ZOOMRX

What Earns HCP Time

What 105 physicians said about pharma engagement in 2026: access, interaction quality, omnichannel coordination, and MSL effectiveness.

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Chitra Alagarsamy is a Product Owner for Promotional Effectiveness Tracking (PET) at ZoomRx, focused on helping pharmaceutical organizations understand how field and promotional activities translate into physician engagement and commercial impact. She specializes in developing measurement frameworks and benchmarking approaches that help teams evaluate execution quality, identify performance gaps, and turn complex engagement data into actionable insights.

Chitra plays a key role in shaping ZoomRx's PET capabilities, with a focus on building scalable approaches that connect physician feedback, field execution, and competitive context into a more complete view of promotional performance. Her work is grounded in the belief that measuring activity alone rarely explains impact, and that continuous feedback and benchmarking are essential for improving commercial effectiveness across the product lifecycle.

90+

Pharmaceutical clients supported in the last 5 years

500+

Pharma brands tracked in the last 5 years

60M+

Benchmark data points built in the last 5 years

Introduction

Physician access in 2026 is predominantly appointment-based unscheduled visits have nearly disappeared from the engagement model, with institutional policy and front office staff carrying as much weight in the access decision as the physician relationship itself. Within this environment, the entry condition for a productive interaction is novel clinical content: nearly all physicians in this study identified new or updated clinical information as the threshold for granting time, with rep preparedness and visit efficiency then shaping whether that engagement converts to a next appointment. The threshold cuts in both directions. Visits that don't clear that bar rarely get rescheduled. Behaviors that signal commercial pressure or unpreparedness tend to end the relationship entirely, not just the visit.

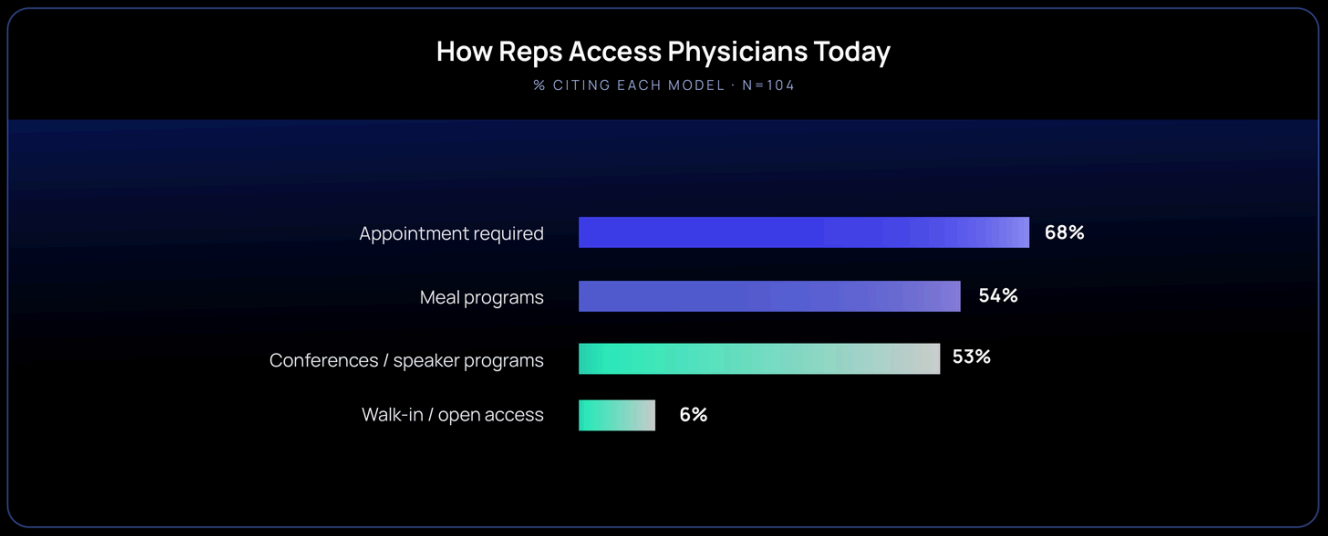
Coordination across channels remains an unresolved gap at the same scale: 47% of physicians described pharma outreach as coordinated; 45% described it as disconnected. Physicians who cited coordination consistently pointed to one element: continuity of conversation across touchpoints. This points to a data-sharing problem between field, digital, and medical teams rather than a channel strategy failure. The MSL relationship follows its own credibility logic: scientific independence from commercial activity is the foundation of physician trust, and one in four physicians with direct MSL experience described a boundary violation that discounted both field roles simultaneously.

Physicians in this study pointed consistently to depth over frequency: richer clinical content, patient access support, and practice workflow integration rather than more touchpoints. More than 70% described human interaction as irreplaceable in clinical decision-making contexts. A meaningful minority sees potential for AI in low-complexity interactions, but consistently excluded contextual clinical judgment from that scope, reinforcing where the human engagement model still holds.

SECTION 01 · REP ACCESS

How reps get time with physicians today

Unannounced rep visits have effectively exited the engagement model. In 2026, access is a scheduled event, governed by appointment requirements, institutional policy, or both. The front office relationship carries as much strategic weight as the physician relationship.



> *I only see reps by appointment now. If they can't bring something I haven't heard, I don't extend the visit, and I don't reschedule.*
>
> ONCOLOGIST · ACADEMIC MEDICAL CENTER

Appointment required 68%

The dominant model across both specialties. The scheduling conversation is now a commercial touchpoint in its own right.

Meal programs 54%

Structured access, heavily concentrated in neurology private practices. The meal earns the room; the content earns the next visit.

Conferences and speaker programs 53%

The primary alternative in academic oncology, where institutional policy restricts on-site access.

Walk-in / open access 6%

Nearly extinct. Persists in a small number of private neurology practices only.

How has post-COVID access evolved?

Post-COVID access has not landed in one place. The largest group, 39%, says things are back to normal. But more than half describe some lasting change: more virtual visits, tighter restrictions, or a preference for scheduled appointments that stuck because it worked. The largest share say norms have returned, but meaningful minorities report lasting structural change:

39%
Access returned to pre-COVID norms

26%
More virtual or hybrid — a lasting shift

17%
Continued restriction or no access

13%
More structured & appointment-driven — and they prefer it that way

> *Appointment-only actually worked better for us. We could manage our time and reserve dedicated space. COVID forced the structure; we kept it because it works.*
>
> NEUROLOGIST · OFFICE-BASED PRACTICE

Who controls rep access?

Access control is distributed across three layers, none of which a rep fully owns. Practice-wide policy is the dominant gatekeeper (61%), followed by the physician's own preferences (56%) and front office staff who manage scheduling and day-of decisions (32%). In academic settings, institutional rep relations departments add a fourth layer that operates independently of the physician entirely. Field strategy that accounts only for physician preference misses where the access decision is actually made.

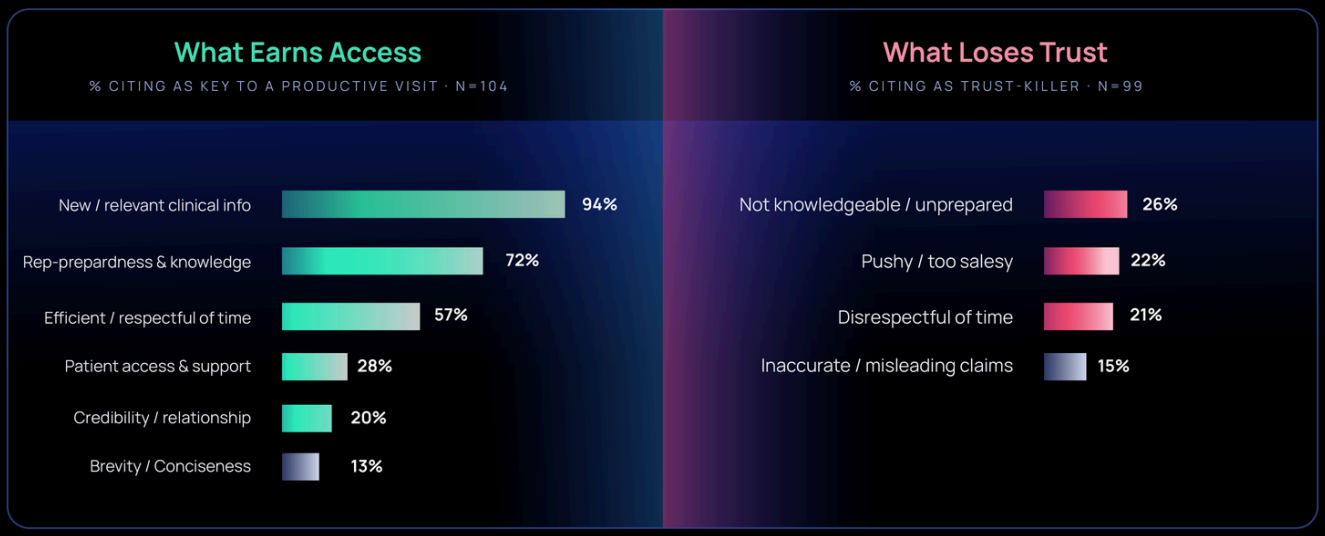
> *Sales reps do not have direct access to physicians in my institution. It has to go through the rep relations department and it is heavily governed.*
>
> ONCOLOGIST · ACADEMIC MEDICAL CENTER

SECTION 02 · INTERACTION QUALITY

What earns the interaction and what ends it

Getting time is the first barrier. Using it well is the second. Physicians are precise about both, and the threshold for a failed visit is lower than most commercial teams assume.

What earns access vs. what destroys trust



Only concise, data-driven medical information earns my time. No new data, no meeting.

NEUROLOGIST · ACADEMIC MEDICAL CENTER

If they ask me to prescribe their drug, or how many patients I'm going to choose, that immediately causes me to lose trust.

NEUROLOGIST · PRIVATE PRACTICE

New data. Specific to my patients. Brought by someone who can actually hold a scientific conversation when I push back. That's a good visit.

ONCOLOGIST · ACADEMIC MEDICAL CENTER

The fastest way to lose me is to pivot from clinical information to asking how my prescribing has changed since our last meeting.

ONCOLOGIST · ACADEMIC MEDICAL CENTER

If a rep knows my patient panel and brings something I can act on right away: a dosing nuance, a new safety signal, that visit is worth my time.

NEUROLOGIST · COMMUNITY PRACTICE

Know that I treat heavily pre-treated patients and talk specifically about that population, not generic phase 3 data, but what that means for my patient type.

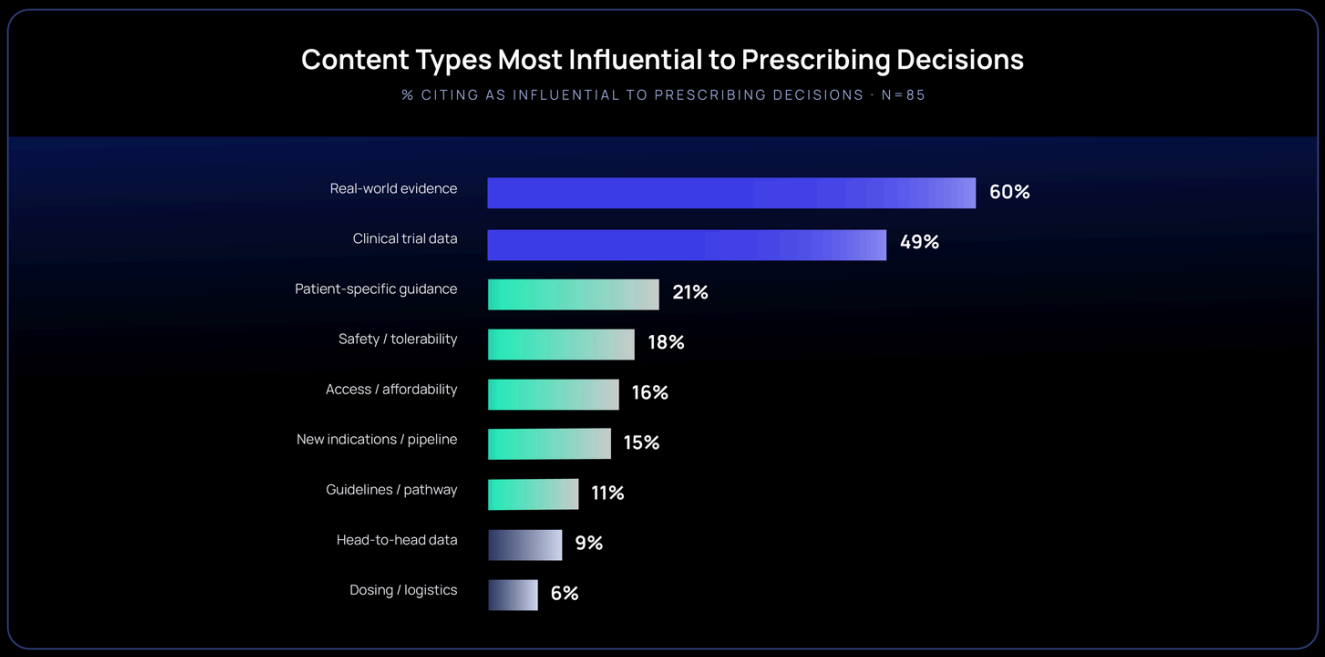
ONCOLOGIST · ACADEMIC MEDICAL CENTER

94% of physicians in this study cited new or updated clinical information as the entry condition for a productive visit, clinical newness sits above all other factors by a significant margin, with rep preparedness and time efficiency then shaping whether the interaction converts into a next appointment.

Clinical newness sits above all other factors as the access threshold in these conversations, rep preparedness and time efficiency then shape whether the interaction converts into a next appointment. Patient access and support carries underappreciated weight, particularly in neurology where practice complexity around reimbursement is highest.

What content actually influences clinical thinking

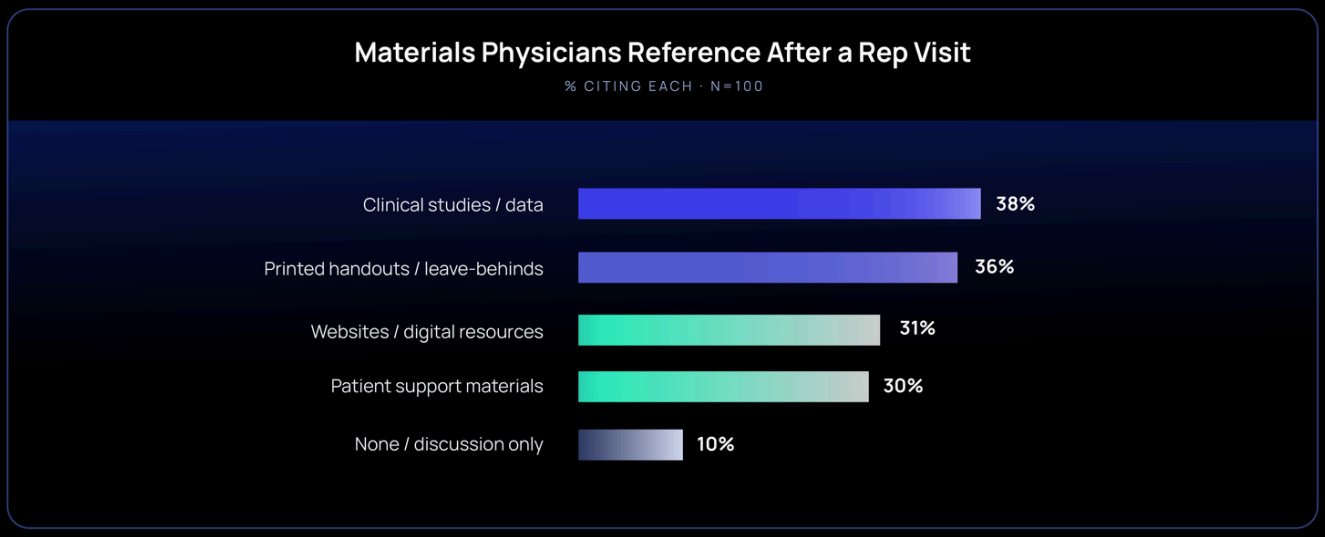
Real-world evidence topped the list of influential content types in this study, cited by 60% of physicians and ahead of clinical trial data. Whether this reflects a broader change in how physicians weigh evidence is a question worth tracking over time.



> *Efficacy data speaks for everything. If there's a survival benefit, it doesn't matter whether it's a new drug or not. Show me the curve.*
>
> ONCOLOGIST · ACADEMIC MEDICAL CENTER

What physicians reference after the visit

The materials a physician turns to after a rep visit are a signal of which touchpoints generate continued engagement. Clinical data leads, followed closely by printed leave-behinds and digital resources. Nearly one in ten physicians reference nothing after the visit. This measures how often visits fail to produce something worth returning to.



> *I'll look up the study they mentioned if it was credible. Leave-behinds go in the bin unless the data is genuinely new. Patient support materials I actually use.*
>
> NEUROLOGIST · OFFICE-BASED PRACTICE

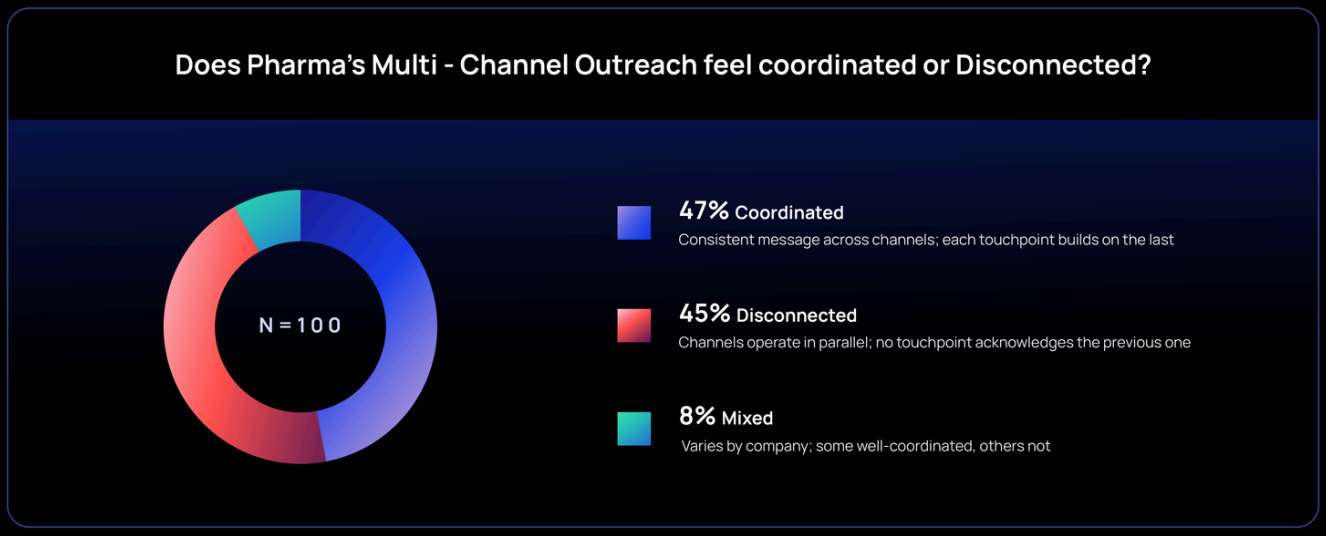
SECTION 03 · OMNICHANNEL REALITY

What makes outreach feel coordinated — and what doesn't

47% described pharma outreach as coordinated in these conversations; 45% described it as disconnected. The near-parity of those two figures is itself a finding. Coordination is far from the norm across this physician sample. What physicians described as disconnected was less a volume complaint than a memory failure: no touchpoint acknowledged the last. The pattern points toward a data-sharing gap between field teams rather than a fundamental channel design problem.

> *Mostly disconnected. I'll attend a panel at ASCO, hear something compelling, and then a rep shows up two weeks later with no awareness that I was even there.*
>
> ONCOLOGIST · ACADEMIC MEDICAL CENTER

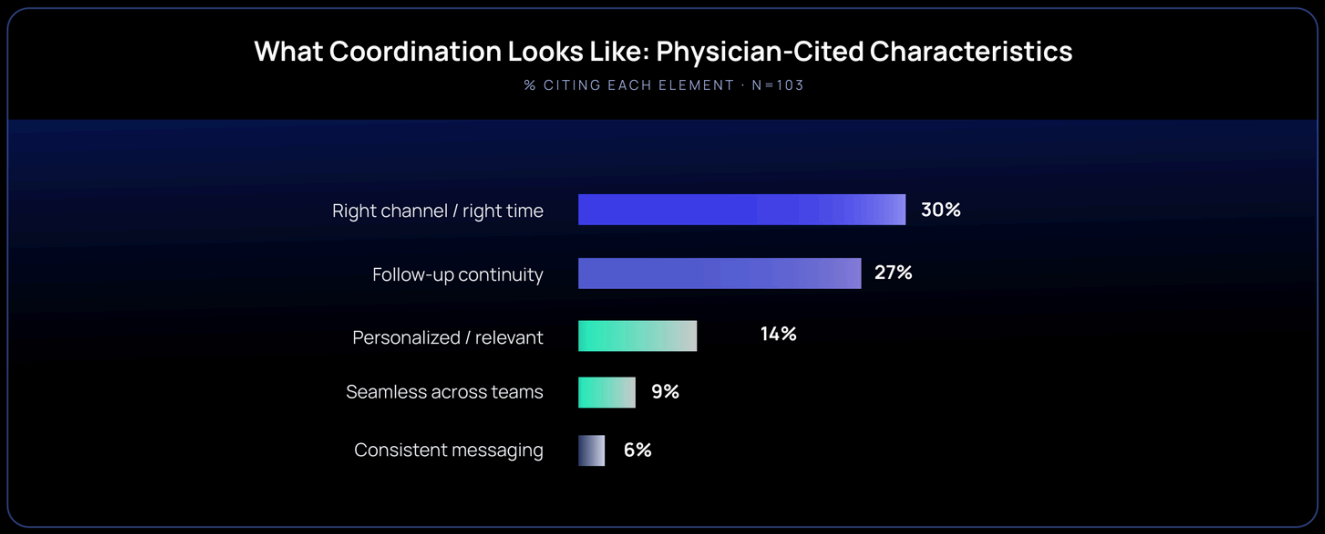
Coordinated or disconnected?



> *It feels disconnected, disjointed, like the right hand doesn't know what the left is doing.*
>
> NEUROLOGIST · ACADEMIC MEDICAL CENTER

Physicians define coordination through continuity, not through channel sophistication. The top two characteristics, right channel at the right time (30%) and follow-up continuity (27%), both describe the same underlying need: each touchpoint should build on the last. Personalization and seamless handoffs between teams matter, but they operate in service of that continuity.

What good coordination looks like to physicians



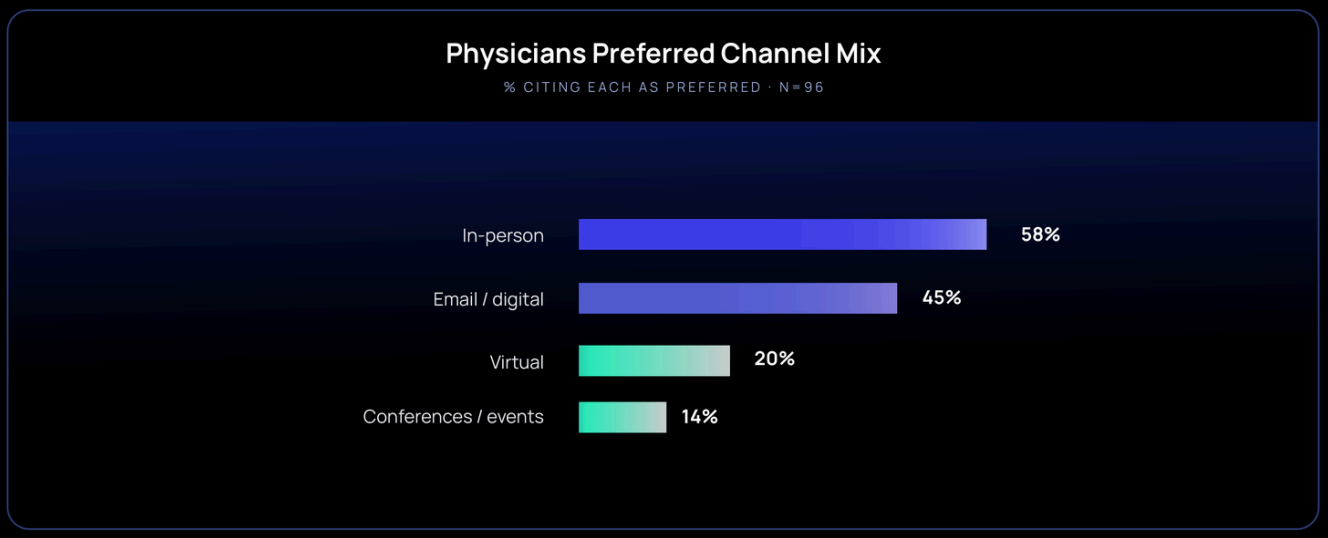
The implication is operational: coordination requires shared interaction memory across field, digital, and medical teams, not just aligned messaging.

> *A well-coordinated experience involves each person who contacts me knowing what was discussed before, and having a specific motive in mind.*
>
> ONCOLOGIST · ACADEMIC MEDICAL CENTER

> *The best experiences I've had are when the rep, the MSL, and the emails are all referencing the same clinical question I raised. That tells me there's a real team behind this product.*
>
> ONCOLOGIST · COMMUNITY PRACTICE

In-person earns substantive engagement. Email and digital serve follow-up and updates. Virtual handles scheduling and routine touchpoints. A strategy that treats channels as interchangeable will overinvest in digital for relationship-building and underinvest in in-person for new introductions.

Channel preferences and where each channel earns its role

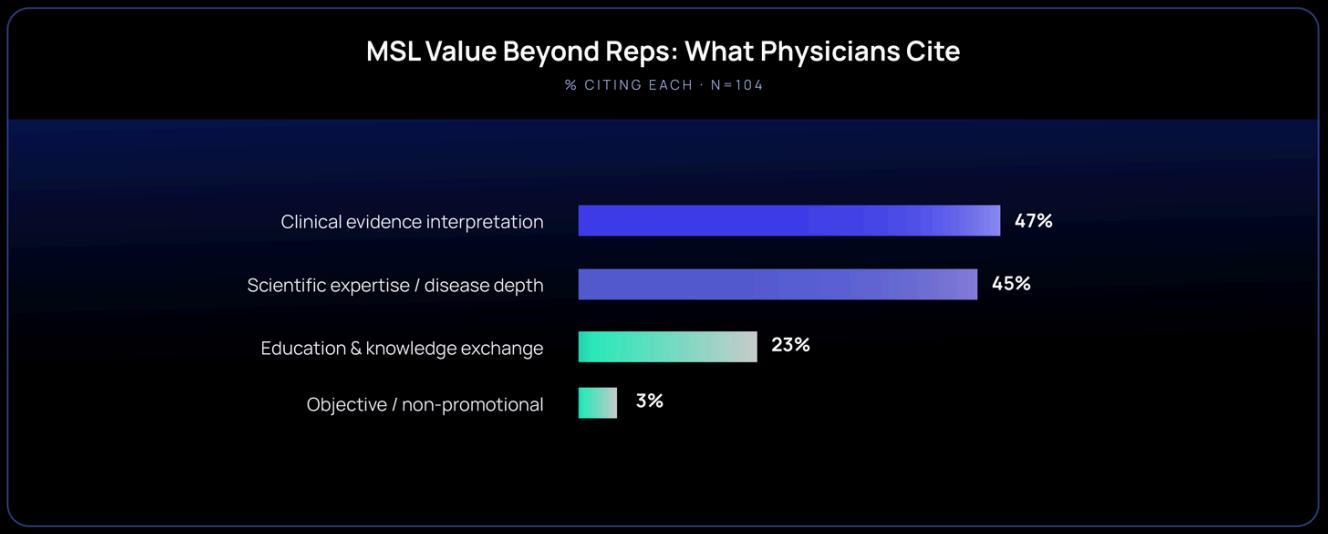


SECTION 04 · MSL ENGAGEMENT

The MSL's value and the boundary that protects it

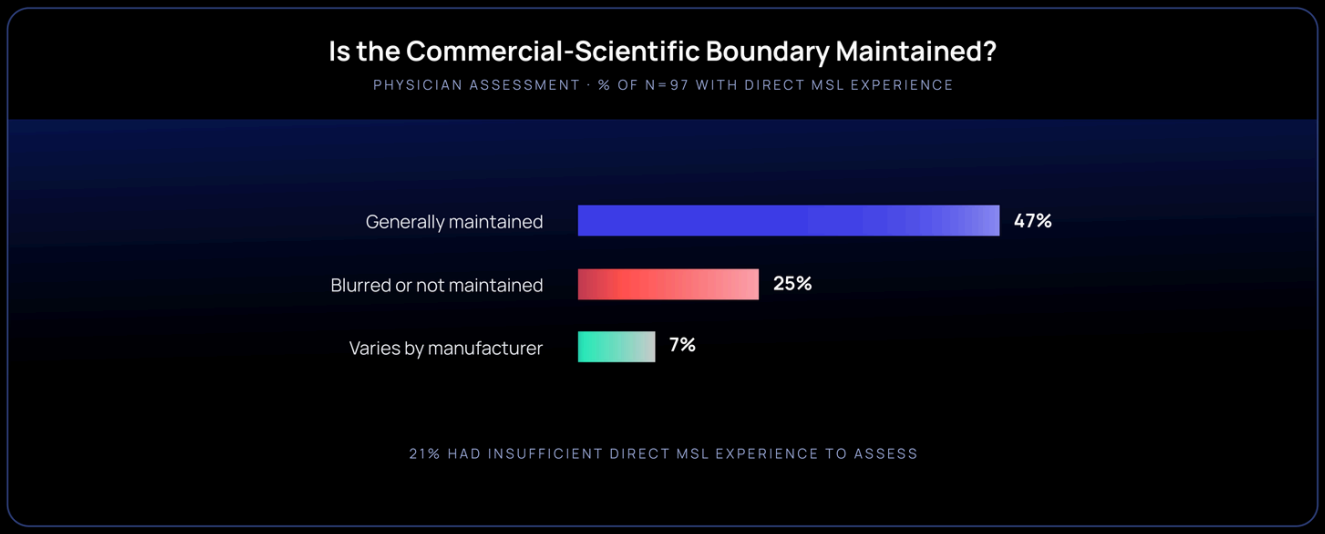
In these conversations, physicians described MSL relationships with more specificity than rep relationships. Clinical evidence interpretation and scientific depth are the entry conditions. What the MSL chooses not to do, sell commercially, is what physicians cited as the foundation of that trust.

What MSLs offer that reps cannot



Clinical evidence interpretation (47%) and scientific expertise (45%) are nearly tied as the top MSL value drivers, defining what physicians expect: not a deeper rep visit, but a scientifically independent engagement that addresses questions reps cannot answer.

> *MSL sticks with scientific and reps do commercial. It's hard to maintain that line, but when it holds, both roles gain credibility at the same time.*
>
> ONCOLOGIST · ACADEMIC MEDICAL CENTER



Among physicians with direct MSL experience, 47% described the boundary as generally maintained, and this group also described MSL relationships most positively. When the boundary was not maintained (25%), physicians discounted both roles simultaneously: the rep who overreaches into scientific territory reduces the MSL's credibility for the next visit. The boundary appears to function as a shared credibility asset, not a problem each role manages independently.

How the MSL role shifts across the product lifecycle

Pre-launch, physicians engage MSLs for scientific framing and trial context, conversations that happen without commercial pressure and that set the credibility baseline.

Post-launch, that same relationship deepens into real-world evidence support, label expansion questions, and complex patient management. The MSL value proposition does not peak at launch and fade, it shifts in character.

> *Pre-launch, the MSL is most valuable, scientific conversation on trial design, emerging data, unmet needs, without commercial pressure. Post-launch, they help me work through the complexities I didn't anticipate*
>
> ONCOLOGIST · ACADEMIC MEDICAL CENTER

> *Where a rep provides real-world data and the scientific liaison backs it up, that's when I find both roles valuable at the same time.*
>
> NEUROLOGIST · OFFICE-BASED PRACTICE

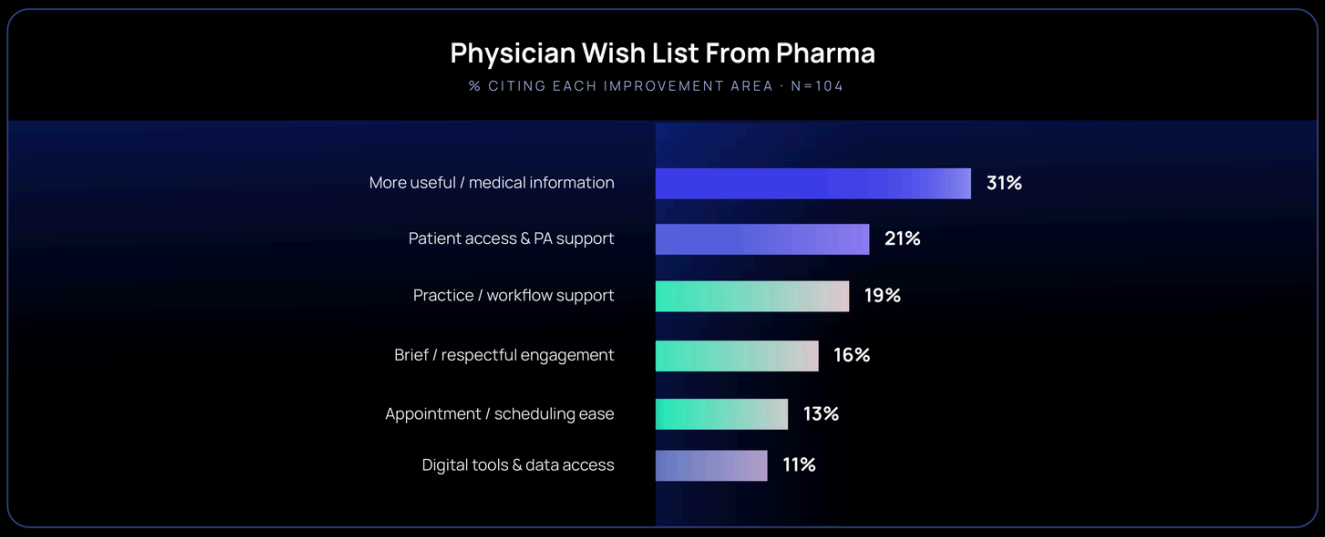
> *There's usually a handoff from the rep: 'I'll bring the liaison in who can discuss the trial data in more detail.' That structure works.*
>
> ONCOLOGIST · COMMUNITY PRACTICE

SECTION 05 · FUTURE STATE

What physicians wish pharma would do differently

When asked what would most improve their pharma engagements, physicians in this study consistently pointed to depth over frequency: richer scientific content, better support for patient access complexity, and visits that fit their workflow rather than disrupt it.

More useful, medical-grade information tops the list: the same depth signal that drives the 94% access threshold identified in these conversations. Patient access and prior authorization support carries the highest expectation-to-delivery gap. Practice workflow support and visit brevity round out the top four. These are requests for more useful engagement from contacts that already happen, not requests for more contact overall.



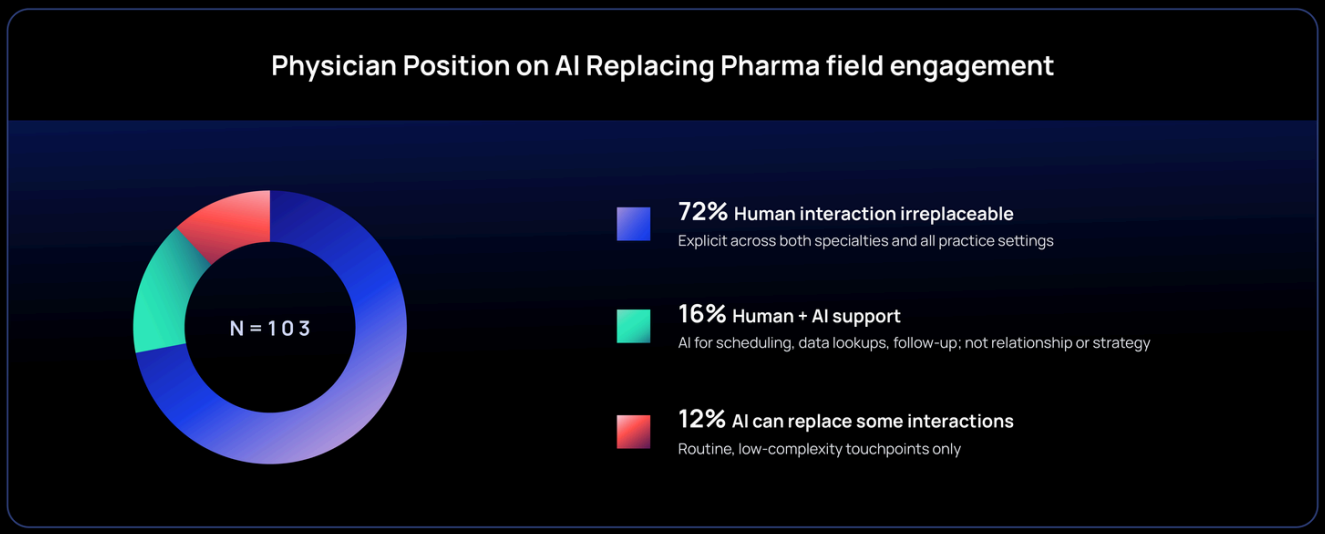
> *More direct help with prior authorizations, information about what pharmacies may cover. The rep who can navigate that earns the next visit.*

NEUROLOGIST · OFFICE-BASED PRACTICE

> *I want a rep who knows the disease state well enough to answer my questions, not just show me new data and go blank when I push back on a subgroup.*

ONCOLOGIST · ACADEMIC MEDICAL CENTER

Can AI replace human pharma field engagement?



The 12% who described AI as capable of replacing some interactions may represent a share larger than prior benchmarks suggest. These physicians pointed to routine, low-stakes touchpoints as where AI has a legitimate role: scheduling, known-drug updates, documentation follow-up. What they consistently excluded was contextual clinical judgment, the territory where reps and MSLs earn the most trust in these conversations.

> *Human interaction is irreplaceable. AI can tell me certain details faster, but the contextual judgment, the relationship. That's not replaceable.*
>
> NEUROLOGIST · ACADEMIC MEDICAL CENTER

SPECIALTY PROFILES

Where oncology and neurology diverge and where they align

Oncology is 57% academic; neurology is 70% private/community. That structural difference drives most of the divergence below.

Shared foundation

Appointment-required access (65% ONC, 71% NEU); new clinical information is the near-universal condition for a productive visit across both specialties.

Access divergence

ONC institutional settings restrict direct rep access, conferences and speaker programs fill the gap. NEU physicians control their own scheduling and exercise a strong in-person preference; meal programs are the primary structured access vehicle.

Content divergence

ONC places significant weight on guidelines and trial design depth. NEU prioritizes dosing logistics and real-world application guidance.

Largest gap — patient access support

Neurologists express materially higher need for prior authorization and reimbursement guidance across every dimension measured.

Access & Channel



Sales reps do not have direct access to physicians in my institution. It has to go through the rep relations department and it is heavily governed.

ONCOLOGIST · ACADEMIC MEDICAL CENTER

I prefer in-person. I gain more information that way. I can ask questions and push back in real time. A Zoom call doesn't give me that.

NEUROLOGIST · OFFICE-BASED PRACTICE

Content

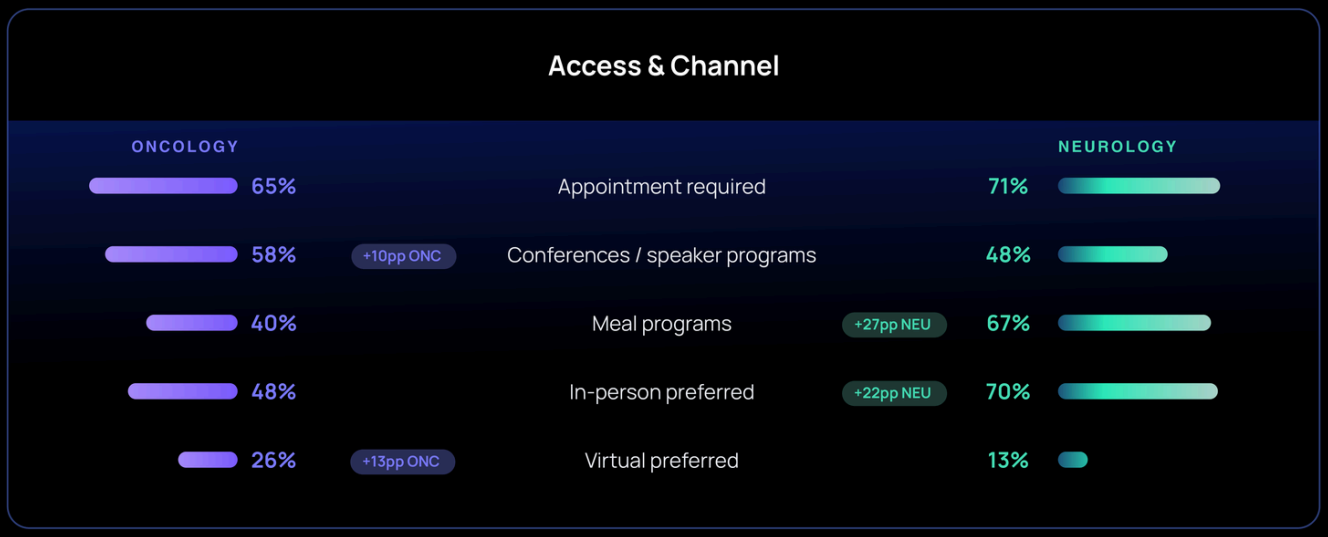


Clinical trial data is everything for my population. I need subgroup analyses, mechanism data, head-to-head comparisons. Anything less is a wasted visit.

ONCOLOGIST · ACADEMIC MEDICAL CENTER

I'll look up the study they mentioned if it was credible. Leave-behinds go in the bin unless the data is genuinely new. Patient support materials I actually use.

NEUROLOGIST · OFFICE-BASED PRACTICE



> *I want a rep who knows the disease state well enough to answer my questions, not just show me new data and go blank when I push back on a subgroup.*
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> ONCOLOGIST · ACADEMIC MEDICAL CENTER

> *More direct help with prior authorizations, information about what pharmacies may cover. The rep who can navigate that earns the next visit.*
>
> NEUROLOGIST · OFFICE-BASED PRACTICE

Base sizes vary by metric. Overall ONC n=53; NEURO n=52. Badges indicate differences exceeding 8pp.

IMPLICATIONS

What this means for your teams

ACCESS STRATEGY

The next appointment is earned in the current visit, not secured by calendar mechanics. In a 68% appointment-required environment, the scheduling decision effectively happens the moment the visit ends. Visits that bring nothing genuinely new tend not to be rescheduled. In institutional settings, a poor visit can close the door to the whole practice.

CONTENT INVESTMENT

Update content at the frequency physicians experience data, not at your launch calendar. The 94% threshold identified in this study, new or updated clinical information as the entry condition, cannot be met with recycled messaging. Reps need a live, product-specific feed of what is genuinely novel by indication, and the scientific depth to hold the conversation when physicians push back.



OMNICHANNEL EXECUTION

Fix the data-sharing problem before adding channels. 45% of physicians in this study described outreach as disconnected. The pattern points less at channel strategy than at a memory gap: no touchpoint acknowledges the previous one. Physicians who described good coordination pointed to a single element: someone on the other side remembered what was said before.



MSL BOUNDARY DISCIPLINE

The commercial–scientific boundary functions as a shared credibility asset. It requires attention from both sides. When a rep overreaches into scientific territory, the MSL's next visit starts from a deficit. Boundary discipline shows up in field training, CRM routing, and rep-to-MSL handoff protocols. MSL deployment should follow the lifecycle shift described in these conversations: scientific framing pre-launch, evidence and patient management support post-launch.



SPECIALTY STRATEGY

Design two engagement models, not a shared brief with specialty tailoring. Oncologists need clinical evidence depth, guideline-level content, and strong pre-launch MSL engagement. Neurologists need in-person access, meal program logistics, patient access navigation, and practice workflow support. These are different models, not versions of the same one. A unified field brief will consistently underserve one of them.



HUMAN CONNECTION

Human interaction is where field investment delivers returns AI cannot replicate, protect it from resource drift. The 72% who described human engagement as irreplaceable were not resisting technology, they were identifying where judgment, relationship, and contextual reading of a specific patient situation carry the most weight. As AI becomes capable in routine touchpoints, the more consequential risk may be commercial resources drifting toward AI-appropriate tasks while high-value human engagements go under-resourced.

Conclusion

Physicians in this study are not disengaged from pharma. They are calibrating to what makes engagement worth their time. The bar is well-defined: novel clinical content, a rep who is clinically prepared enough to engage substantively on the data, and outreach that acknowledges the last interaction. Where gaps exist, they are execution gaps, coordination across channels fails because outreach rarely carries the thread of the previous conversation, and the commercial–scientific boundary erodes when field roles blur. Neither is a strategy failure. Both are operationally addressable.

What physicians want going forward reflects the same logic: depth over frequency, patient access support, and practice workflow integration over more touchpoints. More than 70% described human interaction as irreplaceable in clinical decision-making contexts, and a meaningful minority sees a role for AI in routine tasks only, consistently excluding contextual clinical judgment from that scope. The engagement model that serves physicians is human-led, clinically grounded, and operationally disciplined.

METHODOLOGY

About this study

May 2026. n=105 US physicians (ONC n=53, NEURO n=52) across academic medical centers (45%) and community or private practice settings (55%). Interviews were conducted through ZoomRx's conversational survey platform. The AI moderator adapts follow-up questions based on what each physician says, creating a more natural interview while still applying a consistent coding framework across all responses. Base sizes vary by question. Findings are directional in nature and should not be used to draw in-depth conclusions.

SCHEDULE A CONSULTATION WITH ZOOMRX

Measure the gap between what physicians expect and what your teams deliver.

COMMERCIAL · BRAND TEAMS

Promotional Effectiveness Tracking (PET)

Continuous measurement of how promotional activities land with physicians — rep quality, channel effectiveness, message recall, and behavioral change.

SCHEDULE A PET CONVERSATION

MEDICAL AFFAIRS · MSL TEAMS

Medical Engagement Effectiveness Tracker (MET)

Measure whether MSL engagements are delivering the scientific value physicians expect — reach, interaction quality, topic relevance, and knowledge or perception shift.

SCHEDULE A MET CONVERSATION

ZOOMRX

ABOUT ZOOMRX

ZoomRx is a strategic life sciences consultancy that helps pharma and biotech companies achieve clarity in bringing drugs to market through AI-powered data, technology, and expertise.

ZoomRx Trackers provide continuous intelligence — from promotional effectiveness to MSL engagement quality — tailored to specific brand and competitive needs. The Conversational Survey platform behind this study is available for custom primary research across any HCP audience.

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