A SALES PROBLEM

Why Healthcare Innovations Fail to Reach the People Who Need Them

Author's Preface

Anyone who has ever tried to get a healthcare innovation in front of the clinicians who need it knows 'That Feeling'.

It happens when your product makes a difference. When a surgeon tells you the procedure went better because of your device. When a nurse says patient handovers are smoother because of your monitoring system. When a pharmacist mentions that medication errors have dropped since switching to your format. When a GP says their patients are more compliant with your delivery mechanism. When you leave a hospital, a clinic, a surgery knowing you contributed to someone's care.

'That Feeling' is why people stay in healthcare instead of selling software or financial products. It is untouchable.

I first felt it at twenty-one, more than twenty years ago. I was training the night shift on infusion pumps in an ICU at St Thomas's Hospital in London. A patient died in front of me while I stood watching. The first time I had ever seen anyone die. I walked out at three in the morning, crossed the bridge over the Thames, and knew with absolute certainty that I was never going to do a normal job again.

My path since has been unusual. Not unusual in a planned way. Unusual in the way that happens when you keep following the thing that fascinates you without worrying about whether it makes sense on a CV.

I started with a law degree, which taught me to read regulations as opportunities rather than obstacles. My first healthcare job was in infusion therapy, helping hospitals manage medication and prevent errors. I took the job for a VW Golf and a five pounds daily lunch allowance. I am not going to pretend otherwise.

From there I moved into surgical implants and disposables, where I found myself standing in operating theatres learning how healthcare actually happens at the point of care. It was not a conventional route into medical sales. But then I started asking around and discovered that nobody had taken a conventional route. Everyone had stumbled in from somewhere else. Lawyers, scientists, nurses, engineers, ex-military. There is no degree in this. You learn it by doing it, or you do not learn it at all.

From sales I moved into product management, where I learned how companies decide what to build. Then marketing communications, where I learned how companies decide what to say. Then I started a medico-legal business. I co-founded a pop-up orthopaedic clinic with two surgeons. We converted vacant executive boxes at Ashton Gate stadium into consulting rooms during the week. On Saturdays, Bristol City played football. On Tuesdays, we ran consultations, wrote care plans and injected knees. Healthcare finds you in the strangest places.

Then I built marketing agencies. And that is where the pieces came together.

I remember sitting in a meeting with a client's sales team and their marketing team in the same room. The sales team was describing a product they believed in, a product with genuine clinical evidence, that they could not get in front of the clinicians who needed it. Access had collapsed. Meetings were impossible to book. The reps were driving hundreds of miles for conversations that lasted twelve minutes.

The marketing team was describing a campaign they had built. Content. Digital. Social. Reach into the thousands. But the campaign was talking about the product in language that meant nothing to a clinician, because nobody on the marketing team had ever stood in an operating theatre or sat in a procurement meeting or watched a surgeon decide in real time whether to trust something new with a patient's life.

I looked around the room and realised I was the only person who had been on both sides. Not because I was smarter. I spent most of my career not knowing what I was. Too clinical for the marketers. Too commercial for the clinicians. Too marketing for the sales team. But my strange, unplanned career had put me

in operating theatres and in marketing agencies, in sales territories and in product development meetings, in procurement negotiations and in regulatory reviews. I had seen the same problem from every angle. And from every angle, the same ingredient was missing.

Marketing. Not sales. Not product development. Not clinical excellence. Marketing. The discipline of making sure the right people know about the right innovation at the right time. And not marketing as most healthcare companies practise it. Marketing that understands the clinical world it serves.

Your best salespeople are not the ones you pay. They are the clinicians who already use your product and believe in it. They are having conversations like this constantly, in rooms you will never be invited to, influencing decisions you will never see.

The question is whether those conversations are happening about you. And whether what is being said is accurate, positive, and compelling.

The data is stark. Only 24% of UK healthcare professionals are accessible to suppliers at all. Of those, nearly all limit meetings to just one or two companies. Those who do meet allocate roughly 36 minutes per week for every company trying to reach them. Not for you. For everyone. If you are not already one of those one or two, the chances of becoming one through cold outreach alone are mathematically brutal.

Companies respond the way they always have. More reps. More training. Better CRM. New sales leader. The activity metrics improve. The results do not. This is what "progress" looks like when you are solving the wrong problem.

Most healthcare companies have a demand problem disguised as a sales problem. They keep improving the sales function while the real constraint, that nobody knows who they are or why they should care, goes unaddressed.

This book is about fixing that.

Part One of this book diagnoses the problem. The playbook changed and nobody sent a memo. Part Two provides the methodology that fixes it. Part Three makes it practical, including what good looks like at your company's stage and a 90-day implementation plan.

The playbook changed. Nobody sent a memo.

This book is the memo.

Somewhere today, a clinician is treating a patient with the best option they know about. It is not the best option that exists. It is not the best option that has been developed, tested, and proven. It is just the best option that reached them. The gap between what exists and what reaches clinicians is where patients pay the price.

'That Feeling' only happens when products reach the people who need them. The frameworks in this book exist to close that gap.

Michael Colling-Tuck

Chapter 1: The Complexity You Stopped Seeing

The nurse told me to stand back.

I was twenty-one. I was in the HDU at St Thomas's Hospital in London, training night staff on infusion pumps. It was one or two in the morning and I was running through the setup with a nurse who seemed perfectly happy to be doing product training at that hour. She was calm. Professional. And then she stopped me.

"Just stand back one minute."

She wasn't talking to me like something was wrong. She was talking to me like this was a thing that happened. A thing you waited for, the way you might wait for a kettle to boil.

The machines around the patient began to change. The beeping slowed. The rhythm shifted. I didn't understand what I was watching, not medically, but I understood it the way you understand something in your body before your brain catches up. The room got quieter. The beeping got slower. And then it stopped.

The patient died.

I had never seen anyone die before.

The nurse looked at me. Not unkindly. She asked if I was alright, and I said I was, because I was twenty-one and that's what you say. Then she said, "Right, shall we carry on?"

And we did. We carried on with the training. Because the ward still needed the training, and the next patient still needed the pump to work properly, and the night wasn't going to pause because I was standing there trying to understand what I'd just witnessed.

I walked out of St Thomas's at three in the morning. I remember crossing the bridge. I remember the Thames. I remember thinking that my friends from university were working in offices, selling software, doing normal things. And I remember knowing, with absolute certainty, that whatever I did with my career, it was going to be in healthcare.

I want to talk about something I've started calling the concoction. It's the best word I have for what makes healthcare unlike anything else.

A lot of people describe healthcare as complex. That's true, but it's also meaningless. Everything is complex if you look at it closely enough. What makes healthcare different isn't the complexity. It's the combination.

Take orthopaedic surgery. Joint replacements. The procedure itself is the centrepiece of everything that happens around it. A surgeon's skill, their judgement, their hands. That determines whether a patient gets twenty years of mobility or ends up back in theatre for a revision that nobody wanted. The stakes of every single decision are measured in decades of someone's life.

And you know how wrong it can go. The metal-on-metal hip disaster. The PIP implant scandal. The vaginal mesh crisis. The Paterson case. I don't know whether all of those people intended harm. Some clearly did. But others, I think, lost themselves somewhere in the ego and the alpha nature of a profession that gives you an extraordinary amount of power over other human beings.

But healthcare also holds the most remarkable people I have ever met. Brilliant professors who have spent entire careers solving a single problem. Clinicians who remember your name three years after you met them at a conference. Nurses who run wards with a combination of precision and compassion that would make most management consultants weep.

I loved that concoction. I still do. Emotion and intelligence. Technical advancement and compassion. Ego and humility. The very best and the very worst of human ambition, colliding every single day in the same building. Sometimes in the same conversation.

And that concoction is precisely what makes selling into healthcare so fundamentally different from selling into anything else. Because the people you're trying to reach aren't making purchasing decisions. They're making clinical decisions that happen to involve purchasing. And those two things are not remotely the same.

But here is what I need you to understand. And I am talking to you now, specifically, as someone who has been in this industry long enough that you have stopped noticing what I am about to describe.

You know that the person who chooses a medical product is almost never the person who pays for it. You know that a clinician can fall in love with a product at a conference in March and the deal can collapse fourteen months later because a procurement lead retired and their replacement wanted to start again from scratch.

In healthcare, switching products carries risk that does not exist anywhere else. Real risk. Patient risk. If a clinician has been using a particular implant for fifteen years and they know it works, they know the instrumentation, they know the feel of it in their hands, asking them to switch is not asking them to learn a new product. It is asking them to accept that the next patient on the table is, in some small way, an experiment.

This is why healthcare does not do transformation. It does incremental improvement. Slowly. Carefully. One step at a time.

You can show a clinician better outcomes in three randomised controlled trials. You can demonstrate a twenty-minute reduction in operative time. You can present a health economic case that saves two thousand pounds per procedure.

And they will look at you, nod thoughtfully, and say, "That's very interesting. I'll have a think about it."

The decision is not rational. Not in the way business textbooks describe rational decisions. It is clinical. It is emotional. It is political. It is personal. All of those things at once.

Now I want to tell you about the recognition problem. It is the thing that should keep everyone in this industry awake at night.

Somewhere right now, a clinician is telling a patient there is nothing more they can do. Not because the clinician is negligent. Not because they are behind the times. Because the innovation that could help that patient exists and the clinician does not know about it. The chain between the people who created it and the people who needed to know about it is broken.

How many patients are living with conditions that have solutions they have never been offered? How many clinicians are making decisions based on incomplete information, not because they are bad clinicians, but because the companies that developed the innovations never figured out how to reach them?

Those questions should trouble you. They trouble me. This book is about why that gap exists, why healthcare innovations fail to reach the people who need them, and what you can do to close it.

If you've been in healthcare long enough, you've probably watched the same cycle repeat itself. A product launches. The company hires a sales team. The sales team works hard. Results disappoint. The company responds by hiring more salespeople, or replacing the sales leader, or investing in a new CRM, or running another round of training. Activity goes up. Results don't follow.

And the response, almost always, is to do more of the same thing, but harder. More reps. More calls. More visits. More activity. As though the problem were effort, when the problem was never effort.

The most obvious solution, invest more in sales, is the one that fails most often. Not because sales does not matter. It does. But because sales cannot solve a problem that is not a sales problem. And in healthcare, the problem you think is a sales problem is almost always something else entirely.

Let me show you what that looks like.

Chapter 2: Two Leaders

I want to tell you two stories. Both are composites, drawn from real companies, real people, real outcomes I have witnessed across more than twenty years in healthcare commercialisation. I have changed names and combined details because the specifics matter less than the pattern. And the pattern is what will get you.

One of these leaders does everything right. The other does everything you would do. I know this because I have sat in leadership teams that thought exactly like the second leader. I have been in the room when that plan was presented, and I nodded along with everyone else. It made perfect sense. It was the obvious thing to do. And I watched it fail. More than once.

James was the kind of commercial director people wanted to work for. Calm under pressure. Clear with targets. Popular with the board. He had come up through sales, which meant he understood the grind. He never asked his team to do anything he would not do himself.

His company had been successful for years. Strong product. Great clinical evidence from their home market. A contender brand with a genuine story. They were not the market leader and they did not pretend to be. What they had was something more interesting. They had a reason to exist that was not "we are cheaper" or "we are bigger." They had technology that was genuinely different, clinical outcomes that backed it up, and a heritage that meant something to the clinicians who knew them.

But here is what nobody was saying out loud. Those long-standing reps had become order takers. Not because they were lazy. Because the relationships were so strong that selling had become unnecessary.

Because each rep had found their own way of describing the product over the years, there was no unified pitch. No single message. Rep A explained the technology one way. Rep B led with clinical outcomes. Rep C talked about the company history. Rep D focused on the service package. If you had put all four in a room and asked them what this product does and why it matters, you would have heard four different answers.

James was brought in because the UK market was underperforming. His plan was sensible. Go back to basics. Sales fundamentals. Activity targets. Call rates. Prospecting discipline. Training on the product's clinical differentiators. A new CRM system to track everything. Weekly pipeline reviews.

I want you to notice something. If you are reading this and thinking "that sounds about right," then you are exactly who this chapter is for.

Sarah ran commercial operations at a smaller orthopaedic company. She had less budget, fewer reps, and a product that was entering a market where the established players had been there for decades. On paper, she was outgunned.

The first thing she did was something that looked, to her sales team, like a waste of time.

She hired a product manager. Someone with an MBA and a background in market research. Not a healthcare lifer. Someone who knew how to study a market before trying to sell into it.

For three months, this product manager did not sell anything. Did not produce a single brochure. Did not attend a single conference. Instead, she mapped the UK orthopaedic market from the ground up. Who makes the decisions. How those decisions actually get made. Where the money comes from. What procurement cares about versus what clinicians care about. How long the buying cycle takes. What kills a deal at month fourteen that looked alive at month two.

The sales team thought this was academic nonsense. They had been selling orthopaedic products for years. They knew the market.

Sarah listened to them. And then she kept funding the research anyway.

Six months into his plan, James held a quarterly review. Activity was up. The CRM was full of data. Reps were making more calls than they had in years.

The forecast was down 40%.

James sat in the meeting while his reps explained what was happening. And what he heard was a lot of blame. Operations was not supporting them. Communication from head office was dreadful. Marketing had produced materials that did not reflect what they were hearing in the field. The product was too technically complex for customers to understand in a short meeting. And the meetings were getting shorter.

James listened. He sympathised. And then he said what commercial directors always say.

"We need to get back to basics."

More calls. More visits. More face time. The product sells when people see it. We just need more people seeing it.

There is a story I need to tell you here. New Year's Eve. A rep left home at five in the morning. Drove three and a half hours to Withy Bush Hospital in Pembrokeshire, West Wales. He was supporting an operation. Case support.

He arrived at nine in the morning. Pulled into the car park. Walked into the hospital.

The operation had been cancelled.

"Oh, didn't anyone tell you?"

No. Nobody told him. He had driven three and a half hours on New Year's Eve, left his family at five in the morning, and nobody had thought to call.

He drove home. Seven hours of driving for nothing.

And here is the part that stayed with me. When he got back to his car, the thing he told himself was this:

> *"At least the brand was there and they saw me."*

I have thought about that line many times. It is the saddest summary of a wasted day I have ever heard. And it is the logical endpoint of a system that relies entirely on physical presence for commercial impact. When showing up is all you have, you start believing that showing up is enough.

While James was doubling down, Sarah was doing something unusual. She was listening to clinicians. Not pitching to them. Listening.

She took her findings to the company's cohort of loyal clinicians and asked them a simple question: if we were bringing this product to market, what would you need to see before you would consider it?

Their answers shaped everything that came next.

Sarah's next move looked expensive and slow. She funded an educational programme.

Not a conference stand with brochures and branded pens. Not a sponsored symposium where the company's slides were barely disguised as education. An actual educational programme where experienced clinicians taught less experienced ones.

Annual courses. Senior clinicians teaching juniors. Not product demonstrations. Real clinical education. How to approach complex cases. When to use certain techniques. What the evidence says about outcomes. The product was woven through naturally, because it was part of the teaching clinician's practice, but the

courses were not sales events. They were educational events that happened to showcase the product in the hands of people who loved using it.

Something remarkable happened at those courses. The junior clinicians did not just learn surgical technique. They saw their bosses, the people they admired and wanted to emulate, taking pride in their association with this brand. An emotional connection formed. Not to a product. To a community.

Let me tell you about a dinner.

Four clinicians at a restaurant. Not a company event. Just colleagues eating together after a long day. Orthopaedic surgeons, a mix of senior and mid-career. They were talking about cases, about outcomes, about what was working and what was not.

One of them mentioned a product. Sarah's product.

Ninety seconds. Four decision-makers reaching consensus about whether to take a product seriously.

No rep in the room. No marketing materials. No carefully crafted pitch. Just clinicians talking to clinicians about what works.

I want you to hold that scene in your mind. Because it is the single most important moment in this chapter. That conversation was worth more than four sales calls. Maybe more than forty. And Sarah was not there. None of her team was there. But everything she had built over the previous two years made that conversation inevitable.

Sarah did not orchestrate that dinner conversation. She built the conditions that made it unavoidable. That is demand generation. Not what happens when your rep is in the room. What happens when they are not.

Three years in, James's company was dying in the UK market. Not because the product did not work. It worked beautifully. Patients who received it did well. The technology was sound, the outcomes were good, and the heritage was genuine.

None of that mattered. Because nobody who mattered knew it existed.

If James and Sarah sat in a pub together, I think Sarah would say something like this:

"I spent three months understanding how the market actually worked before I tried to sell into it. I built one message instead of four, sharp enough for a twelve-minute meeting, substantive enough for peer scrutiny. I gave clinicians a reason to teach each other instead of asking my reps to educate every surgeon one at a time. I built channels that worked when my team was not in the room. And I gave my reps a system instead of a quota."

James would nod. And then he would ask the question that every commercial leader asks when they hear this.

"But surely it starts with getting in front of people?"

And Sarah would say, gently, that this is the assumption that cost him three years.

Getting in front of people is not the starting point. It is the reward you earn after you have given people a reason to let you in.

James invested in reaching clinicians. Sarah invested in making clinicians want to be reached. The budgets were similar. The allocation was completely different.

Sarah's product outperformed forecast by two to three million pounds in the first two years. Not because it was a better product. Not because her reps were more talented. Not because she had more budget. Because she understood that healthcare does not have one audience. It has several, sitting in the same buying

process, responding to completely different things. And she built a system that spoke to each of them.

You agreed with James. When I described his plan, you thought it was sensible. You agreed with him because that is what everyone does. It is what the industry has always done. It is what the textbooks recommend. And it is what fails, quietly, consistently, expensively, in company after company, year after year.

James did not have a bad team. He did not have a bad product. He did not have a bad strategy, at least not by conventional standards. What he had was a fundamental misunderstanding of where the problem sat.

He thought he had a sales problem.

He had a demand problem.

And until you know the difference, you will keep making the same investment in the same solution and wondering why the results do not change.

Chapter 3: The Model That Made Us

I was twenty-one when I started carrying the bag. And I want you to know that before we go any further, because what I am about to say might sound like I am burying something I loved. I am not. I am trying to honour it honestly enough that you will stop pretending it still works.

When I used to visit clinicians, I would arrive with something they genuinely needed. Not just a product. Information. I would tell them what was new. What was happening at other hospitals. What best practice looked like. Who was presenting what at which conference. What was working in Germany that nobody in the UK had tried yet.

I was their information resource. I was, and I mean this literally, their LinkedIn feed. Before LinkedIn existed.

Think about that for a moment. There was a time, and it was not that long ago, when a sales representative walking into a hospital was one of the primary ways a clinician learned what was happening in their own field.

And access was real. You could build a territory plan, map your accounts, schedule your calls, and be reasonably confident that eight out of ten people you wanted to see would see you. The door was open. You walked in with information they could not easily get elsewhere, and they gave you time because the exchange was worth it to both sides.

I think of it as the golf caddy model. The clinician was playing the round. They held the clubs. They made the shots. But the caddy knew things. Which club to use on this hole. Where the hazards were. What the wind was doing. What had

worked for other players on this course. The caddy did not play the game, but the caddy made the player better. And the player knew it.

The information asymmetry was the foundation of the whole model. The rep knew things the clinician did not know. Not because the clinician was lazy or uninformed. Because the information was genuinely hard to access. The rep was the connective tissue. They made the network work.

Those reps changed patients' lives. I want you to hear that. Not indirectly, not metaphorically. Directly. Because they carried information about innovations that worked, and they put that information in front of clinicians who could use it, and patients got better as a result.

The model was brilliant.

And it is gone.

Not because anyone killed it. It ended because the world underneath it shifted, and it shifted in multiple directions at once.

Here is what actually happened.

Access collapsed.

In 2008, sales representatives had access to around 80% of physicians. By 2021, that had dropped to 44%. Today, only around 24% of healthcare professionals are accessible to suppliers at all.

That was not a gradual decline. That was a collapse. Three quarters of the market that used to be open is now closed.

And when you do get through the door, the average clinician has approximately twelve minutes per supplier interaction. They have three of these slots per week. That is thirty-six minutes total. Not for you. For everyone. Every company. Every product. Every representative trying to get in front of that clinician with something they believe matters.

The single decision-maker is largely gone.

There was a time when the consultant decided. Not completely, not without any input from others, but substantially. If the surgeon wanted your implant, you were in.

Now? A buying decision in a hospital involves clinicians, operations directors, procurement teams, finance committees, sometimes quality and safety boards, sometimes patient representatives. Each stakeholder has different priorities. The clinician cares about clinical outcomes. Procurement cares about price. Operations cares about implementation complexity. Finance cares about the total budget impact over five years.

Win the clinician and you have won one vote on a committee of eight. Congratulations.

Information became free.

The golf caddy model worked because the caddy knew the course and the player did not. Then the player got GPS.

Today, any clinician can access more information in thirty seconds on their phone than a rep could provide in an hour-long presentation. Clinical studies are a search away. Product specifications are on company websites. Peer discussions happen in online forums and professional networks. The information asymmetry that gave reps value has inverted.

COVID accelerated this by years. And once people discovered they could access information, education, and peer connection without a supplier being physically present, many of them decided they preferred it that way.

Procurement professionalised.

There was an era when pricing in healthcare was opaque. A product could be sold to one hospital at one price and to another hospital five miles down the road at a price 300% higher. That era is over.

Purchasing towers. Framework agreements. Data sharing between NHS trusts. Procurement specialists who came from retail, automotive, aerospace. These people do not care about your relationship with the consultant. They care about unit cost, total cost of ownership, clinical evidence, and whether you can prove your product delivers value for money.

All of these shifts happened simultaneously. Not one after another. All at once. Overlapping. Reinforcing each other. No single shift would have killed the model. Together, they buried it.

I want to be honest about something. When I talk to sales teams about this, they push back. And part of me thinks they are right to push back.

They believe that if you go back to basics, one good rep can do the whole thing. Awareness, interest, consideration, decision, post-implementation support, developing advocates. The full funnel. One person, one territory, doing all of it.

And they are not wrong. Let me show you what that looks like when it works.

The trauma meeting started at eight in the morning. Every morning. I was not a surgeon. I was a medical device rep. But I was there every morning, in hospitals across the region, because I had decided to learn something properly.

I started teaching. Not product training. Clinical best practice around the operative technique. I ran teaching sessions. I organised journal clubs. I attended those 8am trauma meetings not to pitch a product but to contribute.

Six months in, the phone rang. A hospital I had never visited. A department I had never called on. Their current supplier had let them down, and they had heard good things. That account became one of the largest hemiarthroplasty accounts in the country.

I did the whole system. Awareness, interest, credibility, conversion, advocacy. One person. One specialty. One region. And it worked.

But I was one person. With one bag. In one territory. What happens when the company needs that in twelve regions simultaneously? What happens when I leave the territory, or get promoted, or burn out?

The knowledge that made it work walked around in my head. It was not documented. It was not transferable. It was not scalable. When I left, the system left with me.

Some reps have adapted like this. They are excellent, and they deserve recognition. But this is individual excellence. It is not a model. You cannot hire for it reliably, train for it consistently, or replicate it across a geography.

73% of healthcare product launches miss their forecast. I want you to sit with that for a moment. Nearly three quarters. Not in some obscure sub-sector. Across the industry. Three out of four launches do not hit their numbers.

And when you look at why, the same patterns emerge. Confirmation bias in market validation. An awareness gap, where nobody knows you exist because you relied on a shrinking sales force to do an expanding job. A conversion gap, where people know your name but the canyon between awareness and decision has no bridge.

These are not mysteries. They are predictable. They are the symptoms of running the old model in the new world. Every single one of them is what happens when you treat a demand problem as a sales problem and try to fix it with more reps and more activity and more training.

So here is where we are.

The model that built this industry, the model that built careers, the model that built relationships between companies and clinicians that lasted decades, that model was brilliant. It was not wrong. It was right. For the world it was designed for.

And that world is gone.

Respect for what something was should never become an excuse for pretending it still is. And the gap between what the rep model was and what it can deliver today is not a gap that training will close, or activity will close, or new CRM software will close.

It is a gap that requires a completely different way of thinking about how you create demand for healthcare products.

Which, as it turns out, is what this book is about.

READY FOR THE FULL METHODOLOGY?

This sample covers Part One: the diagnosis. The book continues with the complete 3 E's framework — Empower, Evolve, Equip — and makes it practical across eighteen chapters and three parts.

The full book covers everything your sales team needs that isn't a sales problem: demand generation strategy, digital presence, clinical advocate programmes, patient marketing, compliant creativity, event strategy, measurement frameworks, and the first 90 days.

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