Technically Strong. Strategically Marginalized.

Redesigning Medical Affairs for Scientific Authority, Evidence Strategy, and Insight-to-Action

MANOLO BEELKE & PARTNERS

The Scene That Keeps Repeating

A senior HCP sits across from an MSL. The data are correct. The slides are clean. The references are sound.

The discussion is flat. Ten minutes later, nothing has changed.

This is not a training anecdote. It is the symptom of a system that mistakes information transfer for scientific value. Technically flawless. Strategically ineffective.

What Changed. What Did Not.

What Changed

- HCPs no longer depend on MSLs for data access
- AI can summarize and reframe evidence instantly
- Scientific exchange must add interpretation, context, and consequence — not just recall

What Did Not

- Reporting lines still often run through Commercial
- Budgets remain vulnerable to promotional priorities
- Talent is still filtered without domain understanding
- Activity metrics still masquerade as impact

The result: a function that has evolved in scope, but not in operating model.

The Real Diagnosis

Medical Affairs is not failing because most MSLs are weak. It is failing because **the system is built to keep the function downstream.**

Commercial Reporting Logic

Scientific exchange judged too close to quarterly pressure

Promotional Budget Gravity

Scientific work funded through the wrong incentives

Convenience-Filtered Talent

HR rewards template-fit over strategic capability

Activity-Counting Culture

Visits and slides are easier to count than real influence

The Provocation

Medical Affairs should not be treated as a support layer to Commercial. It should **lead**:

- Scientific narrative
- Evidence strategy
- Insight-to-action governance

This is not a power claim. It is a decision-rights claim. Commercial owns promotion and sales execution. Medical Affairs owns the scientific logic that determines whether the company is trusted, relevant, and credible in the first place.

What Medical Affairs Must Actually Own

Three decision rights determine whether Medical Affairs is structurally authoritative or merely performative.

1	2	3
Scientific Narrative Ownership	**Evidence-Generation Prioritization**	**Insight-to-Action Governance**
Disease-first, evidence-first framing across the full product lifecycle	IIS strategy, RWE, registries, pragmatic studies, outcomes evidence, and post-launch development	What counts as an insight, how it is triaged, and what the company does with it

MAPS' 2025 guidance frames Medical Affairs around value, impact, and integrated evidence planning — consistent with this structure.

Budget Architecture

Trust cannot be funded by the sales forecast. The firewall between Medical and Commercial spend is not ideological — it is what protects scientific credibility.

Ring-Fenced for Medical Affairs

- Scientific exchange infrastructure
- Medical information and scientific communications
- Integrated evidence generation
- IIS and RWE governance
- Insights operations and analytics
- Competency development and coaching

Clearly Commercial

- Promotional campaigns
- Brand advertising
- Sales enablement
- Prescribing push

Different flows need different gates. Separate channels are not a luxury — they are the operating condition for credibility.

The Operating Model That Works

Layer A — Central Strategy & Governance

Medical strategy, evidence planning, scientific standards, training framework, and impact model

Layer B — Disease / Franchise Pods

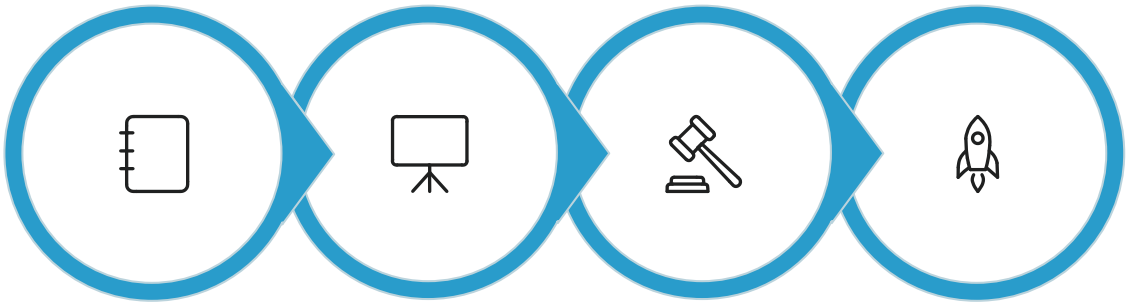
Medical Lead · Field Medical Lead · Evidence Lead · Scientific Communications Lead · Insights Lead

Layer C — Field Medical as Intelligence

MSLs are sensors, interpreters, and catalysts — not slide carriers

The Missing Muscle: Insight-to-Action Cadence

Most Medical Affairs teams collect insights. Very few run an insight-to-action machine. A minimal repeatable cadence changes that.



If the field never sees action, the quality of insight collapses. Closing the loop is not a courtesy — it is the condition for sustained intelligence.

Stop Measuring What Is Easy

What Is Easy to Count

- Number of visits
- Slides delivered
- Congress contacts
- Volume of HCP interactions

What Actually Matters

- Decision influence
- Evidence gaps closed
- Study concepts triggered
- Narrative changes made
- Insight-to-action conversion
- Guideline-, payer-, or access-relevant outputs

The 2025 KPI survey and MAPS' value-and-impact work both support moving toward mixed qualitative and quantitative models tied to real impact. **Volume is not value.**

Stop Training by Osmosis

The Old Model

Shadow someone. Copy the slides. Accumulate years. Become manager.

The New Model

- Define capability domains across six competency areas
- Certify scientific dialogue and evidence-planning competence
- Assess insight quality formally
- Tie progression to demonstrated competence, not tenure

What Serious Medical Affairs Leadership Looks Like

Organizational Identity

Clinical peer · Trusted evidence interpreter · Generator of decision-grade data · Partner in post-launch development

Structural Conditions

Executive parity · Ring-fenced budgets · Evidence-first planning · Structured insight governance · Certified capability progression

That is how Medical Affairs becomes a **growth asset** instead of an expensive ritual.

Where Manolo Beelke & Partners Fits

We help companies redesign Medical Affairs where it actually matters — not at the surface, but at the structural level.

Operating Model & Decision Rights

Structural redesign of Medical Affairs governance and authority

Evidence Strategy Architecture

Post-launch development, IIS, RWE, and lifecycle integration

Field Medical Redesign

Competency frameworks and field intelligence systems

Insight-to-Action Governance

Medical Affairs, HEOR, market access, and scientific narrative for launch and post-launch relevance

This is not training theater. It is structural redesign.

Next Step

If your Medical Affairs organization is technically strong but structurally marginalized, the problem is no longer training alone. **It is architecture.**

- Who owns scientific narrative?
- Who prioritizes evidence generation?
- What happens to field insight?
- What is measured — and by whom?
- Who decides what Medical Affairs is allowed to become?

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