white envelopes as a practice of health and care. The envelope works as a technology of caring and as a mechanism of healing.³⁰

Like envelopes, drug samples in Colombia are technologies of caring that exceed the notion of the gift/bribe. In Dr. Jesus’s words, “When we provide patients with samples, we are providing them with time, the time required to continue getting access to their treatments while they request these same drugs via tutelas. We use samples *mientras tanto* [in the meantime].”

Dr. Jesus explained that samples are used *while* patients and their physicians navigate the medical insurance bureaucracy.³¹ Like stopgaps, these technologies of care can be used until something more permanent can be procured. In the context of chemotherapeutic drugs, branded samples serve as temporary forms of care provided to patients until a permanent supply of the same brand-name drug is secured via tutela rulings. As a result, pharmaceutical samples may help

patients save time, allowing them continuity in their treatments (Alagha and Fugh-Berman 2022). And stopgaps mediate—“mientras tanto”—between elements that are not yet co-temporary, elements that do not yet exist in the same temporal frame, that is, a single branded dosage and the hopes for a permanent supply of the same brand-name drug via the *tutela*. Likewise, drugs samples may reconcile seemingly different business rationalities and interests: health insurers’ need to be vigilant about their spending—which results in treatment deferrals—and global pharmaceuticals’ prescription maximization and lobbying efforts to prolong drugs’ patent periods (Dumit 2012; Sunder Rajan 2012, 2017).

My encounters with pharmaceutical reps and drug samples, however, were not limited to HUV’s Residents’ Room and generic or branded lunch boxes. I also followed reps to upscale restaurants where they typically meet with senior “star” physicians, like Dr. Masa. Crucially, while lunch boxes and invitations to restaurants may be common tools used by the pharma industry to build relationships with physicians—and increase the sales of specific drugs, doctors may also harness these meetings to request specific branded drug samples for their closest patients.

SOCIO-CHEMISTRY

I feel slightly uncomfortable with my new clothes. As per Dr. Masa’s request, I am wearing an ironed shirt with a tie and formal shoes (which I had to buy specifically for today’s meeting). On top of that, Cali’s high humidity and elevated temperatures were making my otherwise enjoyable fieldwork quite challenging. And then there was Dr. Masa’s zigzag driving. Attempting to drive across Cali at noon is a tricky—often risky—endeavor, especially if one is running late. I manage to hold on tightly to the handle above the passenger door.

Today we will be having lunch at a Peruvian restaurant with Helena, a pharmaceutical representative in her mid-thirties who manages Roche’s oncology portfolio for medical providers in north Cali. Her professional ties with Dr. Masa date back almost a decade, when she was working for a competitor and trying to finish an associate degree in marketing. Unlike physicians who are employed full-time at hospitals, Dr. Masa seems to enjoy a remarkable degree of autonomy when it comes to managing his relationships with pharma reps like Helena and prescribing branded chemotherapy drugs that are more expensive than bioequivalent generics. His part-time job at HUV has released him from certain ethical regulations that guide full-time physicians and regulate their relations with reps prohibiting them from receiving direct financial payments from the industry in exchange for prescribing their products.

When we arrived at the restaurant Helena had already ordered several dishes for us: fish ceviche and fried octopus as entrees, among other Peruvian dishes. In addition, a Pisco Sour was waiting for Dr. Masa at the table.³² Like many other woman reps I had encountered, she was impeccably dressed: white blouse, gray

miniskirt, and black heels. A laptop bag was hanging on a chair. Under the table I could see the typical wheeled suitcase that reps pull across HUV's hallways.

The conversation that follows illustrates how senior oncologists like Dr. Masa manage to provide patients with branded drugs by tapping into their social skills and professional relationships with the pharma industry.

Without much preamble, and after taking a sip of Pisco Sour, Dr. Masa made the following request: "Helena, I wonder if you could do me a huge favor. This one patient—a very poor guy with stomach cancer, you know—had to interrupt his chemo regime because trastuzumab has been difficult to get.³³ What are the chances we could get him a sample of Herceptin 440 mg?"

Anti-cancer drugs such as Herceptin and trastuzumab are said to be equivalent in the sense that they contain the same active molecule. Both are available in the same dosages and are administered by "drop" into a vein, or intravenously. Yet they are different because of their prices.³⁴ While trastuzumab is a low-cost POS generic, Herceptin is a branded No-POS medication. Between 2011 and 2013, a single vial of Herceptin 440 mg was around 5,000,000 Colombian pesos (US\$1,600)—more than twenty times what trastuzumab 440 mg costs.

Even though Herceptin is a No-POS and expensive drug, Dr. Masa was confident in the feasibility of his plan for replacing trastuzumab. He shared his strategy with Helena: "Once a writ of tutela is ruled in the patient's favor, we will be able to put him on Herceptin for the duration of his treatment."

Dr. Masa took another sip of Pisco Sour and continued: "You know I am reliable. I have always kept my promises. You are my *socia*." In Spanish *socio/a* is an amigo or friend but not only. It may also refer to business and professional partners.³⁵

"Sure. I am here to help," Helena replied. "I will get in touch with my team at Roche and find out whether we have Herceptin samples available."

To overcome the scarcity of trastuzumab, Dr. Masa had tapped into his long history of partnerships with pharmaceutical reps. His relationship with his socia, Helena, would soon be translated into a single branded sample for one of his patients—with the potential of becoming permanent via a tutela.

. . .

Dr. Masa's cell phone vibrates on the table. His secretary is sending reminders about the long list of patients waiting for him at HUV; the time has come to drive back to the hospital. I rushed to finish my dessert while the rep handed her credit card to the server. "Lunch is on me," she told us. Dr. Masa nodded without displaying any noticeable gesture of surprise—as if these kinds of invitations were rather ordinary. From fried squid and fish ceviche to desserts like *suspiro limeño* (sigh of Lima), our lunch had been fully sponsored by the pharma industry. My usual good old corrientazo lunch had been upgraded. Even though I was fairly used to observing drug sample distribution and the enactment of other marketing tools at HUV, this was the first time I had had the chance to witness these practices outside

hospitals. Helena had not dispensed pens, caps, or mouse pads but rather invited Dr. Masa and me to lunch and committed to provide Dr. Masa with a branded chemotherapy sample.

On our way back to the hospital I shared with the physician the questions I had kept to myself. “It all seemed so natural,” I exclaimed. “Is this how some patients manage to access branded medications when EPSs create barriers or when generics are out of stock within their pharmacy networks?” I asked.

“In some cases, it is. But not always,” Dr. Masa answered. “You see, not every doctor has the same kind of connections with the pharma industry. If you haven’t devoted time to getting to know them [reps] and demonstrating your prescription potential, then it’s more difficult. In other cases, there may be doctors who have built these relations but do not feel at ease with the whole drug sample thing.” “It all boils down to a *cuestión de química* [matter of chemistry],” he added.

Puzzled, I asked him to explain.

“Yes, the *química* [chemistry] or *afinidad* [affinity] I have built with certain pharma reps over the years—with my socios. It’s a special kind of bond, you see. Química is not something you happen to have with the first random person you meet on the street. If you are fortunate enough to develop química with someone, you better nurture it through a mutual give-and-take. When reps help my patients, for instance, I feel compelled to give something in return, you know. There needs to be reciprocity. That’s how relationships are sustainable over time. Everyone must cede something.”

To better understand Dr. Masa’s *cuestión de química*, let me take a brief detour into the world of chemistry (literally) and the relations between molecules. In doing so my goal is to see the chemical space as relational, which has the potential for catalyzing ethical reflections (Barry 2005; Bensaude-Vincent 2014), including those I was silently mulling at lunch. Here I follow Bensaude-Vincent and Stengers’s (1996, 54) reference to the eighteenth-century French chemist and physician Étienne-François Geoffroy, who considered chemical substances “combinations of molecules and their reactions in terms of association and dissociation.” According to Geoffroy, the affinity or strength of chemical relations would vary depending on how the combinations are rendered possible. The chemist, therefore, could be understood as someone who manages molecules and tries to balance their relations.

Geoffroy’s descriptions are not foreign to oncologists like Dr. Masa, whose medical expertise revolves around maintaining balance between multiple anti-cancer drugs. As explained in chapter 1, oncologists must choose combinations of cytotoxic molecules—and their reactions—that can kill tumors without ending the life of patients (Mukherjee 2012). Hence, as Bensaude-Vincent and Stengers (1996) would have put it, weighing what molecules go in and what molecules come out of specific chemical interactions—keeping detailed balance sheets of reactions and organizing them in the form of equations—is a way of increasing the likelihood cancerous bodies withstand aggressive chemotherapy cocktails.

In addition, oncologists need to be keenly aware of the chemical (in)compatibility between drug groups. They need to know which drugs have affinities with which medications, especially when chemo protocols need to be tweaked or when first-line drugs are substituted for second- or third-line pharmaceuticals.

Think about chemotherapeutic generics included in the POS formulary. Cisplatin, for instance, can be used not only to treat testicular cancer, but lung and breast tumors as well. And since carboplatin may be interchangeable with cisplatin, therapeutic options multiply twofold—giving patients a “plan B” in the event one of these lose their potency against tumors or go out of stock within pharmacies. Oncologists also know that doxorubicin and cisplatin work well when combined. But adding doxorubicin to an etoposide regime may not always be recommended.³⁶

“Like drug molecules,” Dr. Masa explained, “humans also have their preferences [affinities] for establishing relationships. It is a matter of knowing who is compatible with whom. This is the chemistry [*química*] I was talking about.”

In other words, not every combination of physicians and pharma reps may render branded samples possible, let alone samples that are considered ethically appropriate. And where these socio-chemical relations unfold matters.

The oncologist continued, “Throughout the years I learned that meeting with reps at hospitals tends to be problematic, you know. At hospitals we must focus on our patients. Therefore, I don’t like getting samples when I am holding consultations. It is uncomfortable for me and unfair to my patients. It just doesn’t look good, you know. A rep standing by my door, giving out gifts, would be seen by many people as *ordinario, de mal gusto* [indecent, vulgar], and unethical. I wouldn’t want to run the risk of someone perceiving this as anything other than what it is. To avoid potential misunderstandings, I prefer going out for lunch with reps whenever possible. Meeting with them at restaurants or social events allows me to think outside the box, talk more freely, and ask for samples. And sometimes I don’t even have to ask for anything; reps are often quick to anticipate my needs. So going back to your question, I would say it’s totally fine to ask for drug samples, as long as your prime motivation is helping patients.”

For Dr. Masa, the moral rightness of asking for samples and accepting them would greatly depend on the location where these are enacted. From hospitals to restaurants, drug samples have multiple modes of existence (Latour 2013) and may coexist in several intersecting social worlds while fulfilling the ethical requirements associated with each of them (Star and Griesemer 1989).

As such, when physicians and pharma reps in Colombia move from a hospital to a restaurant, drug samples acquire different ethical connotations.³⁷ The identity of practices, after all, is dependent on a constellation of elements (Stengers 2005b). From being an *ordinario* physician who disrespects patients at hospitals to a committed and caring clinician who asks reps for costly chemotherapy samples at restaurants, different places are imbued with unique moral potential.

Throughout encounters like these, samples become relations of care woven into oncology practice as a tool for initiating a substitution of generics for branded drugs—therefore saving patients’ time. I argue that the possibility of accessing No-POS chemotherapy drugs such as Herceptin or Zytiga may be partially shaped by drug samples and socio-chemical relations, that is, relations of affinity between socios at a restaurant that extend what physicians and reps could not do in a consultation room. Thus, the kinds of drugs produced and sold by the pharmaceutical industry “can be understood as ‘societies’ of different elements, as long as we understand that societies are associations of non-human as well as human entities” (Barry 2005, 64).

Drug samples, I have sought to show, cannot only be seen as a practice for increasing Roche’s market for oncology products, nor can they be understood merely as a practice of care through which a concerned doctor seeks the favors of a multinational pharmaceutical. The whole of the physician-pharmaceutical relation (see Strathern 2020) I witnessed at the restaurant differed from the individual interests pursued by Dr. Masa and Helena. In other words, individuals who are not supposed to mix—physicians and pharma reps, who typically have different and conflicting interests—suddenly need the other, because alone neither of them would achieve their individual goals.

. . .

The next day, while holding consultations at HUV, Dr. Masa received a text from Helena confirming that two Herceptin vials would soon be shipped to his office—carefully packed inside a white polystyrene box.

“You see, thanks to Helena, I can give hope to many of my patients. That’s why she is my socia. This is the minimum gesture of generosity I expect from the pharma industry. Getting drug samples when I need them is a tiny favor in comparison to the large number of Roche prescriptions I write each month. It’s like removing a hair from a cat. They know I work with several hospitals in Cali; they know I work with many EPSs. They are not dumb. The market opportunity I represent is important. And there aren’t many oncologists in Cali.³⁸ So pharma reps need to maintain good relationships with us.”

Dr. Masa was fully aware that he represented a “market opportunity” for Helena’s sales goals. At the same time, he considered her a socia who provides sample dosages from time to time. Their encounter at the restaurant linked molecules with the destinies of a patient through alliances and relations of affinity—*socio-chemistry*. Hence, living longer for certain (often low-income) patients in Colombia would depend on relations at both the molecular and social scales. Dr. Masa’s “socio-química” highlights how medicine, social relations, drug samples, tutelas, and Peruvian dishes are intimately connected to make cancer care possible. It may also illustrate how frustrated physicians at public hospitals bypass EPSs’ financial vigilance and the time it takes the government to enact new

policies, hoping to provide patients with continuous access to treatments—even when cancers are too advanced.³⁹

The next chapter explores why standard biomedical protocols, which seek to limit aggressive interventions for terminal cancer patients, were rarely followed in many of the clinical encounters I witnessed. After accessing their treatments, often using samples, patients I worked with faced a relentless and sudden chemotherapization of their dying process.⁴⁰ I argue that physicians' moral obligation to help patients live longer, the overabundance of branded drugs, and the national mandate for universal health care have created the perfect storm; toxic and high-cost chemotherapy protocols become the ethically appropriate treatment for many patients whose cancers are metastatic, often in terminal phases. How do oncologists and patients (and their families) decide when *too much is enough* in neoliberal Colombia?