EFFECTIVE AND ETHICAL SALES COMMUNICATION FOR PHARMACEUTICAL REPRESENTATIVES

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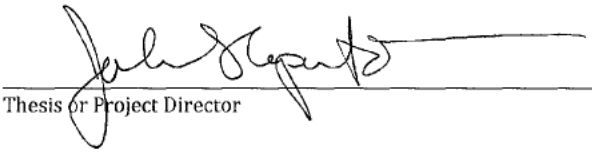

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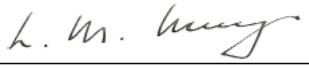

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ABSTRACT

There are so many different communication styles utilized by pharmaceutical sales representatives. This thesis handles the quandary of whether those communication styles are not only effective among the interactions with medical providers, but whether those effective means of communicating are embedded with ethical communication as well. The theory of *symbolic interactionism* and the philosophical basis of *persuasive speech* expound on the methodology pharmaceutical sales representatives implement with the people he or she encounters. Medical providers also need to perceive that their encounters with pharmaceutical sales representatives are congruently effective and ethical interactions, which is revealed by qualitative research methods in the thesis. Lastly, the pharmaceutical sales representative's effective and ethical communication provides recommendations in how to maintain the proper perspective of keeping these medical interactions with the greatest credibility and reputation.

Keywords: Pharmaceutical sales representative (PSR), symbolic interactionism, persuasive speech, nonverbal communication, ethical communication, creating reality

TABLE OF CONTENTS

Chapter 1: INTRODUCTION	1
Importance of the Study	1
Statement of Purpose	2
Definitions of Terms Used	2
Organization of Remaining Chapters	3
Chapter 2: REVIEW OF LITERATURE	4
Philosophical and Ethical Assumptions	4
Theoretical Basis	5
General-Practitioner-Pharmaceutical Representative Encounter	7
The Ethics of Pharmaceutical Sales Representative—Physician Encounters	9
Rationale	11
Research Questions	12
Chapter 3: SCOPE AND METHODOLOGY	13
Scope of the Study	13
Methodology	13
Data Analysis	16
Validity and Reliability	16
Ethical Considerations	17
Chapter 4: THE STUDY	18
Introduction	18
Results of the Study	21
Discussion	27
Chapter 5: SUMMARIES AND CONCLUSIONS	31
Limitations of the Study	31
Recommendations for Further Study	31
Conclusions	33
REFERENCES	35
APPENDIX	37

CHAPTER 1: INTRODUCTION

Importance of the Study

At one point or another, we have purchased a service or product we esteemed of great importance. This is a process we regularly embark on, going to the grocery store to pick up some milk, stopping at our local shopping mall to acquire the latest shoe wear, hiring a caterer to support an extravagant summer bash we are hosting, examples of what can be purchased by means of sales. In the health industry, pharmaceutical sales representatives (PSRs) are the ones who bring pharmaceutical services right to the medical provider at the very location they would be practicing. A PSR introduces their products to specific "targets" or potential clients that would be able to utilize the PSR's products as the medical provider prescribes those products to their patients. Seems simple enough, right? These medical interactions between PSR and medical provider are an everyday occurrence that involves building solid relationships as the PSR disseminates vital medical information to the medical provider (doctor, nurse practitioner, physician assistant, etc.). The question is, what would these interactions look like? How would a PSR influence the great medical minds that have *MD* as their official title when a PSR did not go through the exact medical schooling a doctor would be required to in order to practice on actual patients? If the PSR depends on medical providers writing prescriptions of their products, or *scripts*, to fulfill the PSR's monthly quota, how often, if any, would ethical communication be in question within these medical interactions? Thus, begins our journey of a world that many people may not know or understand too much about, a world of fancy business wear and highly attractive individuals walking in and out of medical offices, a world of sales that affects how our quality of life when it comes to our personal health can be in the hands of the PSR.

Statement of Purpose

There is no actual monitoring of these encounters with the PSR and medical provider, nor is there consistent documentation of what is actually stated within these interactions. All we know is that there are sales going on without actual monies changing hands. The PSR is almost a middleman as the PSR endeavors to persuade the medical provider to prescribe the PSR's products. Then the medical provider writes a prescription of that specific product of the PSR for their patient. The patient, in turn, hands that prescription to their local pharmacy, pays for the product via medical insurance or regular currency, and receives their medication. The data of that specific product gets logged into the PSR's company data that is tied into the PSR's territory and the targeted medical provider who originally wrote the prescription. The PSR receives a hefty compensation by way of a bonus at the end of the year depending on how high of a percentage the PSR exceeds their monthly quota. Following me so far? The actual problem is whether these medical interactions not only involve effective communication practices of the PSR, but would ethical communication practices contribute to the PSR's overall success correspondingly?

Definitions of Terms Used

Scripts: Prescriptions written for patients of the medical provider

Hallway Calls: Medical interaction between PSR and medical provider as the medical provider is seeing patients in-between talking to the PSR in the hallway

Persuasive Speech: Where significant choice is fully divulged to the other person, allowing them to make a free choice of all alternatives available

Symbolic Interactionism: A perspective that seeks explanation for social life in the way in which participants define and interpret the situations they confront

Creating Reality: When an individual plays a part he implicitly requests his observers to take seriously the impression that is fostered before them

Organization of Remaining Chapters

This thesis is composed of five chapters. Following this first chapter, Chapter 2 provides a review of nonverbal communication and behaviors, along with the theoretical basis of symbolical interactionism by way of dramaturgical performance. Chapter 2 also includes the philosophical perspective of persuasive speech and the ethical influence involved in being a moral individual. Chapter 3 explains the approach in gathering the PSR's perspective of a medical interaction and the medical provider's perception of the PSR. Chapter 4 reveals the findings of the study and discusses the meaning of what was gathered. Finally, Chapter 5 reaches certain conclusions and further recommendations of the study.

CHAPTER 2: REVIEW OF LITERATURE

Philosophical and Ethical Assumptions

According to Caputo, Hazel, McMahon, and Dannels (2002, p.9), interpersonal communication is a transactional process of creating shared meaning and building relationships. These relationships could range from friendships, intimacy, or professional/business type of relationships. Depending on what the end goal of that transactional process would be, each communication process may vary. For instance, if I am a single male pursuing another female of my liking, seeking to possibly reach the goal of marriage, my communication approach would be one of romanticism and "wooing." On the other hand, if I am seeking to close a sale of a home with a potential buyer, I would not base this transaction through a romantic means, but with a different, professional charm or business approach. Human beings choose which form of communication to implement in order to basically "get what they want."

One form of communication is ***nonverbal***. A communications professor by the name of Judee Burgoon defines nonverbal communication "as those attributes or actions of humans, other than the use of words themselves, which have socially shared meaning, are intentionally sent or interpreted as intentional, are consciously sent or consciously received, and have potential for feedback from the receiver" (Caputo et al., 2002, p.152). These attributes or actions can be altered as ***nonverbal behavior*** as well. Nonverbal behavior can be defined as "those attributes or actions of humans, other than the use of words themselves, which have socially shared meaning, and have potential for feedback from the receiver" (Caputo et al., 2002, p.153). Tapping my fingers on a desk would be considered nonverbal behavior if no one else saw me. If someone else did see that particular action and perceived I was bored or impatient, then actual communication was captured. People can engage in nonverbal behavior when they are alone or with someone

else, but they can engage in nonverbal communication only in the presence of someone else who chooses to interpret their behavior as messages and assign meanings to them (Caputo et al., 2002).

University of Washington professor emeritus Thomas Nilsen proposes another form of communication as ***persuasive speech***. He upholds the value of persuasive speech to the extent that it maximizes people's ability to exercise free choice. That's how he deems this form of communication as ethical. Nilsen writes, "When we communicate to influence the attitudes, beliefs, and actions of others, the ethical touchstone is the degree of free, informed, rational and critical choice—significant choice—that is fostered by our speaking" (Griffin, 2009, p. 202). For Nilsen, truly free choice is the test of ethical influence because "only a self-determining being can be a moral being; without significant choice, there is no morality" (Griffin, 2009, p. 202). This thesis uses the ethical philosophy of Nilsen for its philosophical foundation.

Theoretical Basis

Symbolic interactionism, defined by Herbert Blumer (1969), is a perspective that seeks explanation for social life in the way in which participants define and interpret the situations they confront; collective activities, in this view, are formed through an on-going process of designation and definition that is continually modified by specific people as they adjust their actions to one another. Herbert Blumer at the University of California, Berkley coined the term symbolic interactionism. He was a top disciple of George Herbert Mead who was a philosophy professor at the University of Chicago for the first three decades of the twentieth century (Griffin, 2009). George Mead taught the best minds of sociology but never set his viewpoints or ideas in any book. After he died in 1931, his students put together class notes and conversations they had with their mentor and published *Mind, Self, and Society* in his name (Griffin et al.,

2009). That's when Hebert Blumer emerged and came up with the term *symbolic interactionism*. The words capture what Mead claimed is the most human and humanizing activity that people can engage in, and that is talking to each other (Griffin et al., 2009).

Mead believed that the true test of any theory is whether it proves to be useful. One application of symbolic interactionism is through ***creating reality***. Erving Goffman (1959) develops the metaphor of social interaction as a dramaturgical performance. He claims that we are all involved in a constant negotiation with others to publicly define our identity and what is truly going on in a situation. When discussing the belief in the part one is playing, Goffman states:

> When an individual plays a part he implicitly requests his observers to take seriously the impression that is fostered before them. They are asked to believe that the character they see actually possesses the attributes he appears to possess, that the task he performs will have the consequences that are implicitly claimed for it, and that, in general, matters are what they appear to be. In line with this, there is the popular view that the individual offers his performance and puts on his show "for the benefit of other people." It will be convenient to begin a consideration of performances by turning the question around and looking at the individual's own belief in the impression of reality that he attempts to engender in those among who he finds himself (Goffman, 1959, p.16).

Goffman also explains that the performer creates his own reality to the extreme his reality is the 'real' reality. The other end of this extreme is that the performer may not believe in his own reality and has no ultimate concern with the beliefs of his audience. He would call this type of performer as *cynical* due to the performer's interest in deluding his audience for the purpose of "self- interest" or private gain (Goffman, 1959). Some of the examples Goffman gives as illustrations of a cynical performer are doctors who give out placebos to their patients, mechanics that "look into it" when an anxious motorist believes they hear a strange noise coming from their vehicle and the mechanic actually does nothing, or shoe clerks who sell a shoe that fits but tells

the customer it is the size she wants to hear. In other words, a cynical performer, although very sincere, may delude his audience for what he considers to be their own good, or for the good of the community, etc. (Goffman, 1959). He warns that the impression of reality fostered by a performance is a delicate, fragile thing that can be shattered by minor mishaps if someone performs out of character. Goffman's colleague, Joan Emerson, emphasizes the cooperative effort required to sustain the definition of a gynecological exam as a routine medical procedure. The doctor and nurse enact their roles in a medical setting to assure patients that everything is normal, no one is embarrassed or thinking sexual thoughts. The audience (client) is assured only when the actors give a consistent performance (Griffin, 2009).

General-Practitioner-Pharmaceutical Representative Encounter

Pharmaceutical representatives learn to build relationships, not only with the providers, but with the entire staff. In order for the pharmaceutical sales representative (PSR) to increase market share and boost prescriptions written (scripts) in a particular office though, the PSR needs to have a successful encounter with the doctor. In a dramaturgical study of meetings between general practitioners and representatives of pharmaceutical companies by Somerset, Weiss and Fahey (2001), they found Erving Goffman's model useful in understanding face-to-face interactions. They went on to explain:

> Goffman proposed that the context of an interaction might be regarded as a stage, the individuals at the center 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 (Somerset et al., 2001, p.1481).

The encounters were acted out in six scenes according to the following:

- Scene 1—initiated by the PSR who acknowledged the relative status of the two players
- Scene 2—provided the opportunity for the PSR to check the general practitioner's knowledge about the product
- Scene 3—was used to propose clinical and cost benefits associated with the product
- Scene 4—the general practitioner took center stage and challenged aspects of this information
- Scene 5—involved a recovery strategy as the rep fought to regain equilibrium
- Scene 6 (final scene)—the PSR tried to ensure future contacts

Within the conclusion of these encounters the general practitioner and the PSR measured the success of their encounter in different ways. Here's what the "finale" of the study looked like:

> 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 demeanor. 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…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 demeanor 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 (Somerset et al., 2001, p.1483).

This study did point out some gaps to Somerset, Weiss and Fahey's approaches. One major gap that could manipulate the data is each encounter was recorded, which could alter actual behaviors of the general practitioner and PSR. Secondly, there were only thirteen encounters, which could limit diversity in representatives' communicative styles. According to this study, it

was posed to search whether youth and attractiveness of the PSR affect the length of the encounter and the effectiveness of how consistent the general practitioner would write more prescriptions for that representative. In addition, the marketing strategy of providing "free gifts" during these encounters from the PSR was aimed to reciprocity, a repayment by the general practitioner that would translate to more scripts, which is a very powerful strategy. Then the question might be how many "gifts" would it take for the general practitioner to prescribe the representative's product? As stated at the conclusion of the study, "Just how many desk diaries does a doctor need?"(Somerset et al., 2001, p.1484).

The Ethics of Pharmaceutical Sales Representative—Physician Encounters

According to Wierwille (1981, p.1):

> Technically, ethics is the science of conduct, producing a defined result. The word "ethics" means the science of morals. "Ethics" is from the Greek *ethika*, which is derived from *ethos*, meaning custom or habit…the goal of a code of ethics is to help people live virtuously, morally, uprightly—in order to manifest the more abundant life.

When it comes to ethical communication in an industry such as the pharmaceutical industry, would there also be a "code of ethics" upheld? Who would be the ones to regulate such a task for many enormous pharmaceutical companies such as Merck Pharmaceuticals that make billions of dollars annually? In their essay that scrutinizes the controversy of Merck's drug *Vioxx* that contributed to between 29,000-60,000 deaths when the drug was in the market from 2000-2004, Lyon and Mirivel (2011) discusses the ethicality of how the representatives were trained to communicate to the physicians. Using Thomas Nilsen's perspective on ethics, Lyon and Mirivel (2011) argue that Merck taught their reps a communication approach that obscured the physician's ability to make a significant choice and placed patients' lives at risk unnecessarily.

Studies have shown that physicians that meet with drug representatives are more likely to add those specific drugs to their hospitals' formulary than physicians who do not meet with reps from those companies (Chren & Landefeld, 1994). There are many communication "styles" that drug reps use in the field to influence physicians to write more of their products, but there have not been too many studies on ethical communication of a drug rep. Current research shows how to sell more effectively, but scant on the ethical communication side of those sales. Lyon and Mirivel bring up an excellent point on what Nilsen argues when it comes to ethical communication:

> Ethical communication, Nilsen argues, should contribute to people's well-being and show "respect for the integrity of the [other] person." From his perspective, people have a unique capacity for rational thought that should be cultivated by communication. Nilsen sees individuals as possessing a self-determining nature that ethical communicators should uphold. Therefore, it is the responsibility of an ethical communicator to "provide adequate information, diversity of views, and knowledge of alternative choices and their possible consequences"…making informed choices is essential for practitioners and consumers in health care. When communication skills are employed to obscure choices to sell more of a potentially dangerous drug, patients' lives are needlessly at stake (2011, p.56, 57).

That is why the essay about Merck's communication amongst their representatives took place. When it comes to placing a patient's life at risk and obscuring information for the physician to make a well-informed decision whether to prescribe this drug to their patients or not is what's considered unethical communication from Lyon and Mirivel's perspective. The essay points out how Merck trained their reps to "downplay" the high risk of heart attacks that Vioxx causes amongst patients. That important "bit" of information cost thousands of lives. After reading this essay, I would want to know how many drug reps did not follow through on what Merck trained them to say due to seeing the high danger of Vioxx by actually giving the physician all the necessary information? Also, how many physicians failed to research Vioxx on their own, and

perhaps even heard how the FDA strongly pushed Merck to remove Vioxx from the market, but did not change their prescribing habits? If some physicians knew the dangers of the drug, why would they still continue to prescribe Vioxx? Is it because it was "convenient" for their practice, or did some of the doctors receive a "kickback" from Merck for prescribing Vioxx? Those would be some of the questions to consider further outside of this study in regards to ethical communication and also doing what's morally right for a physician's patient.

Rationale

Pharmaceutical sales representatives (PSR) seek to build relationships in order to increase market share and revenue for their respective companies. The means to do this can come from a variety of communication styles, sometimes verbally or nonverbally. From the literature review there are performers that have certain roles to play and the outcome is determined by how well each performer interacts with each encounter. Having a pleasant smile, dressing professionally, speaking with a well-known scientific basis of the product, and adapting to each practitioner in order to find "common ground" in relationship-building, contributes to a PSR's overall success in the field (Moldenhauer, 2009).

In the context of pharmaceutical sales representatives, ethical communication is upheld when the communicator provides *all* the necessary information, to the health benefits of a drug **and** the dangerous risks of the drug, so the physician has the knowledge to make alternative choices and their possible consequences. Once that communication is obscured or muddied due to fear of not making quota or the grandeur of what a rep would receive when quota is exceeded (motivated by the love of money, status, etc.), then there's unethical communication taking place amongst the drug rep because he or she has removed those alternative choices and made consequences appear beneficial as we saw from the communication theory of Merck with Vioxx.

Research Questions

This thesis covers the means to show how a PSR effectively grows in sales by effectively utilizing different communication styles to meet the best encounter with the practitioner. Also, this thesis investigates the point of when ethical communication in this field becomes unethical and how the consequences of unethical communication can cost many patients' lives unnecessarily. This study answers the following questions:

- Can ethical communication also be effective communication for pharma reps?
- Do pharma reps and their customers (medical practitioners) have congruent perceptions of what constitutes as ethical communication practices?

CHAPTER 3: SCOPE AND METHODOLOGY

Scope of the Study

The following study will explore the practices of what is considered ethical or unethical communication between a medical practitioner and a Pharmaceutical Sales Representative (PSR) For many years sales people have lived among us, have influenced what we should buy or not buy, made us feel "special" as if they were our best friend. The aim of this study is to identify what is considered ethical or unethical from the pharmaceutical sales representative's perspective and what is considered ethical or unethical from the medical provider's perspective. Then we will understand whether both perspectives are congruent to ethical communication. In addition, we will understand if a PSR can maintain his effectiveness as a PSR by being ethical as well.

Methodology of the Study

This thesis employs People- or Behavior-Oriented Research as described by Rubin et. al (2005). Specific methodologies employed included survey research in the form of questionnaires and observational research, which involves participant observation. I will be using qualitative techniques throughout this study. This study met the University Institutional Research Board (IRB) requirements for minimal risk, and therefore does not require a full IRB review. Methods of participant recruitment, data collection and analysis are detailed in the following sections.

Participants

Rubin (2010) mentions nonprobability sampling is valuable for studying particular groups of people. The two groups of people for a purposive sample will be pharmaceutical sales representatives within various companies and medical practitioners, providers, such as medical doctors (MDs), nurse practitioners (NPs), and physician assistants (PAs) that I have observed

another PSR interaction with for a certain amount of days. Each PSR received a link to the survey and I have carefully recorded notes for the ethnographic study.

Each PSR participant must have at least a few months of pharmaceutical experience and each medical provider has to have had at least more than two interactions with a PSR. PSR participants must also have had different communications with medical providers such as hallway calls, professional educational means via breakfast or lunch and learns, or met with a provider due to an appointed time initiated by the PSR or doctor.

Participants were informed that their participation was entirely voluntary and that their responses would remain completely anonymous when it came to the survey. The group was also informed that the study met the IRB requirements for minimal risk.

Procedure

This study employed two instruments in measuring how the PSR communicates ethically and effectively and whether the medical provider also sees the PSR is ethically communicating during their interactions: a survey and participant observation. Other measures were set in place to avoid any misunderstandings of how the qualitative techniques were implemented and any potential discomfort in answering the online survey for both the PSRs and medical providers.

First, participants completed a 15-item questionnaire administered via an online survey website, *SurveyGizmo*, which will consist *only* the PSRs' responses . Due to the relationships I have built with many of the doctors I see and call upon on a regular basis, it would be a conflict of interest for me to send out surveys to my doctors. Therefore, I will compare data in *Factors Associated with Physician's Reliance on Pharmaceutical Sales Representatives*, written by Anderson, Silverman, Loewenstein, Zinberg and Schulkin (2009), as a means of not jeopardizing

my career as a PSR with the company I currently am employed with and still enabling to gather the necessary information to complete my study. According to Rubin et al. (2005), "Survey research can be used to measure attitudes, opinions, and reported behaviors or behavioral intentions" (p. 227). The survey unveiled the different behaviors and communications a PSR exhibits and whether the medical provider sees those behaviors as ethically acceptable or not and why (See Appendix). Measuring behavioral intentions of the PSR and if those intentions are easily detected to mean the rep is there to fully support the doctor's practice or intended for unethical gain will be interpreted within the survey.

Next, due to the fact that I am a PSR myself, it allows me access and entrée to view my interactions with the medical providers firsthand, determining how "upright" my conduct and dissemination of information is with the providers. As far as what I was able to observe outside of myself, I was able to shadow two different reps in two different states for my "hands on" field training. The purpose was for me to shadow these PSRs, how they interacted with the Staff, their sales techniques in promoting our company's products, etc. Rubin et. al (2005) states, "Participant observers rely on their own observations, on information from group members, and on whatever records and materials are available and pertinent" (p. 231). Many of my colleagues who are PSRs will validate how they approach each provider and the types of communication techniques they use to effectively push their products. Rubin et. al (2005) concludes a participant observer "from all these observations…would form conclusions about effective and ineffective communication patterns" (p. 231). This qualitative technique of a participant observer determined what is considered ethical communication for the PSR and if there is actual unethical communication during interactions with medical providers.

Data Analysis

After receiving the surveys back from the PSRs, they will be coded and reviewed for whether their answers are congruent to how a medical practitioner views the rep's communication, determining what is considered ethical and effective amongst the interaction. It will be interesting to see how each individual responds. The PSR would have been given real-life scenarios where they would interact with a medical practitioner on a hallway call, during an educational lunch, set appointments with the doctor, an after-hours dinner, and so forth. The questions would ask what the PSR determines as acceptable and whether they deem their communication with these marketing means not only effective, but ethical as well. Comparing the surveys done from Anderson et. al (2009), I would be searching for whether they see the interaction as ethical in how the PSR approached the medical practitioner and how the PSR promoted their company's products.

Validity and Reliability

With how the PSR responds to the survey questions, along with how the medical provider responds to similar questions by way of Anderson's et. al (2009) study, there is an equality on the interpretation of an ethical or unethical interaction. Again, as a participant observer I have gathered information that enforces the kind of discussions a PSR has with a medical provider. This study purports an external validity due to "how generalizable the results are to people and contexts other than the group and situation being studied" (Rubin et. al, p. 211). The PSRs who answered the survey are in different parts of the United States and have not interacted with the doctors, medical providers, in my state of Colorado. Therefore, the communication techniques I may utilize during a medical interaction may be not always be the same techniques another PSR

would use living in a different part of the country. For instance, the medical providers in other states could view the way I communicate to them as unethical because where they live, they may be more conservative where people in Colorado may be more liberal (i.e. legalizing marijuana).

Ethical Considerations

Tevin and Winters (2007) points out the specific relationships observed in their study indicate that competent salespeople are "nonverbally immediate, moderately attractive, have the ability to modify or tailor messages accordingly, and are motivated to sell" (p. 476). With that motivation to sell, one has to ask if the PSR truly cares about the practitioner and their office or will manipulate conversations in order to get what they want. A provider may also be skeptical with a PSR's motives and whether the provider is merely a business transaction or does the PSR see their encounter as a *medical interaction*. The provider has to protect their self-interest for the good of their practice and the PSR has to gain the trust and interest of the provider in order to gain market share. The participants in this research study require their informed consent and will not be coerced or deceived when it comes to the online questionnaire. Confidentiality will remain throughout this study, no names or which company the PSR works for. When it comes to participant observations, omissions are required "because knowing the purpose of the project may influence how participants act and answer questions" (Rubin et. al, p. 212).

CHAPTER 4: THE STUDY

Introduction

It has been said that "Life is in the details." Pharmaceutical sales representatives have evolved for decades, detailing medical professionals on the essential highlights of drugs. Before these sales representatives became what we know as PSRs, they were at one time referred to as "detail men." According to Greene (2004), since World War II the 'detail man' was the industry's in-the-flesh representative in every hospital, clinic, and medical office in the country. "'Detailing' here refers to the unique performance, half sales pitch and half educational service, with which pharmaceutical sales representatives present physicians with prescribing information, or 'details', concerning new medications" (2004, p. 271,272). Greene continues to elaborate on the genealogy of the detail man and when they became prominent:

> Genealogically speaking, the detail man was a not-so-distant relation of the traveling patent-medicine peddler: a commercial traveler, familiar with roadside motels, the inside of his automobile, and with a wary outsider status. But the pharmaceutical representative as a familiar fixture in the physician's office resulted from the dynamic re-organization of the industry immediately after World War II. Though the first salesmen for 'ethical' pharmaceutical houses began their travels across the continent in the mid-19th century, the total number of detail men in America was quite small. The 1940s and 50s, however, were a pivotal period for the prescription drug industry, as novel and efficacious medicines began to pump out of a suddenly vibrant research pipeline. Entirely new classes of therapeutic compounds were emerging almost every year, supported by an increasingly systematic body of research and clinical publications. Between 1939 and 1959, sales of pharmaceuticals increased from US$300 million to US$2.3 billion; by 1959 the nationwide corps of detail men had grown from 2,000 at the end of the 1920s to more than 15,000 nationwide (Greene, 2004, p. 272).

With the brief, overall history of what Greene provided for the 'detail man', or what we now know as PSRs, we can understand how the PSR emerged and why there are so many today.

High professionalism is key with being a PSR. How the PSR presents himself or herself to the doctor as a professional supplements the success of the relationship and whether the doctor chooses to accept or reject the information given. On September 30, 1941, just a couple of months before the United States entered into World War II, Columbia University made a course available devoted entirely to the 'detailing' of physicians. The editors of *Medical Marketing*, which was a brand new journal targeted towards an emerging readership of pharmaceutical salesmen and marketing executives, saw it as a portent of the new professional status of the pharmaceutical salesmen (Greene, 2004). Thomas H. Jones, a veteran salesmen who had received a great deal of attention for a textbook of pharmaceutical selling that he had published a year before, spoke in front of this class, mostly derived of pharmacy students and young employees of local pharmaceutical companies, to discuss the fine points of selling. Jones (1940) mentioned to the class the reality of detailing and that it is merely a *sales promotion*, acquainting the doctor with the important facts about a product or products. Ten years later, the first edition of Arthur F. Peterson's textbook, *Pharmaceutical Selling, 'Detailing', and Sales Training* was published as pharmaceutical companies were increasingly becoming differentiated by branded product lines grounded in laboratory innovation (Greene, 2004). Unlike Jones who solely emphasized the selling aspect of pharmaceuticals, Peterson's definition of detailing depicted the pharmaceutical representative not as a specialized salesman, but rather as a skilled and respected professional, entrusted with the vital task of disseminating scientific information to the medical profession:

> The well-informed 'detail man' is one of the most influential and highly respected individuals in the public health professions…Upon him frequently depends the saving of life or relieving from suffering by virtue of his timely introduction of a therapeutic product and his intelligent discussion of it with a physician. His opportunity to render

> service of extraordinary value to physicians for the benefit of their patients is in itself a source of real satisfaction. He serves humanity well (Peterson, 1949, p. 2).

From Peterson's perspective of the detail man one can almost sense there is dignified nobility involved with the pharmaceutical representative, a humanitarian if you will that delivers their messages to physicians with great grace and integrity.

The PSR is a reflection of the company they work for and the products they promote. Due to the fact that pharmaceutical companies cannot fully control what a physician prescribes or the outcome of the medical interaction with the doctors and PSRs, pharmaceutical companies can keep tight control over the quality of individuals they hire. When it comes to a listing of characteristics of the 'ideal representative', Peterson's textbook includes the following:

Good appearance

A pleasing personality

A good speaking voice and effective speaking delivery

Moderate habits, good health, and physical fitness

Alertness, friendliness, and a fighting spirit

Integrity, not inclined to make exaggerated claims

A good cooperative make-up and the will to work and to follow instructions

A good credit report

A satisfactory financial status

A happy marital status

A cooperative wife

A good and suitable educational background

An inclination to keep abreast of modern pharmaceutical science and service

Good retail experience

Good organizing ability

Compatibility and leadership qualities (Peterson, 1949, p. 17-38).

Not too many things have changed for the PSR and what qualities pharma companies are looking for with their emissaries. The interesting points to make with Peterson's list are "Integrity, not inclined to make exaggerated claims" and "A happy marital status." These two inventory items almost suggest morality plays a huge role in a PSR's life, or as Greene explains it, "To establish the legitimacy of a pharmaceutical industry presence *inside* the clinician's offices, it was crucial to select a presentable representative: clean, chaste, moral, married, educated, and pleasant" (2004, p. 276). For the PSR, not only is there a question if the representative can effectively represent his or her company and the products they stand for, but if the PSR can ethically communicate it as well. The following categories were identified and explored in detail—effective elements of communication, perception of ethical communication, and through the eyes of the medical provider will be mentioned within the results of the study and the discussion sections.

Results of the Study

With the methodology of sending a survey via *SurveyGizmo* to 55 PSRs on best communication practices of a PSR out on the field, 23 responded. From those that chose to answer, 11 were valued as male participants and 9 were valued as female participants. The ranges of pharmaceutical experience were as short as 5 months to as long as 25 years of being a PSR. As Peterson (1949) mentioned earlier how the detail men rendered an invaluable service to the physician, serving humanity well, on question number four 74% of the survey participants

strongly agreed that PSRs are a valuable resource in helping physicians learn about new drugs. Being liked by the office and the doctor as the PSR remains upbeat and smiles most of the time (#5 & 7) are important aspects of being a successful PSR as nearly 90% of the participants either strongly agreed or agreed. What was truly interesting with the survey was how many different responses were given for question number 8, "Providing accurate and detailed information about my products is more important than building rapport with the staff and the doctor." Just a little over 50% either strongly agreed or agreed with the statement, over 21% strongly disagreed or disagreed, but the real "attention-getter" was 26% answered neutral (I will provide a thorough explanation of why these results are significant with question eight in the discussion section of chapter fourgood). Continuing with the results of the survey, many of the questions lined up with the 'ideal' PSR characteristics that Peterson portrayed such as *good appearance* and *physical fitness* (question #9), *pleasing personality* (#5, 7, & 10), *friendliness* (#7), *good organizing ability* (#6, 8, 13, & 15), *integrity, not inclined to make exaggerated claims* (Over 90% strongly disagreed or disagreed with #14 & just about every question), and *a good cooperative make-up and the will to work and to follow instructions* (Almost 90% strongly disagreed or disagreed with #12 & just about every question). These were many of the elements PSRs considered as effective communication practices of a PSR.

As a participant observer, I was able to observe two different PSRs in two different locations. One PSR I observed was in Denver, Colorado as he conducted a professional educational event by providing lunch to the staff and speaking about his products. The PSR was well dressed to the point I did not even see one wrinkle on his clothing. He knew just about every staff person by name, what foods they enjoyed, who the doctors were, etc. With some of the staff he would remember their children's names and asked how they were doing, some of the hobbies

some of the staff enjoyed, from favorite television shows to what sports teams they loved. It was quite impressive to witness the many details he recalled with just one office. When it came to detailing his products (he had two that covered back pain management), he spoke to medical assistants (MA), nurse practitioners (NP), and of course to the doctors (MD). There were four MAs, two NPs, and four MDs he spoke to as he detailed each one. The way he spoke about his products was more of a conversational tone, very casual-sounding, non-robotic, but intelligently disseminated the information. There was a voluminous amount of scientific knowledge given as the medical providers nodded and seemed to follow along as they were quickly trying to finish their sandwich in order to get to their next patient in the next ten minutes. When there was a question on side effects or cost of the products, the PSR calmly answered the doctor's questions poignantly and without hesitation. One question was posed about a competitor's product cost being lower than what the PSR was promoting and the PSR told the doctor that he would double-check on that for him. Within a couple of hours after the luncheon, the PSR was able to obtain the correct competitor's price and followed up with that doctor, stating his product was actually more cost effective and why. There were several more doctors that the PSR called on that day. Unlike having several minutes with the doctors that he hosted a lunch for earlier, the PSR had several seconds with these doctors during hallway calls. The PSR stated the products he was promoting and gave one or two highlights of the benefits the patient would receive. On average, the PSR would have about thirty seconds to give their scientific information and sales pitch due to the amount of patients the doctors needed to see between examination rooms. The last thing the PSR would ask the doctor for would be for the business, endeavoring to secure a commitment to prescribe the PSR's product(s) and then thanking the doctor before leaving the

office. In my next observation, I will provide an overall analysis of how this PSR prepares for each office she will be calling and how she was able to request an audience with her doctors.

The location is in sunny San Francisco, California as I await for my colleague to pick me up from the airport. As she pulls up, I noticed that she has her coat hanging in the back of her vehicle and some boxes of marketing materials. She has a target list of offices we will be seeing together, utilizing an IPad to look up addresses and data of what each doctor prescribes for their patients. The PSR's IPad does not contain any names of patients, but does provide the writing habits of doctors for the past months. From what the PSR explained to me, this data allows the rep to position her products and the advantages and benefits her products possess over the competitors the doctor may be supporting. It also allows the rep to see if the doctor is already writing the rep's products and how many scripts the doctor is writing every month. The PSR prepared a call list of offices to see for the day, usually offices that are within the vicinity of her territory. On average, a PSR should be in front of ten different doctors or make ten calls a day. That's fifty calls a week the PSR would make. Depending if the PSR has built rapport with an office or seeing an office for the first time, there was a different approach that the PSR used. For example, on our first call the PSR brought some bagels and fruit cups as a snack for the office. It was around 10:15 am, about the time the office could use a snack. This particular office began seeing patients at 8:30 a.m. until around 4:30 p.m. in general. The PSR knew when it was the best time to come in with the snacks, which doctors or medical providers would be there, and who would be working at the front desk. The front desk personnel, who are also the gate-keepers, decide who will be able to go to the back to check samples and whether it was a good time to see the doctors to sign off on received samples. It was obvious the PSR had a good relationship with the front desk staff. As soon as she walked in they all called her by name,

remarked how great she looked, and told her which provider was in that morning. The PSR knew each person by name as they chit-chatted about the events that took place this past weekend. There was no mention of products the PSR promoted; it was just friendly conversation. Once the PSR made it to the sample closet, she was able to determine how many samples have been used or how many samples are not being used. This office used plenty of her products as the PSR unloaded several samples from her fairly large green bag. Once the samples were in the closet, the PSR took her IPad out to log how many samples were given. Since the doctor she wanted to see was with a patient, the PSR struck up conversations with several of the staff going in and out of the hallway, asking them for any feedback with her products as she waited. As soon as the doctor came out of the exam room, the PSR already had the IPad ready for the doctor to sign. Both exchanged pleasantries as the PSR smoothly segued into a couple of benefits of her products. The PSR knew that this doctor was already prescribing a couple of her products as she provided more highlights for a couple of other products that the doctor was not prescribing much of or at all. She thanked the doctor for the support on the products he was presently writing and asked if he could commit on writing her other products for a specific patient type. She spoke with the doctor for a couple of minutes (instead of thirty seconds) during the hallway call. Due to the relationship the PSR had built with the doctor from past visits, the doctor gave her more time.

In an office the PSR had never been in, her approach was quite different. Before she entered the office, she had her business card on hand and several marketing brochures of her products. Upon entering the office, the rep noticed some exquisite paintings on the wall and remarked how gorgeous they were. It was a good “ice breaker” to lead into why she was there. She then introduced herself and introduced me and explained she was the rep of her lead product in the area. The PSR mentioned she had never been in their office before and wanted to know

what the appropriate office protocols were for PSRs. The person at the front desk provided the protocol by giving the PSR a sign in sheet (name, company the PSR worked for, and their phone number). Once the PSR signed in, the PSR took a card that had the doctor's name on it and proceeded to ask the name of the person working the front desk. The front desk individual gave the PSR her name and then the PSR asked which providers were in the office today. The front desk told her who were in and that she was allowed to go to the sample closet. The PSR knew this particular doctor did not write her products at all. She found some space to place her samples in the closet. The PSR observed her surroundings and noticed the doctor went to the same university she did. When the doctor came out of the exam room, she saw the PSR and immediately told her she does not have any time to talk. The PSR understood, but instead of being discouraged or frantic with the doctor's statement, the PSR quickly brought up that she noticed the doctor went to this university. The PSR commented she also went to the same university. They almost simultaneously cheered, "Go…mascot" and giggled how small of a world they live in. With this common ground the PSR was able to establish, the doctor decided to give her a couple of minutes as the PSR masterfully presented the products she was promoting. The doctor commented on how she has heard of these products, but never had someone detail her on them. The PSR responded that she was the new rep for the area and will be calling on the doctor's office more often. The doctor seemed thrilled to finally have a rep to support her office and committed to begin writing the PSR's products. The PSR profusely thanked the doctor for such a meaningful conversation and told the doctor that there are now samples in her closet to utilize for her patients. In turn, the doctor thanked the PSR, asked if the PSR can schedule a lunch with the front desk, and commented how nice it was to see another person from her alma mater.

Discussion

Some of the nonverbal cues a typical PSR exhibits would be business attire worn (ie. suit & tie for men; blazer, blouse, & business skirt/pant for women), a pharma rolling bag or shoulder bag, a laptop or IPad on hand, well-groomed appearance, outgoing smile, and a confident air about them. Question number seven addresses if the friendly, upbeat PSR who smiles a lot would receive a positive perception from the staff and doctors, 87% of the PSRs responded that they strongly agreed or agreed with this assessment. The two PSRs I observed were well-dressed, wore bright, pastel colors, clean hair style, and had a compelling smile. The PSR ***is*** the marketing brand of the products they represent. Appearance means everything to the overall success of the PSR. Teven and Winters (1998) expressed that "the PSR's effective communication with physicians and other healthcare professionals is crucial to engendering positive perceptions of the sales representative and to increasing sales" (p. 467). Personal appearance, nonverbal behaviors such as a friendly smile, an upbeat attitude, a positive energy exuding from the PSR, and so on, and respecting the office's protocol as mentioned on question thirteen of the PSR survey, answers what is considered ***effective communication*** for a PSR. Then the next question would be "can ethical communication also be effective communication for pharma reps?" The next paragraphs address not only this question, but also answers "do pharma reps and their customers (medical practitioners) have congruent perceptions of what constitutes as ethical communication practices?"

Nilsen introduced persuasive speech and how this speech invokes free choice as the ethical communicator presents all alternative choices so the individual they are influencing can make a well-informed decision (Griffin, 2002). With every medical interaction I observed with the two PSRs, the information disseminated to the doctors were scientifically based with clinical

studies on hand to show the doctor, there was prescribing information (PI) that addresses all indications of the drug, from what the drug was designed to alleviate, to the patients who should not take the drug due to certain health conditions; in other words, nothing was hidden from the medical provider where he or she would be hindered from making a free, well-informed choice to what they should prescribe to their patients. Therefore, from the PSR's perspective and from the customer's perspective (medical practitioner), both have congruent perceptions of what constitutes as ethical communication practices.

Survey question number eight states "Providing accurate and detailed information about my products is more important than building rapport with the staff and the doctor." As mentioned earlier, I would provide a thorough explanation of the significance of what the PSRs responded. Goffman (1959) posits in his Impression Management Theory that individuals want to be perceived in a positive light and thus communicate in order to create desired impressions. How this theory pertains to survey question eight is although PSRs want to be liked by the staff and doctor and how building relationships is a gigantic part of being a rep to thrive in the pharma industry, detailing a medical practitioner accurately and fully is still the top priority of a PSR. Some of the doctors are used to writing a particular drug for years and don't necessarily enjoy change. Many times new clinical and observational studies are introduced and because some doctors may refuse to change what they are used to prescribing, when a PSR presents proven and undeniable facts about what should be used for today's patients, some doctors would almost like "to kill the messenger." Many doctors do not like to be told, "You were wrong for giving out this drug that could potentially be increasing detrimental risks to your current patients." The PSR is responsible to convey accurate, up-to-date messages to each and every provider, regardless if the doctor will like you more or not; it's the PSR's moral duty to provide essential facts of the new

drugs with proven evidence to support higher quality of life for the doctor's patients. The main reason why question eight had over 26% answer neutral is the PSR is required to build rapport, to get accepted by the staff and doctor as a reliable resource in supporting their practice, and to be entrusted that the PSR has correct medical information. On the other side of the spectrum, there is still a moral obligation to provide the doctor with accurate, detailed information of the PSRs products, especially if the drug could potentially be a health risk for the doctor's patients; the PSR still needs to communicate this information with the possible risk of the doctor deciding not to prescribe the PSR's products, losing market share, not getting as large of a bonus at the end of the year, and so forth. Then it is up to the doctor to decide what would be best for their patients. Both aspects of question eight are important, and therefore the PSRs could not fully agree or disagree because they deem most sides equally important. Teven and Winters concisely interprets the competence of a PSR in this manner:

> Therefore, PSR competence would likely be positively associated with adaptive selling, nonverbal immediacy, physical attractiveness, and motivation, meaning that effective PSRs would be well versed in how to adapt their communication to the various physicians they encounter, employ appropriate nonverbal immediate behaviors, look their best on the job, and be motivated to sell their company's products, and close sales (1998, p. 470).

That being said, the physician would be given all the essential information to make a free, well-informed choice, therefore receiving ethical communication in the process since that free choice was not warped or skewed in any way, along with effective communication practices from the PSR.

Question eight answers the other research question, "Can ethical communication also be effective communication for pharma reps" because over 50% of the PSRs strongly agreed or agreed that it's more important to provide accurate, detailed information than to be liked; that's

how a PSR can maintain, not only effective communication in an office, but ethical as well. Sustaining a PSR's credibility and being a reliable resource for the office and medical practitioner (as question fifteen in the PSR survey addressed) allows the PSR to be trusted. Therefore, the PSR's products and ideas become validated. That's how a PSR's ethical communication, when the PSR fully divulges all the essential and accurate information to a medical practitioner about the PSR's products, becomes effective as the medical practitioner can rely and trust the PSR's credibility and the medical information given. This ethical and effective communication of a PSR leads to more prescriptions written, which means a higher sales compensation for increasing market share.

CHAPTER 5: SUMMARIES AND CONCLUSIONS

Limitations of the Study

This thesis had a number of limitations that could have potentially impacted the findings. Being a participant observer widened the scope of how a PSR interacts with a variety of medical providers in several different scenarios. Unfortunately, this part of the study was limited to observing only two PSR professionals. Ideally, having the opportunity to examine at least ten different PSRs can broaden many more effective ways a PSR communicates to the office staff and to the medical providers. In addition, viewing PSRs in different sections of the country can broaden what constitutes as effective and ethical practices, whether there are altered perceptions from the medical provider in the east coast to what is considered effective or ineffective, ethical or unethical communications to how their PSR approaches them, to a medical provider that practices in the northwest and how the PSR conducts themselves in that part of the country, for example. In the section of the study concerning a conflict of interest in sending surveys to medical providers, it would have been enlightening to gather the responses of the medical provider and how they would perceive what is considered effective communication practices of PSRs in general and what the medical provider would deem as ethical or unethical interactions with the PSR.

Recommendations for Further Study

Working strictly with obstetrics and gynecology (OBGYN), there are usually a larger base of female doctors than there are of male doctors. This observation coincides with the office staff of OBGYNs being mainly females as well. One further study that can be conducted is if male PSRs who are highly attractive and personable have a larger success in influencing female

doctors (even though the male PSR promotes *women's* health care products) to female PSRs within the same emphasis. This study may further illuminate if opposite gender dynamics contribute to the effectiveness of a PSR and how often would speaking to the opposite sex potentially lead to any precarious ethical scenarios.

Another intriguing study would be if there was a regulated gift policy for the PSR where they are capped at a certain point to how many samples would be provided or not provided, how many lunch and learns would be conducted per month, and so forth. It would be interesting to see the successfulness the PSR would have with building relationships with these offices. Let's say forty percent of the PSR's targeted offices are not allowed to take samples nor do lunches, how well would the PSR do in reaching his monthly quota? Would the PSR be able to maintain an ethical means to communicating with these offices that are unable to take samples or do lunches, or would the PSR have to take drastic measures in order to "get the job done?"

With the above limitations, I would recommend observing the ten PSRs in different aspects of the healthcare industry other what women's health. For example, I would observe a PSR that specialized in pain management, another PSR focused on providing diabetes medications, another PSR who worked closely with cardiology doctors, and so forth. Having a variety of PSRs to analyze with each having a diverse emphasis would expand my scope of many effective and ethical communicative encounters with the medical providers they engage with on a regular basis.

In regards to the survey limitation to providers I have entrée to, I would suggest sending surveys to other medical providers that I have never encountered or those outside of OBGYNs or women's healthcare. This would provide keen insight to what the general medical professionals

would view as effective communication practices of their PSRs and whether their medical interactions with their PSRs are congruently ethical in the process.

Conclusions

Kouzes and Posner (2003) suggests reputation is "to be cherished and cared for" (p. 25), which supports the natural instinct to want to trust someone. They further expound the following on the importance of having an untainted reputation in order to build a strong credibility base:

> Credibility, like reputation, is something that is earned over time. It does not come automatically with the job or the title. It begins early in our lives and careers. People tend to assume initially that someone who has risen to a certain status in life, acquired degrees, or achieved significant goals is deserving of their confidence. But complete trust is granted (or not) only after people have had the chance to get to know more about the person. The credibility foundation is built brick by brick. And as each new fragment is secured, the basis on which we can erect the hopes of the future is gradually built (2003, p. 25).

Reputation and credibility is truly the bottom line of whether a pharmaceutical sales representative will thrive in the health industry or not. Without building solid, well-meaningful relationships with each office and the medical providers within that practice, a PSR ceases to exist. Why would any PSR jeopardize their career and reputation by not communicating ethically? There have been some, as indicated by Lyon and Miravel, that have abused ethical communication by removing significant choice for the medical provider. For the most part, after a careful and well-put together study on effective and ethical sales communication of a pharmaceutical representative, the central conclusion is PSRs endeavor to effectively communicate with each medical interaction *and* are able to obtain a successful reputation as they uphold ethical communication according to the theories and methodologies presented in this thesis. No one is perfect and there is always a select few that may contradict what is considered

effective or ethical communication, but as long as medical providers hold the line with the knowledge base of all that they have been taught, as long as they continue to challenge and check all information disseminated to them by numerous PSRs in a day, as long as PSRs and the companies they work for maintain their integrity by providing accurate and precise medical information to the providers they serve and support, the patients the medical providers aid will receive the best, overall treatments to a greater quality of life.

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APPENDIX

Survey

Your participation is optional. Your identity and responses will be kept completely anonymous/confidential. Questions that require a response are marked with a red asterisk (*).

1. Age

2. Gender
    a. Male
    b. Female

3. Length of pharmaceutical sales experience *

Please respond to the following statements on a scale from **1 meaning "I strongly disagree"** to **5 meaning "I strongly agree"** to the effective ways pharmaceutical representatives communicate out on the field.

4. Pharmaceutical representatives are a valuable resource in helping physicians learn about new drugs. *

Strongly Disagree		Neutral		Strongly Agree
1	2	3	4	5

5. Getting the doctor and his staff to like me contributes greatly to my success as a drug rep. *

Strongly Disagree		Neutral		Strongly Agree
1	2	3	4	5

6. Remembering key details, like people's names, makes it easier for me to gain access to the doctor's office. *

Strongly Disagree		Neutral		Strongly Agree
1	2	3	4	5

7. Being friendly, upbeat, and smiling a lot places a positive perception of me as a pharma rep. *

Strongly Disagree		Neutral		Strongly Agree
1	2	3	4	5

8. Providing accurate and detailed information about my products is more important than building rapport with the staff and the doctor. *

Strongly Disagree		Neutral		Strongly Agree
1	2	3	4	5

9. Me being physically attractive lends to a higher influence on the staff and doctor. *

Strongly Disagree		Neutral		Strongly Agree
1	2	3	4	5

10. I need humor to give an effective sales presentation. *

Strongly Disagree		Neutral		Strongly Agree
1	2	3	4	5

11. Doctors only care about what I have to say if they see that I actually care about them. *

Strongly Disagree		Neutral		Strongly Agree
1	2	3	4	5

12. The more aggressively pushy I am with the doctor, the more he will write my products. *

Strongly Disagree		Neutral		Strongly Agree
1	2	3	4	5

13. Respecting the office's protocol and being courteous and sensitive to what the practice needs are the best ways to earn the office's trust. *

Strongly Disagree		Neutral		Strongly Agree
1	2	3	4	5

14. If a doctor asks a difficult question about my products, I quickly change subjects to something I actually know. *

Strongly Disagree		Neutral		Strongly Agree
1	2	3	4	5

15. Staying credible by knowing my products thoroughly and accurately is critical if I want the doctor to trust my ideas, products, and services. *

Strongly Disagree		Neutral		Strongly Agree
1	2	3	4	5

Comments

Please use this space for any additional comments you may have about more effective ways a pharmaceutical representative can communicate out on the field.