... and thinking ahead

Dramaturgical study of meetings between general practitioners and representatives of pharmaceutical companies

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Abstract

Objectives To examine the interaction between general practitioners and pharmaceutical company representatives.
Design Qualitative study of 13 consecutive meetings between general practitioner and pharmaceutical representatives. A dramaturgical model was used to inform analysis of the transcribed verbal interactions.
Setting Practice in south west England.
Participants 13 pharmaceutical company representatives and one general practitioner.
Results The encounters were acted out in six scenes. Scene 1 was initiated by the pharmaceutical representative, who acknowledged the relative status of the two players. Scene 2 provided the opportunity for the representative to check the general practitioner's knowledge about the product. Scene 3 was used to propose clinical and cost benefits associated with the product. During scene 4, the general practitioner took centre stage and challenged aspects of this information. Scene 5 involved a recovery strategy as the representative fought to regain equilibrium. In the final scene, the representative tried to ensure future contacts.
Conclusion Encounters between general practitioners and pharmaceutical representatives follow a consistent format that is implicitly understood by each player. It is naive to suppose that pharmaceutical representatives are passive resources for drug information. General practitioners might benefit from someone who can provide unbiased information about prescribing in a manner that is supportive and sympathetic to the demands of practice.

Introduction

Commercial sources of information are known to have a greater influence than scientific sources on general practitioners' prescribing behaviour.[1] Over 20 years ago, Avorn et al found that although physicians believed that drug advertisements and pharmaceutical representatives had a minimal effect on their prescribing behaviour, they held advertising oriented beliefs about the efficacy of drugs such as cerebral vasodilators and dextropropoxyphene.[1] A recent survey of 200 general practitioners and 230 hospitals doctors found that information about the last new drug prescribed was derived from pharmaceutical representatives in 42% of cases.[2] A systematic review also found that meetings with representatives were associated with requests by physicians for promoted drugs to be added to the hospital formulary and with changes in prescribing practice, including increased prescribing costs and less rational prescribing.[3]

Given this evidence, why do general practitioners continue to meet pharmaceutical representatives? Do they regard such encounters as an effective method of accessing new drug information? The amount that pharmaceutical companies spend on these promotional activities implies that the industry believes that they are effective. We explored the general practitioner-pharmaceutical representative encounter using the dramaturgical model proposed by the sociologist Erving Goffman.[4]

Methods

One of the authors, who is a general practitioner (TF), met all pharmaceutical representatives (seven men and six women) who requested an appointment with him at his practice during January to June 2000. With the representatives' signed consent, he recorded the meetings; otherwise, as far as possible, the meetings were conducted routinely. The meetings lasted 10-25 minutes. The representatives were promoting a range of products, including new drugs and topical applications.

We annotated and coded full transcripts of the meetings. MS and MW independently devised a framework for the analysis. The final framework was agreed through discussion among all three authors. We concluded that our interpretation of these categorised data would be enhanced by following the model adopted by Goffman as this provides concepts that are useful in understanding face to face interactions.[4–6] Goffman proposed that the context of an interaction might be regarded as a stage, the individuals at the centre of the interaction as actors, and the interaction itself as a (managed) performance. A person's "performance" is shaped by the need to provide the other person in the interaction with an impression that concurs with personal goals for the meeting. This analogy provided the framework for our findings.

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P+ *Further examples of the interactions appear on bmj.com*

Examples of performance

Scene 1
Rep: "Thank you for your time, it's for a really quick chat about…" (Meeting 2)
Rep: "Here's two diaries…did you want a desk one as well?" (Meeting 1)

Scene 2
Rep: "Maybe you are aware of [product]?"
GP: "No, I'm not, to be honest with you."
Rep: "Well that's fair enough; that's good news. So hopefully I can inform you."

Scene 3
Rep: "Well just to summarise the news for today. Reduction in [the price of the drug] and some new clinical evidence for you to read in your own time." (Meeting 5)
Rep: "So I don't know if you agree with this but when I speak to hospital doctors they say that a meta-analysis of studies is probably the most stringent sort of argument that you can have really…so if they show [name of drug] to be very effective…would you use [it]? (Meeting 10)
Rep: "It's £4.17 for 28 days so it does fit in nicely as a cheaper alternative…The new consultant at [hospital]— he is certainly switching patients over to [name of drug]." (Meeting 1)

Scene 4
Rep: "Do you accept, if you are getting similar levels of cholesterol lowering, you would expect to achieve the morbidity and mortality outcomes?
GP: "Yeah. Well, it is always this difficulty that you are looking at intermediate outcomes. I think the advantage that you are fighting against for [the two rival products] is that they have been shown to reduce coronary events in trials, while these updates you have shown me are just intermediate outcomes. So my mind is open about that." (Meeting 7)

Scene 5
Rep: "I am only supposed to be talking to people who are the decision makers as to what is going on with drugs—which I gather you are?" (Meeting 4)
Rep: "I think one of the reasons why a lot of doctors are using [drug name] is cost…there's a lot of pressure on you isn't there?" (Meeting 9)

Scene 6
Rep: "Before I go I've got a couple of other things you might like. Would you like a paediatric stethoscope? (Meeting 11)
Rep: "All right, and I'll drop in these charts in a few weeks." (Meeting 13)

Results

The central categories from the transcripts were classified under the following themes: stage setting, the roles of the players, the performance, and the finale.

Stage setting

Several general features were characteristic of all the meetings. Firstly, each was initiated, and to some extent led, by the representative. Secondly, although deference was always shown towards the general practitioner, it was not always apparent who was interviewing whom because each party posed similar numbers of questions. Thirdly, some questions recurred at almost every meeting yet they were managed (in most cases) without either party showing outer signs of weariness. Finally, beneficial outcomes for the general practitioner included the receipt of gifts, promotional material, and potential psychological benefits (see below). For the representative, a guarantee of increased sales seemed less essential than establishing a positive relationship and grounds to return for further meetings.

Roles of players

General practitioners—The general practitioner's role within the interaction includes potential purchaser, information seeker, and recipient of gifts. However, these characteristics are not compatible with the desired image of a general practitioner (a knowledgeable person who is not easily influenced). Two central strategies were used to reconcile this conflict. Firstly, the general practitioner presented himself as a sceptic. This is illustrated by the tactic of questioning the information provided. Secondly, he refused to commit to the implicit aims of the meeting—in other words, he did not agree to prescribe any product.

Representatives—The representative's role within the interaction includes potential vendor, educator, and donor of gifts. Personal goals for the meeting include being in control of its agenda and influencing its outcomes. To achieve these goals, the representative must show impartiality, awareness of primary healthcare priorities, and an appreciation that valuable time has been generously surrendered. The management and delivery of a friendly (but knowledgeable) and somewhat submissive interaction assists this compromise.

The performance

The performance is typically played out in six scenes corresponding to six objectives for the representative. These scenes are led by the representative, but the general practitioner (having played this role before) anticipates and tacitly follows the script. Each scene is described below and examples of the different behaviours are given in the box. Further examples appear on bmj.com.

Scene 1: Acknowledgment of relative status (give general practitioner the impression he is the most important person)—The performances begin with a brief acknowledgment of the relative status and importance of the two players. The representative expresses appreciation of the vital and time consuming nature of the general practitioner's work. The greeting is accompanied by present giving. This serves as a token of appreciation for the doctor's valuable time and induces a sense of obligation. For the representative, the act of present giving raises their subordinate status to that of equal (or even superior).

Scene 2: Check general practitioners' ability (find out what they already know)—The representative then assesses the general practitioner's knowledge and current practice. This is best conducted in a non-confrontational style. The general practitioner is allowed to emerge as entirely correct, although perhaps with the potential to do better.

Scene 3: Outline clinical and cost benefit of product (mention name of "expert" practitioner)—Having established the general practitioner's knowledge and use of the product under discussion, the representative's next task is to argue for its clinical (and cost) benefits. Published research that shows its value (in selective aspects) is described. Then, after assessing the general practitioner's critical appraisal skills, the representative initiates a discussion about the research. To round off the scene, the representative will, whenever possible, mention an "expert" who is prescribing the drug.

Scene 4: General practitioner takes centre stage—This scene is acted out if the representative trespasses on territory that is familiar to the general practitioner. The general practitioner shows increased resistance to the persuasive devices in use. In earlier scenes, the general practitioner showed his resistance by refusing to make

emphatic statements. For example, the product in question is "not often used" rather than "never used," and the costs of various comparable treatments are "unknown." The interaction has remained polite and restrained. However, under some circumstances the response can become more forceful, although still polite. The triggers for this mode of response are more direct questions, more extreme factual statements, and, most importantly, statements that threaten to conflict with the intellectual expertise of the general practitioner.

Scene 5: Reinforcement of role (emphasise that you understand how hard the general practitioner works)—Faced with potential rebellion, the representative has to switch tactics and re-establish the characteristics of amenability, understanding, and empathy. Direct compliments and sympathy are universally acceptable.

Scene 6: Reaching closure (ensure opportunity for subsequent performance)—Finally, the meeting concludes with more gifts, reinforcing the sense of obligation. In addition, by not having all of the literature or gifts immediately to hand, the representative is able to secure a legitimate reason for a return visit. The best representative performances induced an apology from the general practitioner if, for example, he was unable to accept an invitation to attend an educational session.

The finale

For the general practitioner, successful management of the encounter results in a pleasant interaction and a welcome respite from usual workday demands. When consulting with patients, general practitioners have to display a caring and sympathetic demeanour. In contrast, in meetings with representatives they can show superior knowledge, be the object of flattery, and receive sympathy. General practitioners view the meeting as successful if they believe they have been in control and have acquired several free gifts or educational opportunities. There may also be lively clinical debate about the merits of different products. This is accompanied by the comforting knowledge that, as the prescriber, the general practitioner will always ultimately hold the winning hand.

For the representative, success can be measured by the sense of obligation induced. Donation of gifts, positive reinforcement of the general practitioner's knowledge, and a general demeanour of sympathy and attentive listening have facilitated this aim. Although the positive relationship resulting from this encounter may not guarantee future prescribing of the company's product, it will make it more likely.[7]

Discussion

Pharmaceutical representatives are adept at taking advantage of people's aspiration to meet someone who is impressed by their knowledge and sympathetic about the challenges they face and who will therefore shower them with gifts. This aspiration may be universal in the workplace. It seems that general practitioners are willing accomplices in their own exploitation.

Our approach provides insights into the general practitioner-representative encounter. However, it has limitations. Firstly, we did not analyse the transcripts by traditional qualitative techniques. This was because the encounters were not true interviews, merely recordings of routine meetings. Secondly, only 13 encounters were recorded, which could have limited the diversity in representatives' styles. Finally, the representatives were aware that the meeting was being recorded, and this may have influenced their behaviour.

What is already known on this topic

Pharmaceutical representatives influence physicians' prescribing in ways that are often unacknowledged by the physicians themselves

Meetings with pharmaceutical representatives are associated with increased prescribing costs and less rational prescribing

What this study adds

Meetings between pharmaceutical representatives and general practitioners follow a consistent format that is implicitly understood by each player

General practitioners may cooperate because representatives make them feel valued

Nevertheless, our findings will strike a chord with many, and they concur with a recent guide published in *Pharmaceutical Marketing* that acknowledges the role of medical education as "a potent weapon to be used by the marketer in supporting promotional activities."[8] Others have described techniques used by the pharmaceutical industry.[9] One of these is "reciprocity," in which someone who is given a gift will feel bound to make repayment. The obligation is repaid through prescribing the company's product. Our study confirms that this marketing technique is a fundamental tactic in meetings between general practitioners and pharmaceutical representatives.

Although doctors may perceive these meetings and the industry's support of medical postgraduate education as benign, the industry clearly believes they are a cost effective way to increase prescribing of their products. Neither the pharmaceutical companies nor their representatives are altruistic or unbiased. What may be needed, therefore, is a third player to provide unbiased educational information about pharmaceutical

Moment of respite:
Smarmy drug rep sees GP.
Score: Rep One; Doc Nil

products and offer sympathetic pastoral care to general practitioners. The company representative would then exit stage left.

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Competing interests: During the course of this research TF acquired 15 pens, two stethoscopes, eight jotters, two desk planners, a fluffy toy, and innumerable invitations (none accepted) to meetings at which a "local expert" would be lecturing as a prelude to a slap-up dinner.

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Commentary: dramaturgical model gives valuable insight

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Somerset et al provide valuable data about the under-researched area of general practitioners' prescribing behaviour and the part played in this by the "educational" efforts of drug company representatives. They acknowledge the limited scale of their sample and the fact that taping the conversations may have affected the interactions.

Goffman's model

The authors analyse the conversations using the dramaturgical model developed by the American sociologist Erving Goffman. His accounts of life in hospital wards, prisons, monasteries, and other institutions are based on an eclectic range of sources, including autobiography, overheard conversations, journalism, and anecdote. For advocates of the dramaturgical method, the minutiae of conversational encounters convey a great deal about wider structures of power and influence.

Goffman claims that in order to have effective interpersonal encounters individuals must put on a performance: hence the use of the term dramaturgical. Analysis rooted in this perspective regards the theatre as a metaphor for understanding conversational encounters. Conversations are bound by rules and possess a pattern similar to any theatrical exchange. For performances to be successful, both parties must pay some attention to their own demeanour while offering an appropriate level of deference to the other participant. Social embarrassment ensues if either reads the signs incorrectly or makes false assumptions. When mistakes are made, rapid repair work is needed.

What does it show?

Goffman's model exposes the ritualised nature of interactions between general practitioners and drug company representatives. Even though each conversation follows a consistent format, moving through scenes 1 to 6, no one wrote the script, fixed the lights, or checked the make up (or perhaps they did—we are not told).

Supporters of the dramaturgical tradition argue that everyday talk is sustained and made possible by the exchange of symbolic and ritual politeness. This engenders respect for all participants and allows faces to be saved. In this example, the pharmaceutical company representative must convey the proper degree of respect for the professional status of the doctor while simultaneously trying to establish his or her credentials as a knowledgeable, detached, and scientific professional.

The hierarchical and unequal relations between the participants pose particular challenges for the players in terms of the establishment and maintenance of self respect. There is an uneasy (hidden) dimension to these conversations. Each party is unwilling or unable to make explicit what they really want from the encounter. The self respect of doctors depends, in part, on the belief that their prescribing decisions are based on an informed appraisal of costs and benefits. The idea that their judgment can be bought in exchange for dinner in an excellent restaurant or the gift of a fluffy toy strikes at the heart of professional self esteem.

The paper is valuable because it uses a method of data analysis that offers a rare insight into the private encounters between doctors and pharmaceutical representatives. A follow up study could test the hypothesis that the youth and physical attractiveness of the pharmaceutical representative influences the frequency and length of encounters with general practitioners. Further work is also needed to test the relative attractions of the various small gifts exchanged in these encounters. Just how many desk diaries does a doctor need?

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