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The impact of marketised discourse on the interaction between drug representatives and physicians

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Abstract

Drug representatives ('drug reps') visit physicians to present and promote pharmaceutical products ('drug detailing'). Against the background of a continuous innovative slow-down, drug companies have shifted strategic emphasis towards marketing and selling. With regards to drug detailing, I am investigating how this shift towards marketing is manifested in discursive terms. I show how the detailing discourse is impacting the attitudes and behaviours of those involved in it, namely physicians, drug reps and their managers. By means of qualitative interviewing I access the individual meaning-making and attitudes towards the phenomenon of drug detailing. I demonstrate how discourse is designed, transformed and responded to. In that, I point to a system of incompatibility resulting in unproductive action. Marketised discourse as devised by management is not fostering collaboration between the industry and the medical profession. Moreover, it leads to a growing detachment of drug reps from their organisations. By highlighting the issue of drug detailing for the first time from a drug rep perspective my research demonstrates that the industry is not an integrated ideological whole. I conclude by advocating a more transparent conduct of business, suggesting controlling means to improve the quality of information delivery. Last not least I want to stimulate a critical public discourse about the sublime ways of constructing and disseminating marketised pharmaceutical information.

The impact of marketised discourse on the interaction between drug representatives and physicians

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Statement of copyright

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<u>Dedications</u>

To my parents, **Ursula** and **Ernst-Ulrich Gehrke**

1. Introduction

1.1. Motivation

This project was originally sparked by my own professional experience that drug marketing is increasingly failing to convince physicians. In particular, visits by pharmaceutical representatives ('drug detailing') showed to have a decreasing leverage. Market performance figures and customer feedback pointed to a growing wear out of sales initiatives versus physicians. In response to these developments, product positioning and customer segmentation have been further refined in an attempt to make the product offering more convincing and relevant to physicians. However, increase in marketing toil did not significantly improve the situation out in the market. Gradually, I came to realise that the issue at hand must be of fundamental nature. In my view the relationship between industry and profession is in a state of disruption.

As a matter of fact, relationships between the industry and the medical profession are manifold. However, in the area of drug marketing the most important connection is clearly the one between drug reps (also referred to as 'detailers') and physicians. From a management's point of view, drug reps act as transmitters of management's marketing ideas to physicians. Out in the field, drug reps are visiting physicians in order to discursively disseminate the marketing brief. Detailers thereby link management to physicians and vice versa. In every drug company, detailers make up the biggest single group of employees. In short, detailers are important, both from a strategic and from an investment point of view. Physicians, on the other hand, are regarded to be the key arbiter between industry and patients. Both, office-based and hospital doctors are prescribing or recommending ethical drugs (i.e. drugs only available on prescription) to patients. Furthermore, physicians are a source of information as they regularly feedback their experiences with particular drugs, therapies and patients. Thus physicians are the crucial point of contact for any drug company.

In my search for systemic perturbations, I decided to take a closer look at the interaction between drug reps and physicians. When approaching the detailing complex I identified three key elements: the drug rep, the physician, the talk. As talk is the bridging element between the two it became the focus of my investigation. To me,

examining the detailing encounter implied examining its discourse. In the pursuit of the project, however, I recognised that the phenomenon of discourse in drug detailing is not only shaped by drug reps and physicians. Equally important are the role and attitudes of managers who by means of strategy, design and training provide the discursive patterning that drug reps are instructed to follow. Based on this insight my research project was expanded to investigate how talk is forming – and is formed by – the three different protagonists in drug detailing. In this respect, I believed that discursive interaction should be approached from a cognitive perspective in order to identify crucial differences in values and motivations. Therefore, I was interested to explore the individual meaning-making, perceptions and attitudes that carry the discursive interaction. It was only later that I found that this area is highly under-researched and that demand for qualitative investigations is high. This was aptly illustrated in the opening chapter of a WHO sponsored study on drug promotion, where it reads:

Studies on people's attitudes to promotion rely too much on quantitative surveys, on the use of convenient, accessible samples, and on describing the prevalence of attitudes rather than relationships between attitudes and other characteristics. Qualitative studies are needed in this area.

(Norris, et al., 2005, p. 7)

1.2. 'A priori' beliefs and research questions

As indicated this project was essentially driven by my 'a priori' belief that discourse between industry and physicians is somehow disconnecting. In other words, the parties' respective codes of communication are not matching. Certainly, this can have many reasons yet on closer inspection one cause stood out rather prominently: professional background. Whether by training or occupational socialisation, managers, drug reps and physicians are rooted in very different social systems. I assumed that both managers and drug reps fit in the self-interested world of business, while doctors belong to the collectively oriented world of medicine. To my anticipation, different occupational socialisation, norms and objectives would lead to divergent motivations with respect to drug detailing. Simply put, I expected drug reps to reproduce management's self-interested commercial rhetoric to the advancement of sales and

profit generation. In this context, I came to employ the term 'marketised discourse' as a marker for promotional talk, clearly with reference to Fairclough's work on the phenomenon of 'marketization' of social spheres through discursive processes (Fairclough, 1992).

At the other end, I predicted that doctors would resist these discursive practices on grounds of morale, divergent ideology and professional pride. Altogether, I thought these cognitive contrasts to be the main cause for unproductive drug detailing. At the same time, I presumed that it must be challenging for drug reps to continuously perform promotional discourse in front of a professional group that largely rejects the commercial idea. The notion gained in relevance considering the fact that drug reps spend the majority of their time in a medical environment compared to rather few contacts in the world of their corporate employers.

Based on these projections the following research questions emerged:

1. Is there discursive construction of marketization in drug detailing?
2. If there is marketised discourse how does it manifest in discursive terms?
3. How does such discourse impact the roles and attitudes of drug reps & physicians?

I like to reveal that in several parts my a priori beliefs were confirmed by my empirical work. However, my research findings also show that the phenomenon of promotional discourse – its design, implementation and reception – is a much more complex process than anticipated. The research highlights that managers, drug reps and physicians all have different motivations to engage in discourse, whereby the cognitive gap between managers and drug reps is surely the biggest surprise. The findings further reveal that despite all efforts the three actors fail to achieve their objectives respectively. The results point to a system characterised by incompatibility and waste, in which drug reps constantly balance between organisational goals, own motivations and customer needs.

1.3. Research background

With the rise of neo-liberalism in the last quarter of the 20th century a strong trend of commercialisation of the medical profession (Relman 1980, 2008; Angell, 2004) was observed. Commercialisation implies that provision of a service is bound to its economic return. Thus the service becomes conditional, negotiable and ultimately a commodity. This stands in contrast to the moral belief that wellbeing is a generic right to every human being which must be unconditionally protected and supported (Gewirth, 1978). While there is debate about the degree of unconditionality there is broad agreement that wellbeing belongs to the cultural core of society. On the basis of functional expertise, rational conduct and collective orientation society has appointed physicians to act as guardians to the right of wellbeing (Parsons 1939, 1958). As a matter of mandate, physicians must stand diametrically opposite to the idea of treating healthcare as a commodity. While many social theorists (e.g. Durkheim, Parsons, and Freidson) have regarded physicians as a protecting element against the onslaught of capital, doctors' guarding powers are in fact shrinking. The world of business has targeted medicine for profit making. Capital is constantly pooled to yield an even greater return. To leverage capital's full breeding potential, efficient organisational structures are put in place, dividing up medical work similar to the division of labour process in industrial production (McKinlay & Arches, 1985). Vast knowledge production in medicine is further aiding the process of specialisation and labour division. Physicians' autonomy and authority with regards to providing healthcare is increasingly challenged.

For many years drug companies have been experiencing a diminishing rate of innovative return. This is indicated by the declining number of truly innovative drug molecules launched each year as shown in Figure 1 on the next page. Regression is partly caused by research exhaustion in the area of traditional chemical compound pharmacy while new areas like biotechnology are not yet effectively mastered.
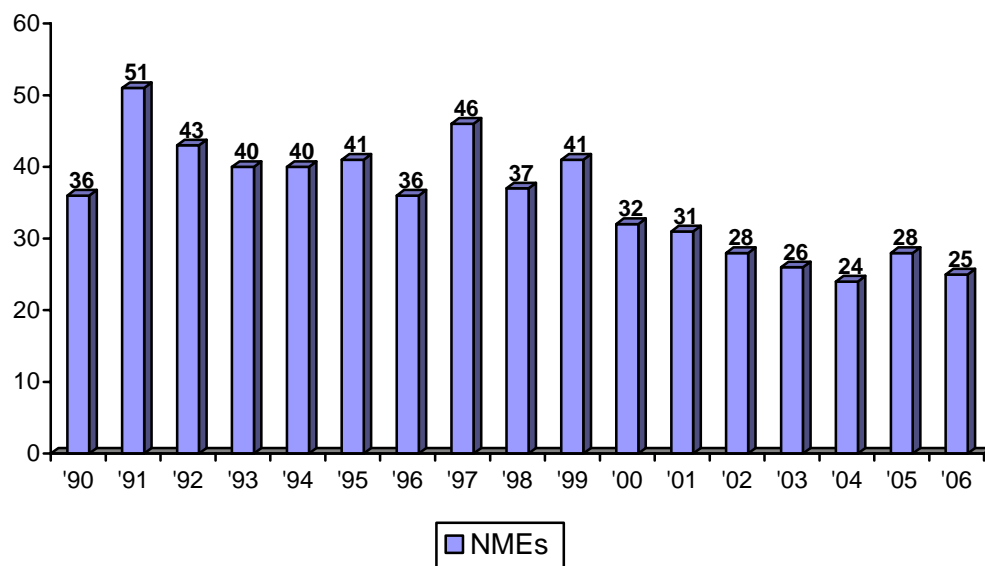
Figure 1: New Molecular Entities (NMEs) first launched worldwide 1990-2006

Critical observers like Angell (2004) argue, however, that innovative scarcity is equally caused by the industry's financial greed which fosters a risk-averse research & development (R&D) policy. In any case, the number of new molecular entities registered in the market each year is gradually shrinking. In order to compensate the innovative slow-down, firms are eagerly trying to increase sales productivity of existing as well as marginally improved 'new' drugs. The ratio between entirely new drugs and slightly modified drugs is breathtaking. While in 2006 only 25 entirely new molecular entities were launched world wide, in the same year 2'640 'new' drugs were registered in Germany alone (BfArM, 2009). These drugs are mostly variations in form, size or dosage of existing drugs. Pseudo innovations put growing pressure on the drug rep to 'sell' his products to the physician. Given the products' low innovative profile, drug reps are facing the paradoxical task of having to sell more of less. As per industry sources (Bayer Healthcare, 2007; Novartis, 2004) today's marketing of drugs is essentially modelled on consumer marketing which focuses on brand building and promotion rather than on technical and scientific minutiae.

1.4. Geographic research focus

The research focuses on Germany, a central European country with 82.5 million inhabitants and a GDP of about 2.5 trillion Euros of which c. 10% are spent on health related products and services. Pharmaceutical companies in Germany experience the same innovative decline as elsewhere in the Western world. In addition to research exhaustion and focus on profit maximisation, also came restrictive research conditions which further aided to the innovative decline. Germany – once considered "the pharmacy of the world" – experienced a drain of experts and research laboratories, which moved to other countries, preferably to the US. Responsible for this intellectual draw off was the fact that in the 1980s German politics largely blocked the use of genetic technology to develop and produce drugs. Furthermore, bureaucratic restrictions slowed down or obstructed research activities.

At the medical professional end, the German market principally shows the same dynamics as other Western healthcare markets. German government is forcing economisation of healthcare in order to control cost and lift service efficacy. This brings along rationalisation and bureaucratisation of medical work. Yet, the German healthcare system, which is based on a premium financed social insurance, equally displays fundamental differences compared to tax-financed or private insurance systems. Systemic differences allow for different leverage points in terms of controlling and changing the system. To illustrate this I have listed the specifics of each system in the table on the next page.

Table 1: <u>Overview of healthcare systems</u>

Characteristic Properties	Tax-financed system (Beveridge type)	Premium financed system (Bismarck type)	Private insurance system
Type	National Health Service	Social insurance	Pluralistic (Medicare/Medicaid – Managed Care)
General definition	Government regulated care with health services	Health care as guaranteed basic right	Health goods are largely consumer goods
Finances	Taxes. Every tax payer contributes	Contributions from employees/employers	Largely private finance
Service organisation	Public	Private/public	Largely private
Service package	More supply-oriented	More demand-oriented	Demand-oriented
State intervention	Strong/direct	Mostly direct	Weak/indirect
Payment transfer	Indirect	Largely indirect	Direct and indirect
Role of professional associations	Not very strong	Strong	Very strong
Opinion-forming	Top-down	Bottom-up	Bottom-up
Examples	U.K., Scandinavian countries, Italy, Spain, Greece, Canada	Germany, France, Japan, Belgium, Netherlands, Austria	USA, Switzerland

Source: Schmidt, et al. (2001)

In the following I will brief the reader about the German health care system as well as the country specific features of the drug industry.

1.5. The German healthcare system – Emergence & overview

The modern day healthcare system in Germany dates back to the foundation of the national health insurance in 1883 as part of the Bismarckian social security legislation. The legislation was introduced to buffer the growing social contrasts and political tensions following the process of industrialisation in Germany during the 19th century.

The national health insurance was designed as a compulsory insurance and was gradually expanded to cover workers and employees in industry and other business enterprises. The system was carried by larger insurance associations as well as thousands of small insurance companies which all entered into individual contracts with physicians. This led to conditions of vast complexity, legal uncertainty and highly diverse quality of medical service within the system. As insurance companies were granted the right to determine the type and number of physicians they wished to collaborate with in a given region, physicians became highly dependent on insurance companies. A large part of them was completely excluded from the statutory service. To strengthen their position against insurance companies, in the year 1900 physicians founded the German association of physicians ('Leipziger Verband', later called 'Hartmannbund'). Yet, ever more powerful insurance associations, leveraging their right to individual contracting, led to a continuing imbalance of power between the two parties, resulting in severe struggles and labour disputes. The situation of conflict prevailed throughout the first three decades of the 20th century until the economic crisis and global recession in 1931 led to a systemic re-design. On the physician side, associations of statutory health insurance physicians (organised by region) were granted the status of public bodies and could now enter collective contracts with health insurance companies. The contracting parties were granted the right for self-administration by the government. At that stage, about 60% of the people in Germany were covered by statutory health insurance.

However, shortly after the National Socialist Party rose to power in 1933 administrative autonomy was replaced by central gearing according to the 'Fuehrer principle'. All insurance companies were merged to a single insurance body ('Reichsversicherung') and subjected to state control. Physicians were ordered to join the national chamber of physicians ('Reichsärztekammer') controlled by the ministry of the interior. In 1938 all Jewish doctors (c. 13%) had been deprived of their approbations and subsequently denied to treat any publicly insured patients. In 1945, after the end of the Third Reich the system and its various organisational bodies ceased to exist. Since 1949 until re-unification in 1990 there were two different political as well as two different healthcare systems in Germany. Analogous to the system in the Soviet Union, in Eastern Germany a centrally organised healthcare system was established, yet – in contrast to the Soviet system – with a clear organisational division

between ambulatory and stationary (in-patient) service. After re-unification, the newly formed German states were fully integrated in the healthcare system of the West.

After World War II, in Western Germany a structure developed that in many aspects resembled the system in place prior to the Fascist period (Preusker, 2008). Elements largely unchanged to date are the public corporation format of statutory health insurance companies, the tying of insurance obligation to employment status, the linking of insurance fee calculation to individual income level, the splitting of fees between employer and employee and the dualism of statutory and private health insurance. As indicated in Table 1 (p. 16) these elements are still prevailing in the current system. The statutory healthcare system is essentially financed by employment related contributions (premium financed system) with only a small portion coming from taxes. For 2009 this means that 14.9% of a person's gross salary goes to statutory health insurance, of which 7.9% is paid by the employee and 7% by his employer. Those who are self-employed and those who are earning above a certain income level (for 2009 the level was set at 44.100 Euro per year) are exempted from joining the statutory system. Yet many employees voluntarily remain in the system because coverage is automatically extended to one's children without any extra charge. Currently, 90% of Germans are members of the statutory health insurance system while only 10% percent are privately insured.

Consequently, in Germany physicians' remuneration is largely coming from statutory health insurance. Approximately 80% of their earnings are generated through the system by which the individual physician is balancing accounts directly with the Association of Statutory Health Insurance Physicians. In turn the associations are collectively balancing their accounts with the insurance companies belonging to the statutory system as displayed in Figure 2 on the next page.

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            ┌─────────────────────┐
            │  169* Statutory Health │
            │  Insurance Companies   │
            │    (Public bodies)     │
            └─────────────────────┘
```

Collective contracting
and compensation

(Compulsory) Membership,
Entitlement to services,
Obligation to fee payment

Physicians as part of 17
regional associations
(Public bodies)

Service for insurance proof

Members / Insured
(90% of population)
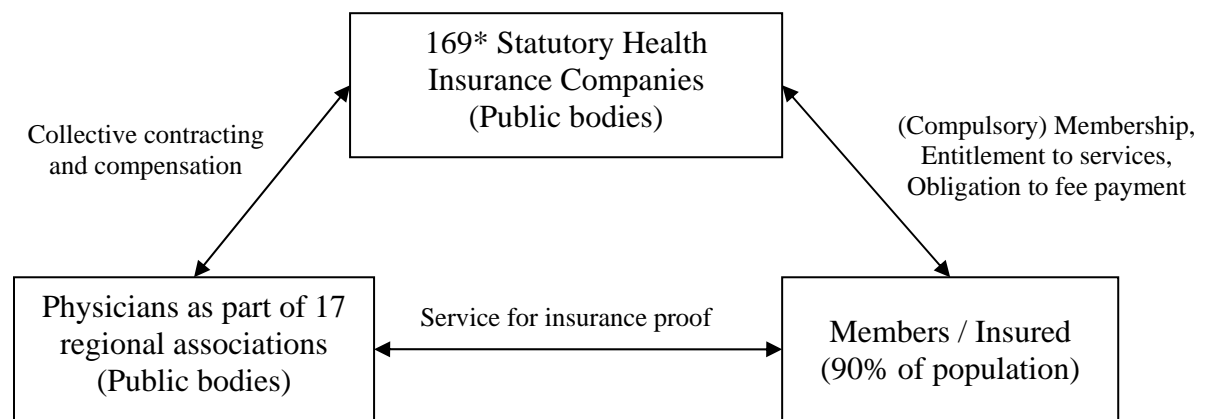
* as per Feb 1, 2010

Source: Based on Preusker (2008)

Figure 2: <u>Relationship between the insured, service providers and insurances</u>

In contrast to the private market the statutory insured patient is not directly charged but simply has to provide proof of insurance. Thus patients are unaware of the actual cost of their treatment which according to critics of the system is aiding to wasteful behaviour also known as ex post moral hazard (Pauly, 1974; Nell, 1993). To further illustrate this, people in Germany go to see a doctor 18 times (in 2007) a year on average, which is one of the highest visit frequency rates in the world (BMG, 2009).

In 1993 German government first introduced a budgeting system to control cost. Since then, the budgeting system has been revised several times to manage an undiminished rise of healthcare cost. To put this into perspective, between 1993 and 2003 the costs for statutory healthcare have grown by 2.9% per year on average. However, over the same period the GDP has only grown by 2.5% per year on average resulting in a net loss in total.

Different from many other healthcare systems in the world, in Germany hospital facilities are not meant for out-patient treatment but are essentially reserved for in-patient treatment only. The ambulatory service is mainly left to family physicians and specialists who are office based. This duality of service is also reflected in the absolute physician numbers. Altogether 311'230 physicians are working in Germany (as of

31.12.2006) of which 148'322 (47.7%) are working in a hospital setting and 136'105 (43.7%) as office-based practitioners. The remaining 26'803 (8.6%) physicians are working in non-clinical areas (Bundesärztekammer, 2009). On one hand, the large network of office-based doctors allows high medical service coverage. With 264 inhabitants per physician (in 2006) Germany has a relatively high physician density compared to other markets (e.g. Japan = 476, UK = 433; USA = 385). On the other hand, the duality of medical service is producing a high degree of duplication. For example, costly diagnostic procedures are often replicated once patients move between the two sectors. In many areas medical care is simply available twice – yet often delivered at very different quality levels – leading to costly inefficiencies of supply. Compared to other European countries, Germany – with altogether 2'100 hospitals – has the highest relative number of hospital beds available (6.2 per 1'000 inhabitants compared to e.g. 3.7 in France and 2.2 in the UK; Source: OECD, 2008). However, these capacities are largely underused with an average bed occupancy rate of just over 76% (in 2006) although Germany shows the longest average residence time (8.6 days in 2006) in Europe (OECD, 2008).

Altogether, the German system is characterised by oversupply and duplication of medical care which is artificially stimulating demand for service. At the other end, statutory insured patients, who neither have information nor control about actual therapy cost, tend to exploit the system (ex post moral hazard). German government is forcing economisation of healthcare in order to control cost. This brings along rationalisation and bureaucratisation of medical work. Since 2000 governmental healthcare reforms are fostering a higher degree of integration between office-based and hospital care whereby local doctors and hospitals are collaborating in form of integrated healthcare networks. The number of hospital beds is constantly reduced to cut idle capacities and improve efficiencies. Medical procedures are increasingly monitored and standardised (e.g. via treatment guidelines following evidence based medicine) to increase and align quality across the spectrum. Budgeting of office-based medical therapy is further refined. For each quarter of the year physicians are assigned an individual budget calculated by combining average treatment cost rates per professional speciality with the physician's individual treatment and prescription profile of the previous year period. This method was issued at the beginning of 2009 to

increase overall efficiency and to stop physicians to enhance income through applying expensive procedures to their patients.

Next to cost containment measures, office-based healthcare provision gradually moves from a single practice mode to a large practice setting (ambulatory care centres). Increasingly, integrated healthcare networks similar to HMOs (health maintenance organisations) in the US are installed in Germany. In this context government is advancing privatisation of large parts of hospital care by transforming e.g. municipal hospitals into private corporations or by selling them to already existing corporations in the field. Privatisation also affects university hospitals at traditional universities like Marburg or Giessen. Furthermore, ambulatory care centres are allowed to be run by non-physicians opening medical service to capital interest. Private healthcare corporations have been granted the right to enter into individual contracts with statutory health insurance, thereby undermining the collective contracting between statutory health insurances and physician associations.

Attempts to restructure out-patient care are judged critically by both physicians and patients. In Germany, healthcare service is (still) conceptualized as a highly individualized service where each patient is expecting to have his 'personal physician' (Münch, 2009). The working mode and organisational form of medical healthcare still very much resembles that of pre-industrial craftsmanship where cluster-artisans are surrounded by a pool of helpmates (Münch, 2006). Emotionally, German society largely ignores the fact that with circa 500 million physician-patient contacts per year healthcare has long become a mass market.

To illustrate this in figures, the total healthcare market in Germany is worth approximately 250 billion Euros or 10% of GDP. This figure includes all healthcare related products and services. In 2008, statutory health insurances spent 161 billion Euros (64%), of which 32.7% (52.6 bn) went to hospital care and 15.1% (24.3 bn) went to office-based medical services. 18.2% (29.2 bn) were spent on drugs (AOK, 2009). As such pharmaceutical drugs are a significant matter of expense. The majority (c. 87%) of drug expenditures come from prescription drugs. Of these, circa 85% are generated in ambulatory care (office based doctors) while the remaining 15% come from acute hospital care. This does not imply that hospital doctors are irrelevant in

terms of prescribing. On the contrary, prescriptions by hospital physicians have a signalling effect to office-based doctors. Therefore, both hospital doctors and office-based doctors are critical target groups for drug companies.

1.6. The pharmaceutical industry in Germany

At 35 billion Euros Germany is the largest drug market in Europe next to France. In Germany, roughly 127'000 (BPI, 2009) people are employed in pharmaceutical industry sector, of which approximately 20'000 are working as drug reps. The industry is estimated to spend around Euro 2.5 billion on drug reps (Korzilius & Rieser, 2007) resulting in approximately 25 million doctor visits per year, which makes each call account for c. 100 Euro on average. Statistically, one drug rep serves 14 doctors, however, considering that pharmaceutical firms only cover the relevant doctors in their respective target segment the figure comes down to five (i.e. five doctors are covered by one drug rep). As a rule of thumb in Germany, 20% of all prescribing doctors are responsible for around 60% of total scripts. Consequently, high prescribing physicians in large therapeutic segments like cardiology or gastrointestinal are literary overrun by drug reps. Those doctors are estimated to receive visits from seven drug reps on average per day (Glaeske & Janhsen, 2007).

1'031 pharmaceutical companies are currently registered in Germany distributing 8'764 different drugs coming in over 50'000 presentation forms (i.e. different pack sizes and application forms per drug) (BPI, 2009). Just over 20% of the 8'764 different drugs account for 90% of scripts in Germany. Among the listed 1'031 companies 76.8% employ less than 100 people and only 5.9% of firms have more than 500 employees. The top 10 pharmaceutical companies in Germany account for 35% of drug sales (IMS, 2008). Compared to the US market where the top 10 firms account for 51% of total market sales Germany shows a much lower market concentration. Table 2 on the next page displays the top 10 pharmaceutical companies in Germany side by side with the top 10 players in the world:

Table 2: <u>Top 10 pharmaceutical companies</u>

Rank	Germany*	World**	Global Sales 2008**
1	Hexal (generics)	Pfizer	44.2 bn
2	Novartis	GlaxoSmithKline	43.0 bn
3	Sanofi-Aventis	Novartis	38.0 bn
4	Bayer	Sanofi-Aventis	36.0 bn
5	Pfizer	AstraZeneca	31.6 bn
6	AstraZeneca	Johnson & Johnson	24.6 bn
7	Kohl Pharma (imports)	Merck	23.6 bn
8	Ratiopharm (generics)	Roche	21.0 bn
9	GlaxoSmithKline	Eli Lilly	19.3 bn
10	Boehringer Ingelheim	Wyeth	19.0 bn

Source* : IMS PharmaScope Germany, basis: ex factory pharma sales in Euro in 2008

Source**: IMS Health Inc., basis: ex factory pharma sales in USD in 2008

As per their financial statements big pharmaceutical companies spend between 25-30% of sales value on marketing and selling. Pharma critical researchers like Angell (2004) argue that the real number is even higher because some marketing activities are simply 'hidden in the books' by allocating them to non-marketing cost centres. An example would be continuous medical education programmes – which are in fact drug specific marketing & communication measures to physicians – becoming part of the R&D budget. As per my own experiences actual marketing and selling expenses are rather to be located in the 30-40% (share of total sales) bracket.

Yet even at 25-30% the average share allocated to marketing is significantly higher than expenses for R&D. According to the European Federation of Pharmaceutical Industries and Associations (EFPIA) the R&D to sales ratio was only 17% on average (Europe) in 2007. In Germany the R&D rate is slightly above average at currently at 18.5% of sales (BPI, 2009). Although the amount spent on marketing and selling significantly outweighs the amount spent on R&D, pharmaceutical companies are eagerly presenting an image as innovators to the public. Firms point out their enormous

investment into drug innovation while downplaying their vast expenses of drug marketing (Angell, 2004).

Sales visits by pharmaceutical representatives ('drug detailing') is the primary marketing instrument in the ethical (i.e. prescription only) drug business. Traditionally, drug reps visited physicians to inform doctors in detail about their products, an activity for which the term 'detailing' was coined within the industry. With the rise of so called generic drugs (i.e. low priced replicas of original drugs which have lost their patent rights) companies began to send their drug reps also to 'detail' pharmacists. This was done in response to a governmental policy by which the individual physician can determine whether or not a particular drug can be substituted ('switched') with an equivalent drug at the point-of-sale (i.e. pharmacy). This policy – called 'aut idem' (lat.: 'or the same') prescription – was introduced by German government in 2002 in order to advance the use of low priced generic drugs. Currently generic drugs make 47% in unit and 20% in value share of the total drug market in Germany (IMS, 2009). Hence, marketers of generic drugs are increasingly focussing their detailing activities at the pharmacy channel, trying to ensure that 'aut idem' prescriptions are 'switched' their way. In contrast, marketers of patent protected original products continue to focus their detailing activities on physicians, making sure that their product stands out among the numerous highly similar 'original drugs'.

Although the share of generic drugs is rising and the top selling company in Germany in 2008 is a provider of generics (see Table 2, p. 23), the German market continues to be driven by patented drugs. This is due to the fact that there is essentially free pricing for patent protected drugs in Germany. Ex-factory prices are determined by manufacturers without either negotiations involving governmental agencies, direct price controls or profit controls (WHO, 2009). Only if drugs run out of patent are they subjected to forced rebates in order to be reimbursed by statutory health insurance. However, to manufacturers of original drugs post patent marketing is financially unattractive and thus their internal return on investment projections usually end at the very day the patent expires. Instead, original manufacturers rather try to prolong patent protection or they reformulate their existing drugs just enough to be granted a new patent.

In the market of 'innovative' patent protected drugs (i.e. 80% of total market in value terms) detailing of office-based as well as hospital physicians plays a crucial role. Thus leading drug companies send out teams comprising of many hundred drug reps to visit doctors. Drug companies thereby precisely differentiate physicians according to a number of factors, including prescription potential, loyalty or opinion leadership. As per my own experience, increasingly physicians are classified by their projected likelihood to adopt a certain attitude or behaviour in line with a drug's brand positioning (Bayer Healthcare, 2007). These projections are based on qualitative and quantitative research with physicians executed prior to a product's launch. Physicians are subsequently structured into (behavioural) segments of different value. Typically, drug reps are instructed to visit doctors belonging to a highly valuable segment more often than others. This implies that highly relevant physicians are visited several times a month while those of lesser importance are only called upon once or twice in a quarter. Depending on a company's target market (i.e. speciality) drug reps visit between 5-10 physicians per day. According to industry sources as well as my own research findings, a detailing encounter in Germany typically lasts between 5-15 minutes.

1.7. Research objective

This research is carried out to investigate if marketization is discursively constructed in the context of drug detailing in Germany. Moreover, it is to show how such discourse is actually figured according to those involved in it. Centrally, it is to understand the impact that a (presumably) marketised discourse has on the roles and attitudes of drug reps and physicians. Further to that end, the study is to present physicians' attitudes towards drug representatives but equally it will reveal drug reps' stances towards physicians as well as to their own company management. The latter two aspects are a highly under-researched area to date. The fact that very little is known about drug reps' attitudes to physicians as well as to their own company management could be due to the following: First, pharmaceutical companies grant little access to their – often publicly criticised – promotional practices and hence are reluctant to invite external researchers to study their detailers. The second and probably more important reason is that research interest is likely driven by assumed scale of change. Unsurprisingly, the

focus is on those who are expected to change, namely physicians, rather than on those who have to sell that change. Social scientists so far have done little to challenge the common belief that the detail man's mind-set is always in line with the promotional strategy of the company he represents. Yet drug reps' year long exposure to medical professionals could equally make them experience a conflict of interest followed by a discord in identity. My research will thus shed light on how drug reps assess and deal with the situation of presenting a marketised discourse to physicians.

1.8. Research approach

My study is about investigating if and how promotional discourse is cognitively influencing physicians, detailers and managers. As such I am researching the results of individual meaning-making, which implies that there is no objective truth to discover. The research rests on the ontological belief that social reality is constructed. Furthermore, it assumes that language is the chief instrument for crafting social reality. Consequently, by analysing discourse one gets access to meaning which makes discourse studies a central element of my research. The particularity of my research approach is that it examines discourse about marketised discourse. Hence, the term discourse is to be understood in two different ways: (1) as a source for accessing meaning and (2) as an instrument for swaying physicians. In order to further clarify this, the two notions of discourse must be precisely defined. With regards to the first connotation I define discourse as spoken accounts given by drug reps, physicians and managers. These accounts have been provoked by means of qualitative interviewing of altogether 24 respondents, of which there were ten physicians, ten drug reps and four managers. Interview data was transcribed and subsequently structured into themes, followed by interpretation of their underlying content. The second notion of discourse is talk performed by drug reps during their interaction with physicians. In other words, it is the discursive practice employed in drug detailing. This talk - which is expected to be marketised - is the key matter of interest when interviewing drug reps and physicians.

1.9. Thesis structure

At the outset I will review the emergence and concept of professions. In turn, I will discuss the various outlooks on the profession of medicine. In doing this, I will distinguish between sustaining and non-sustaining theories. According to the former set, physicians have a norm controlling function in society and thus are predicted to continue to play an outstanding role. The other set is assuming that due to economic pressures and continuous functional differentiation the medical profession is gradually loosing its significance, changing into an 'ordinary' occupation. Subsequent to the reviewing of physicians I will turn to examining the emerging role of drug representatives. Along this context, key perspectives on the purpose of drug detailing will be discussed. In the second part of the literature review I will introduce various ideas on language and meaning followed by a detailed discussion on marketization of discourse.

In the middle section, emphasis will be laid on presenting and debating the theoretical framework, research questions and empirical method. Theories and uses of analysis of discourse and qualitative interviewing will be discussed in detail. I will round off the chapter with presenting my approach to sampling.

The final section will be dedicated to presenting and discussing the research findings. This will be done by structuring my results alongside a theory model. Subsequently, outcomes will be balanced against research questions. I will conclude my thesis by demonstrating both the theoretical and practical relevance as well as implications of my research findings.

2. Perspectives on professionalism

Investigating the phenomenon of discourse in drug detailing requires understanding about its context. This involves obtaining knowledge about the medical profession as well as about the pharmaceutical industry and their concept of drug detailing. In the first part, I will introduce the reader to the concept of medical professionalism. Importantly, the development of the medical profession is essentially related to the emergence of professions in Western societies. Thus before I present the evolution and idiosyncrasies of modern day physicians I like to review the idea of professions and professionalism in general.

2.1. The idea of professions

According to White (2006) professions are defined as group of occupations that provide highly specialised services, typically based on esoteric knowledge, which only they can measure. Members of a profession have autonomy over their own work and often direct others (mostly lower qualified individuals) in the conduct of their occupations. Thus professionals have monopolistic control in their area of expertise and exercise dominance of subordinate occupations. A key guarantor of professional power and monopoly is its exclusive licensure by the state. In exchange for professional autonomy, members promise to adhere to a code of ethics (e.g. the Hippocratic Oath in medicine) by which they are required to put their client's interest ahead of their own. As such professionals confess themselves to a relationship of trust with their clients, thereby subordinating any self-interested profit-making. Committing oneself to a code of ethics must be judged as being largely a symbolic act because governance remains with the professional body. As such the professions basically govern themselves (Freidson, 1970).

Today's notion of profession is historically linked to the emergence of occupations in the early modern period (Conze, 1972; La Vopa, 1988). Essential to that period was the gradual dissolving of the corporative state (the three estates), further accelerated by the upcoming industrialisation coupled with urbanisation. The concept of occupation was significantly differing from the organising principles of the feudalist system in that an occupation is actively chosen rather than is the privilege of an ascribed social status.

By choosing an occupation the individual can attain social attributes, which he or she would have been prohibited from gaining under feudalistic rule. Hence, the rise of occupations gradually stopped the arbitrary structuration of society. By means of personal accomplishment subjects were overcoming the formerly rigid and predetermined social order. Functional achievement increasingly challenged ascription in form of inherited status.

Within this development 'professions' emerged to be a particular type of occupation. Differing from holders of plain occupations, members of a profession began to treat their underlying occupational idea in a highly reflexive manner. Occupational knowledge and ethos were cultivated, discursively crafted and codified in order to convert it into a body of theory and ultimately into an academic teaching profession (Abbott, 1988). By institutionalising their occupational body (Freidson, 1986), professionals are equally shaping and serving the social claim associated with the profession in society. Evans & Laumann (1983) thus describe professions as standing in particular close relation to the 'core' parts of the cultural system. Core parts of Western society are broadly defined by man's relationship to himself (medicine), to others (law) and to God (theology) (Stichweh, 2008). By connecting the corpus of professional knowledge to the cultural core parts of society, professionals secure themselves an exceptional position in the system. Starr (1983) spoke of 'cultural authority' in this respect. Professionals manifest their exceptional status by emphasising inaccessibility to the corpus of knowledge as well as by suggesting completeness in terms of number of professions (Stichweh, 2008). As such professionals have gained a new kind of independence and autonomy, formerly only granted to those holding property. Professionalism thus allows a decoupling of autonomy from property and capital. Instead, professionals are functionally legitimizing their autonomy by means of institutionalised knowledge.

To many, the professional complex was - or is again - seen as a stabilising counterpart to the world of capital (Parson, 1939, 1951; Freidson, 1994, 2001). Parsons was convinced that organisational forms modelling professional associations will steer society in the future. Freidson (1971) predicted a 'professionalized' society and Halmos (1970) was expecting the service ethos of the professions to be generalized to society as a whole. He predicted a society in which personal service is valued more

than power and material gain. In contrast to these euphoric views, Becker (1962) declared that profession was rather a folk concept, a semantic technique for winning occupational status and minimizing occupational constraints.

Traditionally, the professions of theology, medicine and law have served the cultural spectrum of needs. However, constant evolution of society's cultural core equally brings changes to the relevant corpus of knowledge. This, in turn, alters the composition of professions within a social system. Enlightment, realism and scientification, for example, have gradually marginalised theology as a profession in Western society. At the same time, demands for e.g. technical (engineers) or management (consultants) knowledge have brought new professional groups to the fore (Ackroyd, et al., 2007). Concurrently, functional differentiation takes place among existing professions such as medicine. For example, over the past 50 years the profession of medicine has produced dozens of new professional subgroups (specialities), each of them carefully delineating their respective body of knowledge & skill. Ongoing functional differentiation is driven by the professions' exponential production of scientific knowledge. Providing the whole spectrum of professional knowledge now requires professionals to organise themselves (or to be organised) beyond the level of collegial cooperation (McKinlay & Arches, 1985).

However, growing functional specialisation and interdependence plus public dissemination of expert knowledge (Haug, 1973) is weakening the professions' cultural authority. Loss of significance in turn impacts their function as a stabilising element against the self-interested world of capital. The world of capital is developing in the opposite direction. Capital is pooled to leverage an even greater return. Further to this end, new areas like education or medicine – once firmly under professional rule – are targeted for profit making. Subsequently, efficient organisational structures are being established in order for capital to leverage its full breeding potential. In summary, professions essentially come under pressure from two ends: growing capitalisation and knowledge explosion. Professional work is thus subject to change and professional status is challenged in many ways. In chapter three I will portray and discuss this development in detail with respect to the profession of medicine. I like to introduce this by making a short excursion to the origins and approaches to research on professions.

2.2. Research on professions

The critical importance of the professions in political and economic society was initially highlighted by Max Weber in his central work "Economy and Society" first published (after his death) in 1922. It was central to Weber's work to understand the idiosyncrasies of capitalism in Western society. In particular Weber was concerned that the rise of capitalism, along with the forces of rationalism and bureaucratization, would result in an "iron cage of servitude" (Weber, 1952). This view was supported by Émile Durkheim who hoped that professions would function to organize scientific and expert knowledge into associations of colleagues, forming a 'moral authority' that would serve as a buffer between the public and the onslaught of industrialization (Durkeim, 1933, p. 26 in Hafferty & Light, 1995). To Durkheim professional associations played a central role in advancing trust and stability in a society otherwise driven by utilitarian self-interest. In line with Durkheim, sociologist Carr-Saunders (1928, 1933) regarded the rise of professions as an important source of standards, services and moral authority in the modern world of corporations and markets. Truly foundational in this respect was the work on social control of E.A Ross (1901/2009). Ross raised the question of how social order and social cohesion can be established and preserved. Ross opposed the utilitarianism behind economics which believed that the economic interests of the individual would be sufficient to ensure social cohesion. Instead he promoted the notion of professions as independent experts in the service of public interests.

Within the group of professions, medicine was given particular attention by sociologists. Physicians were perceived as an important occupational class that sought to advance public welfare by strengthening licensing laws, by opposing commercialism in medicine, by driving out proprietary medical schools, and by attacking the 'hucksterism of the nostrum industry' (Light, 1989).

Despite the grounding works of Weber and Durkheim research on professions became an Anglo-American domain. Particularly in the US – with its fast expansion of high capitalism – sociologists were interested to understand the motivations, dynamics and conflicts of professional work that is allegedly focussed on public welfare and which enjoys high social status and autonomy. The ever prevailing conflict between market and morale seemed to have sparked researchers' interest. During the 1950s and 60s

numerous research projects in the US were investigating the current as well as the future role of the professions. The most prominent protagonist of that period was sociologist Talcott Parsons who devoted much of his work to decipher the medical practitioner's pattern of action as well as his role and function in modern society. Yet Parsons' perspective had largely emerged out of theoretical analysis not substantiated by direct empirical research. His interpretation of professionalism is therefore of normative quality, essentially viewing professionalism as a value system (Evetts, 2003). In that Parsons followed the traditional definitional approach to professions as previously exercised by e.g. Durkheim. The definitional or taxonomic approach to professions (Klegon, 1978) was continued by researcher like Barber (1963), Wilensky (1964) or Goode & Etzioni (1969).

More sustained research and analysis of the actual ways professionals practised (e.g. Freidson 1970) triggered a significant turn within the research on professions in the 1970s and 1980s. Focus was now placed on aspects like social closure, domination and self-interest, which altogether resulted in a critical view of professional conduct. The critical ('professionalism as ideology', Evetts, 2003) research approach began to acknowledge the social meaning as well as social consequences of professional work. Thus it recognised that there is an internal and external dynamic of professionalism. Contemporary research on professions is more concerned with the diminishing leverage of professional power before the background of economic, social and political change (e.g. Hoff, 2001; Domagalski, 2007; Adler & Kwon, 2007). Throughout the various stages that research on professions underwent, studies on the medical profession always took a central role (e.g. Parsons 1958, 1963, 1975; Freidson 1970, 1986, 1994, 2001; McKinlay & Arches, 1985; Hoff 2001, 2003).

2.3. Summary

In this chapter I have shown that the professions have reached an extraordinary position – or what Starr (1983) called 'cultural authority' – by addressing the core needs (e.g. health, legal order, and religion) of a society. Importantly, members have treated the underlying occupational idea and knowledge in a highly reflexive manner, cultivating and discursively crafting it into an institutionalised professional body.

Against this background, professionals were able to gain a large degree of autonomy over their work. Their independence and authority was seen as a stabilising counterpart to the forces of capitalism. Yet I have equally displayed that members of the professions are selfishly manifesting their exceptional status by limiting access and suggesting completeness in terms of professional service. However, it has also been demonstrated that professional leverage is increasingly weakened by growing functional specialisation. Furthermore, many professional areas like medicine or education are now progressively rationalised in the pursuit of profit.

In the second part I have introduced the key developments in the research on professions. It became clear that research approaches have changed along with the standing of the professions in society. While at the outset researcher followed a definitional approach, they subsequently reverted to a more critical style by pointing to the social consequences (e.g. misuse of power) of professional work. Due to the rise in economic and structural pressures, current researchers are preferably addressing the professions' adaptation to environmental changes.

Having addressed the professional complex in general, in the following chapter I like to focus on the medical profession specifically.

3. Perspectives on medical professionalism

There are many outlooks on the medical profession arguing from e.g. normative, critical or realist positions. I could easily take on this labelling structure to guide my review of the literature. Yet I prefer to organise the works differently, namely to group them into two main strands differing by future prospect. One is predicting physicians an outstanding and controlling function in society, the other is assuming that doctors continue to loose in significance, gradually becoming an ordinary occupation. Based on this approach I am e.g. joining the normative work of Parsons with the critical studies of Freidson. This is suitable in my view because despite all of Freidson's criticism about professional conduct, both authors essentially plead for a strong position of physicians in society. Importantly, as the various perspectives have been developed and brought forward at different points in time they are not based on the same corpus of empirical knowledge. Naturally, some authors would probably revise their points of view given a more up-to-date knowledge of the factual developments of the profession. On the other hand, the most influential writings – like the work of Parsons – are normative in kind. Thus they should be seen as timeless provisions for an ideal role function and positioning of physicians in society.

In the following, I will present and discuss the two clusters of perspectives to medical professionalism. For the purpose of clarity I have called them 'sustaining' and 'non-sustaining' theories. I will begin with presenting the sustaining theories of medical professionalism. In that context, Parsons' theory of structural functionalism plays a fundamental role because his view of the medical profession is still influencing the academic debate as well as the perception of physicians in contemporary society (Naber, 2005).

3.1. Sustaining theories of medical professionalism

3.1.1. Parsons' interpretation of medical professionalism: still internalised today?

3.1.1.1. Parsons' structural functionalism

The idea of professional life as the embodiment of service to the public was advocated by Parsons (1939) who characterized professional work as universalistic yet functionally specific, rational, and altruistic (Hafferty & Light, 1995). This characterization followed Parson's theory of structural functionalism and the embedded concept of 'pattern variables' to describe the individual's behaviour in social context. The focus of Parsons' theory is on how individuals' actions are organized through their roles in social institutions in ways that contribute to society's basic functional requirements. Pattern variables in this respect are dichotomous types of social behaviour which individuals have to decide between. This refers to a series of specific choices individuals make within the normative guidelines of their society. It is for example describing whether an individual is following a collective or personal interest in his work. Parsons used this concept to describe the idiosyncrasies of professional work. When he portrayed professional work e.g. as 'functionally specific' he argued that technical competence – which is the key determining factor of role and status within the academic professions – is always limited to a specific area of knowledge and skill (Parsons, 1951). Specialist knowledge fosters professional or academic authority over lay people who are less or not at all familiar with the subject in question. This type of authority is not based on ascription like family heritage or ethnic background but solely on knowledge acquirements. While Parsons was originally concerned with professionalism in general he was subsequently applying his theory to the medical profession specifically.

3.1.1.2. Parsons' patterning of physicians

In his employment of pattern variables Parsons emphasised the medical practitioners' universalistic orientation. To his expectation, physicians treat each patient equally, regardless of class, gender or race. Thus doctors are receiving everyone in need of

medical care. On the other hand, universalism allows physicians to refrain from establishing a too personal or intimate relation with patients. Physicians maintain 'affective neutrality' by approaching each patient case in an objective and rational manner, thereby waiving any personal preferences. However, according to Parsons, neutrality is not be confused with keeping a cool distance but implies that physicians are showing empathy to their patients. Physicians are collectively oriented in that they submit their personal interest to the wellbeing of the patient. Thus doctors should not turn away patients in need even if they cannot fully pay for their treatment. Physicians act functionally specific by limiting their service to their area of medical expertise. Altogether, Parsons sees physicians as being moral actors who by their altruism, knowledge and impartiality have been assigned a social organising function. I will be elaborating these points in the following sections.

3.1.1.3. Physicians as moral actors

Parsons carefully followed and chronicled the development of medical service in the USA. He was particularly interested in medicine and healthcare because he was convinced that health is a prerogative for a functioning social system as illness makes it impossible to fulfil social roles (Parsons, 1958). Parsons' perception of illness has an important ethical dimension to it. If one acknowledges that wellbeing is a prerequisite for social being, health becomes a generic right to each individual. Following Gewirth (1978) the generic right for wellbeing is not to be compromised and hence should be given unconditional support. According to Gewirth, physical (and psychological) integrity is thus a fundamental right equal to freedom. From this perspective, healthcare can not be left to the individual to deal with. Society – through its representatives – has the obligation to supply a functioning area-wide system of healthcare. Additionally, society must support those who do not have the resources to pay for medical care. However, the question of unconditional support is frequently balanced against the individual's obligation not to impair his own health (e.g. Bobbert, 2003). Should individual risk-taking or neglect of one's own health be penalised? From a utilitarian or self-interested perspective, the question is typically answered by issuing a positive list, defining conditions for unrestricted access to medical care. Healthcare thus becomes conditional, negotiable and ultimately a commodity. From a deontological or

collective-interest view, 'wrong' behaviour submits to moral obligation. In other words, society can not penalise someone who neglects his health by restricting (e.g. through higher pricing) his access to medical care.

This is a complex subject in that one needs to consider social causes for health neglect as much as 'ex ante' moral-hazard. As such it goes far beyond the scope of this project. My point simply is that physicians, who – according to Parsons – should adhere to a collective orientation, consequently must take issue with treating healthcare as a commodity. With respect to drug detailing this implies that physicians are expected to oppose any promotion beyond the medical use value of a drug.

3.1.1.4. Physicians as norm managers

Parsons' view on healthcare goes past the question of moral. He is particularly interested in reflecting on social norms as well as on roles taken under condition of ill-health. To Parsons, morbidity is not only a biological phenomenon but a way in which individuals react to social pressure. According to Parsons' understanding, morbidity is a means for individuals to escape their social roles – at least for a given time – which assigns the notion of illness a socio-psychological dimension. Consequently, if morbidity is to a certain extent socially determined it must also be open to social influence. Out of this logic Parsons postulates a functional requirement of society to control disease. Fundamental in this respect is the temporary character of 'role deviance' (Parsons, 1975) with relation to sickness. While the individual is 'allowed' to retreat from social obligations for a short period of time, he is expected to eventually return to his role and to meet the demands the social system brings to him. The physician on the other hand is expected to pave the patient's way back to the societal norm.

This all leads to institutionalized role behaviour on part of doctors and patients. A society that accepts disease only as temporary deviance from the norm, assigns clearly defined rights and obligations to the protagonists of disease control. What follows is the development of a stable system of interlinked behaviours and roles, which Parsons believes can be best analysed und understood via his categorical toolbox (i.e. the

pattern variables). To Parsons, the medical practitioner is exercising social control to enforce (organisational) norms of society. Parsons defends such superior standing in society: "With respect to the inherent functions of effective care and amelioration of conditions of illness, there must be a built-in institutionalized superiority of the professional roles, grounded in responsibility, competence, and occupational concern"(Parsons, 1975, p. 271). Next to being a moral actor, according to Parsons, physicians function as social norm managers.

3.1.1.5. Criticising Parsons' conception of physicians

Contemporary researchers like White (2002) come to a different assessment of physicians and the medical profession as a whole. White is emphasizing the self-interested practices of social closure, of doctors seeking to maintain their occupational autonomy, their pursuit of high incomes and the maintenance of their social status. Furthermore, White notes: "Whereas Parsons emphasised the long period of training, the knowledge base and the commitment to service and ethics, contemporary sociologists point to the gate keeping exercise of closing off training options for other health practitioners, the self-interest and the venal motivation of the profession" (White, 2002, p. 107).

Hafferty & Light (1995) critiqued Parsons' innocence with respect to his belief in the restraint of self-interest on part of medical practitioners. They argued that "no attention was given to the ways in which the enlightened paternalism of doctoring, that Parsons extolled, resulted in part from cultivating ignorance, helplessness, and a sense of incompetence in patients as techniques of social control" (Hafferty & Light, 1995, p. 134).

Further critique of Parsons' work is concerning the lack of empirical substantiation. Balog (2000) remarked that based on his theoretic concept Parsons made statements regarding causal and functional interactions that legitimately could only have been done if based on empirical analysis (Balog, 2000, p. 94). Parsons' claim of the medical profession's altruistic and long-term collective orientation in fact has the status of a hypothesis. Nevertheless, it is presented as if based on empirical evidence.

Overall, Parsons' work is criticized for normatively overstating the professional complex leaving little room for behavioural heterogeneity and inconsistencies (Cohen, et al., 1975; Naber, 2005). Parsons' concept of structural functionalism is hence disapproved of for being too reductionistic and simplistic (DiTomaso, 1982). Further critique is focussing on Parsons' strict and idealistic behavioural patterning. In contrast, physicians are rather believed to manoeuvre in between the dichotomous behavioural options. Firm adherence to one idealistic extreme – like Parsons postulates it – is found rather unlikely.

3.1.1.6. Why is Parsons' theory relevant to studying drug detailing?

While Parsons' functionalistic approach might be perfectionist in kind, to me it is nicely demonstrating how Western societies came to look on the medical profession. Conceptualising physicians as collectively oriented moral authorities standing in contrast to the self-interested forces of capital – despite numerous criticism – has provided a strong cultural scripting. Further to that end, Parsons' perspective that disease is socially produced leads to a convincing theory of why the medical profession is perceived as a normative guide to society. All this becomes a vital reference point when assessing reactions and conceptions about physicians by de facto lay people like drug representatives. It is important because, as Goffman (1959) postulated it, people's attitude and behaviour versus other people in society is strongly determined by their respective socio-culturally assigned roles. In other words, for the gearing of communication it is still more important how an individual is thought of as role model than how he is presently experienced in a given situation. With regards to my research topic of drug rep vs. physician interaction, it implies that each party's attitudes are not only driven by individual experiences and perceptions. Primarily they are determined by the internalised socio-cultural norms with respect to the other party. If according to Parsons, society assigns a superior role to medical doctors, drug reps will incorporate this in their attitudinal modus.

3.1.2. The power approach: uncovering the dominance of medicine

During the later part of the 1960s Parsons' functionalistic approach of system stability and consensus was gradually pushed aside by what became generally known as the power approach. This critical school of thought disapproved of Parsons' harmonistic model, in particular its attempt to justify doctors' privileged status in society with a higher collective calling. To the contrary, in their analysis of the medical profession they pointed to the exertion of power to protect particularistic interests like social prestige, high income or self actualisation. While Parsons was criticised for not substantiating his theory with empirical evidence, followers of the power approach took to intensive field work to support their stances.

In contrast to the functionalistic approach, the power approach interprets the dominance of physicians not as a result of an apolitical act of modernisation. The power concept emphasises conflicts and claims of power, which characterised an apparently natural rise of modern medicine. From the power approach perspective, the process of (medical) professionalization serves the objective of monopolization. Physicians are not seen as altruistic fiduciaries of society's collective values but as socio-economic agents of power (Naber, 2005).

The most prominent representative of the power approach was its founding father Eliot Freidson. His research was sparked by the "accusations of greed, hubris, fragmentation, insensitivity to patients" (Hafferty & Light, 1995, p. 135) Freidson had observed among the medical profession by the late 1960s. At the same time he detected that the interpersonal basis of authority was rather weak. Hafferty & Light carve out the revolutionary difference between Freidson's and Parsons' work, when noting that

Parsons may have emphasized that authority emanates from technical knowledge, but that locus alone leaves professionals with little more than their powers of persuasion. To solve this problem professions seek to institutionalize their authority. They use licensure and public identity to attract clients suffering from a persistent problem. They gain control over valued services and facilities, like prescription drugs and hospitals and medical excuses from work.

(Hafferty & Light, 1995, p. 135)

Freidson distinguished between the pure scientific knowledge and theory and the application of that knowledge in practice (Freidson, 1970), with which he meant to highlight that medicine as a science is essentially neutral or apolitical. In contrast to this, the application of medicine was powerfully organised by the professional bodies to primarily meet the self-interest of its members. Freidson is deeply concerned about the growing gap between society's health care needs and a system of health care provision controlled by a privileged and self-idealising medical profession legally empowered to monopolistically define disease and even to control all adjunct medical occupations (Naber, 2005). In his early criticism of the medical profession's actual conduct Freidson pleas for a 'social' opening of medical training. He regards this as a means to break with the predominantly white, male, middle class phenotype that is representing the profession in Western societies. He also supports a greater scientific evaluation of medical practice within the profession and asks for greater transparency towards patients.

It is important to note that Freidson is not questioning the crucial role of professionalism in medicine for society. He is however criticising the deviation from the ideal typical by members of the profession 'in realitas'. Different from Parsons he is probably less naive about the effects a privileged position will have on medical doctors' conduct in the long-term. In his early works Freidson was literally bashing on the medical profession's self-serving conduct of business. Nevertheless he was having a clear picture of what medical professionalism should comprise of, that is not far from Parsons' view. Freidson equally believes that doctors have the power to organise and control their own work. They should have power over the division of medical labour, the medical labour market as well as medical training. Similar to Parsons Freidson also demands from medical professionals "an ideology serving some transcendent value and asserting greater devotion to doing good work than to economic reward" (Freidson 2001, p. 180).

In contrast to Parsons' perspective, Freidson is not one-dimensional in his view of professionalism's relevance to society. While to Parsons, professionalism is the centre of social gravity, to Freidson, professionalism is just one out of three pillars carrying modern society. In his later work "Professionalism: The Third Logic" (Freidson, 2001)

he is promoting the theory that modern society's structure and actions are driven by three complexes (logics): the market, bureaucracy and professionalism. Interestingly, in this work Freidson returns to a normative approach to professionalism. Freidson critiques that over the last two decades of the 20[th] century, the relative importance of the three logics have come out of balance. He diagnoses an expansion of market and bureaucratic ideologies at the expense of professionalism. Responsible for this shift is the rise of neo-liberalism connected with managerialism and consumerism during the last quarter of the 20[th] century. Freidson sees managerialism with its focus on cost reduction and hierarchical control as driving medicine towards standardization. At the other end, Freidson suspects that the ideology of consumer freedom is undermining the medical practitioner's authority over his patients. Consumerism which is fostering transparency of information and freedom of consumer choice is gradually tearing down the wall put up to protect the dominant role of suppliers characteristic of late Fordism.

3.1.3. Making peace with medicine: Freidson's turn

Surprisingly, Freidson's differentiated and critical view of the medical profession's conduct is not resulting in a gloomy outlook. On the contrary, he believes that doctors will regain and eventually even strengthen their social position if they just remember and comply with the ideal typical form of medical professionalism. This seems a surprising conclusion that puts Freidson remarkably close to Parsons' apology for a privileged position of medical practitioners. I believe that Freidson is underestimating the disparity between ideal typical and existent behaviour and – even more important – that he is underrating the strength behind market forces unleashed to the empowerment of individual fulfilment. Despite being the founding father of the power approach, Freidson is ultimately not accepting the conditions many followers of that school are observing. Daheim for example argues that an 'expertocratic' interpretation of medical practice, that allocates a subaltern position to the 'incompetent patient', is no longer accepted by an increasingly reflexive society. He suggests that patients progressively refuse to be treated as lay people. Patients, Daheim states, reject a relationship with physicians that is resting on a difference in rationality between science and everyday life (Daheim, 1992).

In his believe in the social and economic resurge of the medical profession Freidson is not alone. Swick, for example, deems the absence of a consistent and clear definition of medical professionalism among doctors to be the key reason behind the loss of professional authority and influence (Swick, 2000). Swick proposes a catalogue of professional norms aimed at winning back society's lost belief in the profession's collective orientation. In essence the catalogue is covering the ideal typical believes as presented by Freidson and Parsons. Despite its regulatory dress-up, Swick's work remains nothing but a plea for ideal behaviour. Swick is neither proposing how to implement the norms in practice nor does he suggest what to do in case of non-compliant behaviour.

In a collective action by several European and US medical associations a 'Charter of Medical Professionalism' (Sox, 2002) was compiled. This document was meant to reemphasis medicine's key values analogous to the Hippocratic Oath, demonstrating its fundamental differences to the growing primacy of marketization of self-interest as displayed by capitalism. However, the charter was neither a binding document nor a pledge that physicians are sworn to uphold (Domagalski, 2008). Similar to Swick's catalogue it was mainly a symbolic instrument.

In summary, Freidson's perspective on the medical profession remains altogether positive, supportive and even protective. He began as a virulent critic of a dominant medical profession which he observed during the 1960s and 70s. He happily proposed measures to destabilize the medical complex to the benefit of transparency, accountability and equality. When eventually the forces of a free market economy took hold of the profession, forcing it to compete for limited budgets, to justify their treatment plans and to hand over inefficiently executed parts of their 'labour process', it seems that Freidson began to regret that he helped braking up the old structures. In his later years Freidson is mainly advocating an ideal picture of medical professionalism, almost stubbornly predicting its continuation as an extraordinary as well as elevated element in society.

Altogether, the works of Parsons and Freidson indicate that physicians should exercise a controlling as well as corrective function against the self-interested world of business. Their contributions provide reason why physicians should remain sovereign from the

market economy system. Essentially it is to ensure that health and the provision of healthcare becomes a generic right to all members of society and that it is not subjected to personal interests or market forces. Both Parsons and Freidson demand a strong and autonomous position of physicians to the benefit of the collective of patients. In that they provide a normative proposal of framing society. Moreover, their ideal depiction of the role, status and function of the medical profession is equally a reference with regards to the perception and self-conception of physicians still prevailing today.

3.2. Non-sustaining theories of medical professionalism

In this part I like to present those perspectives on medical professionalism that predict a decrease in physician power and autonomy. Most of these views are not ideological motivated but simply interpret environmental pressures (e.g. economic, social, political changes) with respect to their projected effects on medical work. However, next to substantiating the arguments for professional decline, also new options for medical work will be introduced. I will begin with portraying the key theories on professional decline.

3.2.1. Deprofessionalization and proletarianization of physicians

While Parsons and Freidson have portrayed physicians as being a central guiding element to society, Haug (1973) projected an alternative scenario regarding the future of the medical profession. Known for creating the term of 'deprofessionalization' (Haug, 1973), Haug inspired a school of thought that believed in a gradual alignment of medicine to other occupations. In the early 1970s Haug pronounced medicine's fall from professional grace (Haug, 1973, 1988). She was reacting to the prevailing mantra of 'professionalization of everyone' (taken from Wilensky, 1964), the common sociological belief of the 1950s and 60s "that all occupations were becoming professionalized, and we were on the verge of a professionalized society" (Haug, 1988, p. 48). Haug was building her counter scenario partly on Wilensky's (1964) disbelief in total professionalization and was sympathizing with his prediction that increasingly mixed forms of professional labour – combining professional and bureaucratic models – were on the rise. Haug's main argument supporting a counter development was the knowledge explosion in science and technology that was to be observed during the 1970s. She mainly turned to the development of information and communication technology as the key reason for change. Already in the mid 1970s, Haug argued that computer technology could destroy the monopolization of knowledge and lead to the obsolescence of the concept of profession (Haug, 1977).

While from today's perspective, this was clearly an overstatement, it is true that in the present day the internet is providing lay people with all sorts of specialist information around disease and treatment of disease. Surveys have found that 50%-75% of people

with internet access use it to obtain health information, and that this group of people will search such information more than three times a month (Powell & Clark, 2002). Adler and Kwon (2008) conclude that the World Wide Web affects the power relationship between professionals and those they serve. Together with a large array of popular sciences books, articles and TV features, the general public is able to acquire a quite good understanding of some or many medical indications and procedures. This leads to a questioning attitude towards physicians combined with public demands for participation in decision making (Haug & Lavin, 1981). Haug argues that a gradual loss in knowledge monopoly is eventually undermining physicians' authority over patients which in turn can be described as deprofessionalization of the occupation. On the positive side, Adler, et al. remark that broad dispersion of expert knowledge in turn forces physicians to keep up with technical knowledge in their field through continuing education. This would lead to an increase in technical expertise and quality of medical service, a stance that is rather supportive to the viability and continuation of the professional complex.

Based on Haug's thesis of deprofessionalization Ritzer & Walczak (1988) took to the Weberian theory of rationalization and the conflicting concepts of formal and substantive rationality, to analyse the changes affecting the medical profession. According to Weber "The emphasis in formal rationality is on rationality at the macro levels – rules, regulations, laws, bureaucracies, economies – and its impact on the conduct of individuals" (Weber, 1921, in Ritzer & Walczak, 1988, p. 3). Substantive rationality on the other hand is determined by a coherent set of social values. Ritzer & Walczak note that in the 'golden age of medicine' (Burnham, 1982) medical professionals have been characterized by substantive rationality as they are guided by social values to make rational choices of means to ends. They argue, however, that the changes in governmental policies as well as in the delivery of medicine "are impelling the medical profession away from substantive rationality and in the direction of formal rationality. Increasing formal rationality is likely to lead to greater external control over physicians and to a decline in the ability of the medical profession to distinguish itself from bureaucrats and capitalists. These changes, in turn, are likely to lead to some degree of deprofessionalization of physicians" (Ritzer & Walczak, 1988, p. 1). As the division between medical doctors and bureaucrats becomes blurred, it is difficult for

physicians to claim a distinctive position of profession and to have that claim accepted by the public (Ritzer & Walczak, 1988).

Building on Haug's deprofessionalization thesis (Haug, 1973), some years later McKinlay and Arches (1985) predicted an equally deteriorating trend which they coined 'proletarianization' of physicians. The main idea behind this prediction is the medical practitioner's loss of holistic control over his work to the benefit of a highly rationalized division of medical labour. This development is compared to the changes that traditional craftsmanship underwent during the process of industrialization. More technically put it denotes "the process by which an occupational category is divested of control over certain prerogatives relating to the location, content and essentiality of its task activities and is thereby subordinated to the broader requirements of production under advanced capitalism" (McKinlay & Arches, 1985, p. 161). It is argued that proletarianization is induced by bureaucratization. For a long time, and different from other occupations, physicians through a variety of tactics (see Freidson, 1970) have been able to postpone or minimize this process. However, during the last quarter of the century bureaucratization has finally taken hold of medical practice. According to Larson (1972) it is functional efficiency and its ability to handle large-scale issues that gives legitimacy to bureaucratization of medical care. McKinlay & Arches, drawing on Marglin (1971) and Edwards (1979), alternatively propose that bureaucratization serves mainly the function of controlling the professional worker (e.g. physician-employees) making him strive towards the capitalist goal of accumulation. In a bureaucratic setting the personal objectives become different namely to ascend the managerial hierarchy and to advance the organization as a whole. Both objectives, McKinlay & Arches argue, are logically intertwined. Furthermore, in a bureaucratized (medical) organization the personal element is minimized in order to avoid individualistic decision-making. Instead, an approach of deciding via pre-existent set of rules is desired.

McKinlay & Arches regard medical specialisation as a key system-inherent driver to change. Specialization forces the division of labour, breaking up a formerly holistic workflow. It allows codification (e.g. through the system of diagnose related groups (DRGs) and automation (e.g. via computer-controlled diagnostic procedures) and favours the influx of paramedical workers which happily take over activities from

physicians. Additionally, the rise in specialization makes the individual physician progressively dependent on knowledge of others.

3.2.1.1. Why is it relevant?

Theories of deprofessionalization & proletarianization are essentially reference points for assessing situational context. In other words, one needs to have an understanding of the occupational situation the physician is arguing from. Although the presented models are projections rather than reflections of reality, to me they provide an effective orientation on a general level. Thus these theories are relevant when analysing physician accounts about their views on commercialisation, their role conception as medics as much as their interaction with industry. Importantly, this goes beyond relating respondents' perceptions to existing contributions. It is to take the existing frameworks and compare them against the results of knowledge production (interview data) in order to come up with interpretations beyond the text value.

3.2.2. Economic pressures from the periphery

Since the 1980s researchers (e.g. McKinlay, Hafferty, Light) observed a growing pressure on the medical profession from the periphery of medicine. Hafferty & Light identified five main groups exercising pressure: (1) government, including local, state and federal; (2) corporate purchasers of health care for their employees; (3) corporate sellers, such as manufacturers of pharmaceuticals and medical products; (4) consumers, as represented by consumer groups and government but also reflected by consumer spending on health; and (5) other providers such as nurses, physical therapists etc. (Hafferty & Light, 1995). The professional complex is beleaguered by government which is aiming to rationalize healthcare delivery to reduce government spending. The rise of integrated medical service structures such as HMO (Health Maintenance Organisations) in the US is one example for government pushing organizational streamlining to cut cost. In Germany, in numerous health reforms throughout the 1990s and 2000s, government has imposed strict price and treatment restrictions on medical procedures administered to statuary insured patients. In a country where almost 90% of

the population are covered by statuary medical insurance, physicians and dentists battle for the remaining fraction of privately insured patients (10% of all insured) and for those who have add-on private insurance (23% of all insured) (Preusker, 2008). Consequently, physicians focus on cost-effective patient management and segmentation, giving priority to the treatment of privately insured patients. This has lead to the public denouncement of doctors' providing 'two-class-medicine', a development which is heavily criticised for breaking with the ideal typical professional characteristics of altruism and impartial service to everyone (see Parsons, 1963).

Players in the pharmaceutical industry are heavily competing to acquire a dominant position in the medical market place. Progressively, they do this by exerting influence on treatment plans. In Germany governmental health reforms have dramatically reduced the number of drugs that will be reimbursed by the statuary health insurance system. In their battle for the remaining territory drug companies intensify their detailing of doctors to gain control over physicians' prescribing behaviour. Company representatives lobby government as well as insurance companies thereby influencing treatment and reimbursement plans. Pharmaceutical companies have furthermore begun advertising to patients, encouraging patients to demand their product from the physician (Adler & Kwon, 2008). All this puts pressure on doctors' therapeutic sovereignty and altogether weakens their professional authority.

On top of this, physicians have come under economic pressure from paramedical professions such as nurse practitioners eager to establish a distinctive sphere of work and to increase their share of medical service delivery. Domagalski (2008) remarks that the granting of licensure by the state to traditional disciplines such as nurse practitioners and to speciality areas like nurse anaesthetists, optometrists and podiatrists has created healthcare providers who are less expensive and often preferred by patients. Hafferty & Light (1995) argue that corporate sellers of medicine like for-profit-hospitals have welcomed this emancipatory turn and have moved aggressively to transfer clinical services down the traditional medical hierarchy.

Hafferty & Light remark that pressure on physicians equally comes from inside the profession. The medical knowledge explosion combined with many advances in diagnostic technology increased the degree of specialization. Faced with tightening

revenue streams, individual specialities compete for control of diagnostic or therapeutic modalities. Competitive behaviour is most prominently reflected in the rise of physicians' public advertising, a measure originally prohibited and regarded a taboo. This internal battle for revenue is weakening the professional group's cohesion and thwarts a uniform resistance towards external pressures.

3.2.3. New options for the medical profession?

McKinlay and Arches (1985) foresee physicians' gradual development towards proletarianization. Haug (1973, 1988) has projected deprofessionalization of medical work. Ritzer & Walczak – despite agreeing with much of Haug's work – nevertheless present other possible options regarding the future development of the medical profession. The most prominent one is, that new forms of medical professionalism will emerge that will combine formal and substantive rationality. These new forms, Ritzer & Walczak believe, would still tend to point in the direction of deprofessionalization, yet to a lesser degree. This alternative path has been picked up in Hafferty & Light's work on the emergence of new elites within the medical profession (Hafferty & Light, 1995).

Hafferty & Light (1995) are advocating a re-evaluation of professionalism to better organize expert knowledge in the service of public problems. They are questioning the pivotal role of professional autonomy and instead propose to put greater emphasis on professional accountability. The quest for greater scientific rationality in medical practice, the strengthening of effectiveness and quality through e.g. evidence based clinical practice guidelines (CPGs) will require a different kind of professional elite. This new professional elite must balance accountability for a 'greatly improved product' (i.e. clinical services) with the concept of discretion and service orientation. Individuals in charge of constructing and assessing entire systems of care, including their financing and organization, would have to be managers as much as they have to be physicians. This evolution will gradually replace traditional physician administrators with what Hoff calls physician-managers (Hoff, 1999). While Freidson foresaw "dire consequences" (Freidson, 1987, p. 144) for the status and stability of the medical profession if physicians enter the managerial ranks, Hafferty and Light introduce a

counter-scenario when arguing that "Medicine's powers and prerogatives are being maintained because physicians – not lay persons – are serving in critical decision-making positions and thus securing medicine's control over the technical core of its work and the organizations in which it is clinically applied" (Hafferty & Light, 1995, p. 139).

In contrast to this view, Montgomery's work on 'individual reprofessionalization' (Montgomery, 1990, 1992) suggests that once physicians move from clinical to management ranks they begin to shift their identity and commitments from the medical profession to the organization for which they work. Adding to the argument, Freidson in his early work on professional dominance (Freidson, 1970) saw the current work environment being more influential than education and prior socialization. Weighing up the evidence, also Hafferty & Light eventually come to the conclusion that in organized or corporate medicine the new physician-executives are not primarily representing the points of view of the medical rank and file. As physicians' time and involvement in management duties increase, they are more likely to adopt interests of "capital and the state" (Hafferty & Light, 1995, p. 140). Domagalski (2008) finds that somewhat intriguing "as those who have examined the developmental experiences of professionals such as physicians find that the intensity of the socialization process to which they are exposed instils a deeply rooted ideology of social welfare and concern for the individual patient at foremost" (Domagalski, 2008, p. 123).

Hoff's work on the impact of mode of employment (Hoff, 1999, 2003) on physicians' adaptation to a corporate ideology displayed that those who were self-employed are more resistant to corporate conduct and structures than salaried doctors in a staff model HMO setting. In general, this seems not to be a surprising outcome. However, Hoff's findings stood in contrast to the long-held assumptions that physicians tend to remain adversarial or ambivalent toward the organization for which they work. In his later work and in contrast to his earlier thinking, Freidson, for example, believed that physician-employees due to their professional mindset would resist the highly volatile dynamics of a corporate environment (Freidson, 1994). Yet, Hoff's longitudinal studies displayed a dominant impact of the actual working environment over the effects on educational or training socialisation. Nevertheless, it must be stressed that according to Hoff's findings exposure time is a critical element to the equation. Hoff argues that the

form and substance of individual physician adaptation to organizational life, as displayed for example in a HMO setting, is dependent of social exchanges over time with the HMO, "making it an emergent, evolutionary process rather than a pre-determined, static phenomenon" (Hoff, 2003, p. 75).

A prominent sign for a growing embracement of economic principles on part of the medical profession is their increased pursuit of advanced degrees in areas such as business and law (Domagalski, 2008; Adler and Kwon, 2008). A substantial increase in integrated MD-MBA and MD-JD degrees can be observed in US, Canadian but also in European universities. In Germany, for example, the private university of Witten-Herdecke has offered a reformed medical degree including modules of business administration and health economics for several years now. While this has been received with mixed emotions by many representatives of the professional associations it is greatly welcomed by students who could not help to notice – mainly through information exchange with their already practicing peers – a great disparity between traditional training and actual qualification requirements in the workplace. Domagalski (2008) concludes that the pursuit of advanced business degrees is unlikely to be a symbolic move by physicians. Instead it is likely to represent the undermining of the traditional characteristics connected with the profession and a shift towards the values of the business enterprise.

Adler & Kwon (2008) foresee chances for a re-strengthening of the medical community arising. Scientific as well as procedural medical knowledge is growing at an ever-accelerating rate. The market economy today is heavily relying on knowledge production, control and application. A precondition for effective knowledge management, as required by the post-modern capitalist system, is community. Adler argues that neither market nor hierarchy nor any combination of the two is as effective as community in supporting knowledge generation and diffusion (Adler, 2001). By developing a new form of community physicians can regain control of the key part in modern medical service production. For Robinson (1999) joining of physicians in medical groups opens "possibilities for informal consultation, evidence-based accountability and a new professional culture of peer review" (Robinson, 1999, p. 234). Others declare 'collaborative interdependence' to be the new leitmotif of professionalism (Silversin & Kornacki, 2000a, 2000b). I believe a centrally geared top-

down organisational approach might be required in order to form a really powerful and controllable knowledge alliance within the medical profession. This may be difficult to achieve given the various interest groups within the profession. Still, even if a powerful alliance is not realized completely, the profession would more than benefit if they were "moving away from the insular, elitist model and towards a greater interdependence with a broader range of stakeholders" (Adler & Kwon, 2008, p. 160).

3.3. Summary

In this chapter I have presented different outlooks on the medical profession. At one end there has been the view of Parsons who conceptualises the medical profession as a central element of a value system that guides society. In his theory Parsons is stressing the altruistic, impartial and expert character of physicians which permits them to take the role of moral authorities and norm managers within society. Subsequently, I have discussed the critical perspective of Freidson, who in his early works had focussed on revealing the self-interestedness, dominance and protectionism that physicians have displayed. However, despite criticising the way medicine is actually practiced, Freidson ultimately joined Parsons' in his view that – given their recollection of values like altruism and neutrality – physicians should (continue to) have an outstanding controlling function in society.

At the other end, I have displayed various positions that predict the decline of the medical profession. These views are typically informed by the insight that physicians have to give in to economic, social and political changes and pressures. Most prominently and influential in this respect are Haug's theory of 'deprofessionalization' as well as McKinlay & Arches' notion of 'proletarianization' of the medical profession. Both theories predict a continuing decline of medical power and authority which eventually will result in medicine becoming an ordinary occupation. Responsible causes for this trend are advances of information technology (Haug) and ongoing rationalisation processes in neo-liberal societies (McKinlay & Arches).

Last not least, new options for medical work have been portrayed. In this respect, the view was presented that physicians could exert greater influence by joining the management ranks of medical organisations (e.g. hospitals, HMOs). Together with a revision of medical training to include areas like e.g. business administration, new types of physician-executives would be able to represent the interests of the medical profession. However, several authors (e.g. Montgomery 1992, Hoff 1999, 2003) rather point to the shift of commitment, which will ultimately make physician-executives pursue corporate interests.

4. Evolution and function of drug detailing

While in the previous chapter perspectives on the profession of medicine were presented, I will shed light on the drug rep side in this chapter. I will draw attention to the historic development of drug detailing, followed by outlining the particular situation of drug reps in Germany. In this respect, the difference between formal work requirements and actual job expectations will become apparent. I will round off this chapter with a comprehensive review of the key perspectives in the literature regarding the purpose and impact of detailing. Altogether, I like to point to drug reps' unique and challenging position in between industry and medical profession.

4.1. The history of drug detailing

Drug detailing is a relatively young occupation. It gained its distinct profile first in the US from where the occupational model was subsequently exported around the world. Greene (2004) provides a sketch about the emerging role of the pharmaceutical salesman in the growth years of the American post-World War 2 pharmaceutical industry. This was a period of intense expansion of the industry – characterized by the emergence of entirely new classes of therapeutic compounds – in which many of the structural relations between drug companies and medical practice were consolidated. In line with this development drug reps began to re-invent themselves as skilled and service oriented professionals "apostolic of medical modernity and they set about encouraging the dissemination and consumption of newly synthesized pharmaceutical compounds with a distinctly moral sense of the value of their work (Greene, 2004, p. 272). Before that time Greene noted that "the detail man was a not-so-distant relation of the travelling patent-medicine peddler: a commercial traveller, familiar with roadside motels, the inside of his automobile, and with a wary outsider status" (Greene, 2004, p. 272).

Sales and marketing managers in the pharmaceutical industry aspired to give drug detailing a professional status. In their bid for professionalism of pharmaceutical detailing they looked to physicians as 'model professionals'. This gave rise to a growing volume of trade literature, training manuals and guides highlighting the public

health responsibilities of drug reps. A prominent apologist of the drug rep's new professional status was management consultant Arthur F. Peterson, who stated in his textbook on pharmaceutical selling: "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 of 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)

Industry's attempt to provide its drug reps the status of health professionals was met by scepticism and outright refusal on part of the medical profession. Greene noted that "as much as they might boast about their public health responsibilities, detail men, and their sales and marketing managers above them, had little immediate power over physicians or ability to bridge the vast differences of social and economic status that separated them" (Greene, 2004, p. 275). This was particular apparent during the 1950s and 60s where medical practitioners were almost entirely self-regulated and self-reliant. Drug reps simply had difficulty inserting themselves (as partners) into the medical world.

The pharmaceutical industry soon realised their inability to truly measure up with doctors in terms of legitimacy and status. In turn, they began to professionalize aspects of the encounter. Much attention was given to "scripting the pitch" (Greene, 2004) in order to exert maximum influence onto the physician during the visit. In the first ever class devoted entirely to detailing of physicians, Howard H. Jones, a veteran sales man turned author and lecturer, told his students at Columbia University: "Webster might define detailing as the telling of a story in all its details…but here we will limit the scope of the word, as applied to personal calls upon the doctor, to mean acquainting the doctor with the important facts about a product or products. Detailing is, in reality, sales promotion, and every detail man should keep that fact constantly in mind" (Jones, 1940, in Greene, 2004, p. 273).

Two fundamental barriers had to be overcome by the industry. One was to handle the physician's sentiment of superiority born out of his functional specific competence and

responsibility (see Parsons, 1978). In this respect Jones noted that "nothing antagonizes a doctor quite as much as having a detail man attempt to teach him his profession" (Jones, 1940, in Greene, 2004, p. 282). The other was to overcome the drug rep's overly respect for the medical profession coupled with feelings of his own illegitimacy. These sentiments were responsible for causing what Greene called 'doctor fright' (Greene, 2004).

Jones (1940) suggested that the drug rep must overcome his fear "through hard work and determination" but most of all by "projecting a strong positive mental attitude and a thorough knowledge of the subject material" (Greene, 2004, p. 280). While thorough technical knowledge on part of the drug rep was fostered by the industry it was only one part of the equation. By mid-century the pharmaceutical companies and their management advisors reverted to a detailed set of rhetorical and psychological measures to bridge the doctor – drug rep gap. Greene (2004) stated that the trick was "to internally visualize the physician as a benign everyman, while externally treating him as a sort of scholar-prince" (Greene, 2004, p. 280). In order to provide that sort of manipulative treatment the industry began to carefully train and orchestrate the rep's body-language and motions. The following excerpt of Peterson's textbook on pharmaceutical selling exemplifies this nicely:

When the P.S.P. [pharmaceutical sales rep] prepares to shake hands with the physician, he should 'measure off' the proper distance between them. He should stop in such a manner that the body is naturally erect and relaxed, the right foot about a short step in advance of the left. He can then bow very slightly from the waist as a full grasp is taken of the physician's hand.

(Peterson, 1949, pp. 271-272 in Greene, 2004, p. 281)

With the choreographing of gestures, postures and movements also came along in-depth rhetorical preparation. To influence prescriptions, drug reps needed to develop a powerful voice within the exclusive and elite medical context. Rhetorical training was very much directed at leading the physicians by means of suggestion (Greene, 2004). The drug rep had to present his case as if it was information already held by the doctor. Formulas like 'I presume you are aware of X' were part of the rhetorical tool box given

to the drug representative. Equally popular was the quoting of statements by fellow clinicians, which implied delegating the educational part up the professional latter. These were discursive gambits to deal with the doctor's aversion of being lectured by lay people. Greene aptly described it by stating "like a cuckoo hen slyly inserting her own egg into another's nest, the detail man could camouflage company material within parcels that physicians might mistake as part of their own knowledge" (Greene, 2004, p. 282).

A further lever was placed by categorizing medical professionals in terms of psychological and economic typology frameworks. It started out as a training method to identify and deal with physicians expected to put up resistance against detailing. Drug reps were asked to compile 'informal bestiaries' (Greene, 2004) consisting of drawings of difficult doctors. Together with those caricatures drug reps created a language to label character types and their associated behaviour. Physicians were given bold tags like 'Dr. Snob' or 'back-slapper' but also more precise descriptions like 'decided, self-confident type' were made. While these typologies were informal and individual at first, they later formed the basis for a standardized framework of rating physicians. In 1949 Peterson proposed a method of placing physicians on two axes, one assessing their potential patient volume (ranked A to E), the other classifying their attitude to medical innovation (ranked V to Z). Peterson's scheme was an evolution from anecdotal accounts to unbiased data-oriented depictions of doctors. In the course of time it allowed to be substantiated by increasingly fine-grained sets of empirical data provided by an upcoming market research industry. The founding of the Institute of Medical Statistics, short IMS – the world's largest pharmaceutical marketing data base – demonstrates the industry's aspiration to overcome barriers to communication through reading physicians and anticipating their conduct.

In their zeal for information sales and marketing managers increasingly used the drug rep as an instrument for data collection. The so called detail-based marketing tactics (Greene, 2004) added important feedback about which promotional activities did or did not work with which types of doctors. The conjunction of data sources eventually enabled the pharmaceutical industry to obtain a clear picture of the practice of medicine. The drug rep played a central role in obtaining this action oriented knowledge which he subsequently employed to discursively influence physicians'

prescribing behaviour. As such he became the fundamental link between the industry and physicians. Yet the drug rep was never a sovereign actor who self-reliantly plans and executes the call. To Greene the drug rep represents "the extension of a hierarchically structured marketing apparatus – based on rationalized principles of management and market analysis – into social spaces previously thought to be occupied only by doctors and patients" (Greene, 2004, p. 285).

As indicated in the introductory chapter, today a vast amount of drugs (over 50'000 in Germany alone) are on the market of which many are offering no or just marginal differences (so called me-too drugs). Except for the manufacturers of generics – which are replicas of off-patent drugs sold purely on price – the rule of thumb goes: The less innovative a drug is the more refined its marketing has to become in order to make up for the product's technical mediocrity. As per my own work experience, marketing managers are more than ever asked to identify those physicians who are most likely fall for increasingly feeble product advantages. This results in a highly specific tailoring of target segments. A combination of refined qualitative and quantitative research techniques allows positioning a drug according to physician's attitudes and behaviours (Bayer Healthcare, 2007). Relevant physician segments are selected by the likelihood of their members conforming to a desired (by marketing) behaviour. A typical example of a 'desired behaviour' would be to submit patients to a new diagnostic test, which, if it turns out positive, would indicate the use of the drug in question.

At the end of a complex and lengthy segmentation and positioning process marketing managers come up with a plan that outlines precisely which behaviours have to be induced at which types of physicians by means of which arguments. On the one hand this plan is employed to create drug advertising to physicians (and sometimes also to patients) but more importantly it is to brief the sales force on whom to target at which intensity with what type of messages. It is through in depth training given by product managers, sales managers and outside consultants (e.g. psychologists) that the drug rep receives detailed but also 'chewable' instructions regarding the content and choreography of the detailing talk.

4.2. Drug reps in Germany

The German association of drug reps (BDP) (2009) uses the term 'Pharmaberater' – which roughly translates into pharma-advisor – as occupational title. The same designation is used in the wording of the German medicines law emphasising the advisory purpose of the job. Approximately 20'000 drug reps are working in Germany producing c. 25 million doctor visits per year. At an estimated total cost of 2.5 billion Euros (Korzilius & Rieser, 2007), each call accounts for 100 Euros on average. Drug reps are out in the field nearly every day of the week, typically visiting between 5-10 doctors per day. Leading pharmaceutical companies in Germany employ between 500 and 1'000 drug reps. Increasingly, teams are supplemented with leased sales force members, as they allow firms to react more flexibly to changes in demand. Approximately 18% of drug reps in Germany have a leased contract status (Sandner & Klöpf, 2006).

4.2.1. Formal requirements

The occupation is regulated by the medicines law (*Arzneimittelgesetz*, AMG §§75,76). According to this law, a drug representative is to inform the physician about the technical aspects of a drug either in person or by phone. Any product samples handed over during the encounter the drug rep has to document. He is furthermore required to report back in writing all observations by physicians about the presented drug's side effects or any other risks. In order to do this the drug rep has to have 'knowledge of the subject'. Candidates applying for the job must have a university degree either in pharmacy, biology, chemistry, medicine or veterinary medicine. They need to have worked in a healthcare related field for at least two years. If they do not possess one of the above listed academic qualifications they have to attest work experience of at least five years plus undergo a certified six months intensive training programme. The programme includes modules in pharmacy, pharmacology, biochemistry, anatomy, physiology as well as courses in health economics, marketing and law. Applicants then have to pass a formal written and oral exam in front of the chamber of commerce to obtain the status of a certified pharmaceutical advisor. Given these preparatory

requirements one should assume that drug reps are equipped to competently present a drug to physicians.

The German medicines law portrays the occupation of a drug rep as rather neutral and scientific. This comes naturally as the originators (most and foremost the Ministry of Health) have no interest to encourage any e.g. promotional activities towards physicians by the industry. Yet to a commercial organization like the pharmaceutical company drug reps are more than just data intermediaries. One of the leading providers of drug rep curricula in Germany lists the following key job responsibilities for drug reps as defined by the pharmaceutical industry:

- Customer selection
- Target-oriented preparation of physician visits
- Post processing of customer pitch
- Launch of new products
- Placement of post-marketing studies
- Strategic analysis of sales data
- Recruiting of new customers
- Networking
- Planning, organisation and execution of training events, workshops and meetings

Source: Akademie für Pharmaberufe (2009)

The above listed duties indicate that in fact drug detailing goes beyond scientific information provision. In the following, I like to take a closer look into the industry's definition of the occupation.

4.2.2. Industry's requirements

Pharmaceutical companies provide very little public information about their understanding of the role of the drug rep. Statements found on company websites are

mere copies of the medicines law's definition. However, job adverts for drug reps are somewhat indicative of job duties that go beyond scientific information and reporting.

In a job advert issued by Novartis Pharma Germany it reads for example:

*Pharmaceutical representative, oncology, for the **marketing-oriented consulting** of office-based doctors and hospitals...*

In a drug rep advert by Bayer Germany it states under qualification profile:

*In dealing with physicians [...] you convince by poise, **very good rhetorical skills, persistence**, initiative, self-motivation...*

Ipsen Pharma Germany is listing key job duties for a drug rep in the area of neurology and oncology:

Marketing-oriented *consulting of physicians [...], targeting and **target group analysis**, developing and executing of **action plans***

Bristol-Myers Squibb Germany is looking for a field trainer who:

*...is working closely with sales and our trainings department to identify marketing specific training requirements and to develop appropriate training concepts. You run **marketing specific trainings and coaching sessions with our sales reps** and you support the induction of new hires.*

The above examples show that marketing related skills and profiles are actively looked for by leading drug companies. While this is not representative of every firm, I have nevertheless found it quite prevalent in job adverts published in Germany. Increasingly, drug companies recruit on a similar profile like firms in the consumer-goods industry, whereby the promotional aspect takes the centre stage. Furthermore, the task of commercial analysis and customer evaluation is strongly demanded in job adverts. This corresponds to my own professional experience by which more and more business graduates have been searched for as candidates.

4.2.3. Physicians' requirements

Having illustrated the industry's perspective I equally like to present the physicians' relevant set of expectations. Unfortunately, there were only industry sponsored reports and surveys available in Germany that would inform about demands from the physician end. According to one industry sponsored study among 743 family doctors and specialists in Germany (Gebuhr, 2007), physicians see the role of drug reps as to:

- Inform about new products on the market
- Inform about drug dosing, side effects, drug interaction, drug combination
- Provide free drug samples for testing
- Organise scientific training courses
- Consult on health politics issues and practise management

As per another survey about family physicians' working environment, doctors feel ambivalent about drug reps. 20% of respondents rate visit by drug reps as informative yet only 10% rate them as a pleasant experience. The majority of family doctors regard the current form of visits as undesirable (GfK-Healthcare, 2007). In its negative appraisal the German study is mirroring the findings of similar studies executed in the US (e.g. Poirier, 1994), however, German physicians are altogether more negative in their rating. On the other hand, 80% of doctors in the study believe that visits by drug reps are indispensable in general. From the distance, these results have to be treated with caution because it is not clear (to me) what e.g. stands behind the notion of 'undesirable'. Nevertheless, the findings point to large service gap existing in the German market.

In summary, demands on drug reps are differing quite strongly between legislator, industry and physicians. The biggest discrepancy is to be observed between industry and the German medicines law. While the German legislator requires drug reps to focus their activities on scientific information provision, pharmaceutical companies according to their job adverts seek representatives to be highly marketing-oriented. Physicians are interested to obtain scientific information especially about new drugs yet they are also concerned to receive free product samples.

4.3. Perspectives on drug detailing

In this part of the chapter, I would like to point out key perspectives on the purpose and effect of drug detailing. In relation to its economic contribution there is relatively little information published regarding drug detailing and the customer service in the pharmaceutical industry. Although the pharmaceutical industry is constantly measuring the efficacy and efficiency of its sales force the results nevertheless remain well kept company secrets. This secrecy indicates the importance that the pharmaceutical industry is assigning to its sales forces.

There is no clear agreement in the literature about the key objective of pharmaceutical detailing. Sociologists Berger and Offe (1980) view consultation and knowledge transfer as the primary objective of the pharmaceutical sales representative. They rate pharmaceutical detailing as an "extraordinary" service that is initiated by the pharmaceutical industry alone. For Berger and Offe the service is untypical in that the doctor has neither requested information about a drug and its properties nor will he be paying for the medication in the end. In contrast to a typical sales person who interacts with a customer to directly sell his product the medical sales rep indirectly (through consultation) tries to induce the doctor to prescribe a certain drug. From this Berger and Offe conclude that consultation rather than sales promotion is the primary objective of the pharmaceutical detailing (Berger & Offe, 1980).

According to empirical research conducted by Elina Hemminki the pharmaceutical industry regards sales promotion (rather than knowledge transfer) as the key objective of pharmaceutical detailing (Hemminki, 1977). To Hemminki, success of a drug rep is not measured by the degree of knowledge transfer but only in terms of prescriptions induced. Today, this can be perfectly tracked and allocated by globally operating research institutes, first and foremost by the Institute of Medical Statistics (IMS), through script reading at the point of purchase (i.e. pharmacy). Hemminki defines activities such as consultation and relationship building to be only instruments in order to reach the overall objective of generating scripts.

While there are different positions regarding the ultimate objective of pharmaceutical detailing there is agreement about the critical question each representative needs to

tackle, namely how to influence the prescription behaviour of the doctor (Rohrbacher, 1988). Furthermore, there is agreement that preceding to that one must know "how does the doctor keep up with what's new?" (Coleman, et al., 1966). In other words, what is the critical source of information that makes the doctor prescribe one drug over another? In their review of existing studies on doctors' source of information, Bauer & Wortzel (1966) found that physicians use commercial references both as the first source of information about a drug as well as the source that convinces them to prescribe the drug.

Further to the findings of Bauer, in an empirical study among doctors Coleman et al. found that the drug representative has a key role in creating awareness for a new drug. According to Coleman for 57% of doctors the drug rep is their first source of information about a new drug. Once the initial information is provided doctors turn to other sources of information, preferably literature. Yet according to the Coleman study the majority of those who turned to literature as an intermediate or final source chose commercially driven literature as a reference (Coleman et al. 1966). In a similar study executed ten years later in the UK, Eaton and Parish found that drug reps are used extensively to inform doctors about the existence of a drug preparation, but are relied upon much less by doctors in their establishment of a drug's usefulness (Eaton and Parish, 1976).

Avorn et al. (1982) criticised these studies as relying heavily on self-reports as a major source of data, thereby introducing a strong potential bias. Introducing a different methodology – by which different messages were sent to doctors through a) commercial and b) scientific channels – they managed to show the subjective reality construction by doctors. The study showed that doctors in fact heavily rely on commercial sources but nevertheless claim their influence to be minor. Avorn concluded that the nature of drug promotion is such that physicians often deny the relative importance of commercial sources in influencing their prescribing, either because they are unaware of it or because they are reluctant to admit to being influenced by non-scientific sources. While the results of Avorn et al. confirmed the importance of commercial sources it introduced the important aspect of subjective reality perception. The aspect is crucial because it sheds light on the potential difficulty of message and meaning transfer in e.g. drug reps – physician communication.

Altogether, it remains unclear why the preceding studies by Coleman et al. and Eaton & Parish have produced similar results (to Avorn et al.) yet without controlling for subjective reality perception as Avorn did. In other words, how could the self-reports by doctors, rate commercial resources favourably while according to Avorn doctors "officially" tend to deny their influence?

In any case, the empirically confirmed importance of the drug rep as the key source of doctors' information needs to be viewed critically. One could argue that the importance scores measured are in fact a 'self-fulfilling prophecy' generated by the pharmaceutical industry itself. If doctors name the drug rep as their primary sources of information it is most likely due to the fact that drug reps exclusively carry information about a new drug. Other relevant channels have no or only restricted access to this information. Hence, the physicians' rating is not surprising. In fact the pharmaceutical industry measures a reality that is self constructed.

Contemporary research has further strengthened a critical outlook on drug detailing. Several studies in Anglo-American markets have shown that physicians have a rather negative and disillusioned attitude towards detailing (e.g. Poirier, et al., 1994). Poirier revealed in a study among US physicians that only 24% of the physicians were satisfied with the detailing encounter, while almost 50% were dissatisfied. In a survey among Canadian general practitioners Strang, et al. (1996) displayed that over 90% of the respondents thought that drug detailing is mainly about promotion. Consequently, study interest shifted to investigating the quality and consequences of detailing contents. A meta-analysis done by Lexchin (1997) revealed that drug reps only transmit positive information about their products. Side effects and contraindications are rarely mentioned and a lot of data given to physicians is simply inaccurate. Lexchin concludes that taking the detailers' information at face value would not serve the interest of the doctors' patients. In turn, Lexchin urges the medical community to put pressure on the pharmaceutical industry for better monitoring and increased quality of detailers' presentations. Further to that point, recent product specific studies by Steinman et al. (2006, 2007) indicated that drug reps frequently promoted non-approved uses of a drug (in the particular study it was the anticonvulsant drug Gabapentin®). The study showed that as a result of these off-label promotions, physicians were prepared to increase the use of the drug.

In parallel to qualitative assessments, researchers were interested to investigate the quantitative impact of detailing on actual prescriptions. In general, most studies found a positive significant effect of detailing. Cleary (1992), in a study on the impact of detailing on antibiotic prescribing at a US university hospital, found a significant correlation between detailing efforts and number of new prescriptions. In another US study, Rizzo (1999) discovered that detailing efforts systematically lowers physicians' price sensitivity. In other words, as a result of detailing physicians become less reluctant to prescribe high priced drugs to patients. Manchanda & Chintagunta (2004) showed a positive relation between detailing frequency and script writing. Altogether, considerable evidence has been produced to substantiate the assumption that drug detailing has a quantitative impact on physicians' prescription behaviour. Unfortunately, I was unable to identify any quantitative market response study in Germany.

Very little research has been done into the causes of physicians' attitudes towards drug reps. Typically, studies have focussed on expressing attitudes but have rarely informed about attitude formation. Furthermore, emphasis was placed on negative issues yet relatively little is known about what might strengthen the bond between physicians and detailers. In a study among US physicians, Lagace, et al. (1992) revealed that if ethical behaviour and expertise is shown by drug reps it has a positive effect on physicians' trust and satisfaction with regards to detailing. In another US study, Andaleeb & Tallman (1995) further identified factors that affected physicians' attitudes. They discovered that doctors' were positively influenced by the level of informational and educational support they receive from drug reps. At the same time, their study showed that manipulative and aggressive selling practices was causing unfavourable attitude formation.

4.4. Summary

So far, drug detailing has been looked upon either from a physician perspective (e.g. Poirier et al., 1994) or from a conceptual angle (e.g. Berger & Offe, 1980). Altogether, researchers were focussing their interest on the receiving end of drug detailing, measuring effects and reflecting attitudes. In such a research framework drug reps were conceived as instruments of sales and marketing but not as individual actors and meaning-makers. Studies are missing that investigate the mind-set, role function and overall motivations from a drug rep point of view. What stimulates drug reps to engage in drug detailing? How do they define their role? What do they think about their customers? These and other questions remain unanswered to date. Moreover, no light has been shed on the relationship of drug reps to their organisations. Until now, researchers have viewed drug reps as tools of management, assuming that the pharmaceutical industry is a uniform operational and ideological entity.

I have indicated at the outset that I would like to get a more complete idea about the phenomenon of drug detailing. As drug detailing is essentially a discursive process, my attention is set on the qualitative assessment of the discursive practices employed in detailing. I am interested to learn how discourse is manifested and subsequently how it impacts the roles and attitudes of those involved in it. In this respect, I like to shed light on the issue from the individual physician, drug rep and manager perspective. Especially by investigating the subject from a detailer's point of view my research offers a new approach to research on drug detailing.

Based on the previous discussion on the evolution (section 4.1.) and the purpose (section 4.3.) of drug detailing and given my own professional experience, I assume that discourse in drug detailing has a strong promotional character. When researching this particular type of discourse my focus is thus set on the marketization aspect of it. More specifically, I like to understand if marketization of discourse exists, how it is constructed, perceived and responded to from a subjective meaning point of view. This endeavour requires providing an overview on the notion of language and discourse and its capability to inflict cognitive and factual change. Hence, in the following chapter I will present the relevant stances with regards to language, discourse and marketization of discourse, all this in relation to the issue of drug detailing.

5. The power of marketised discourse

This part of the literature review will be dedicated to the role language and discourse plays in the marketization process. Attention will be drawn to the notion that marketization (or commodification) is to a significant extent a linguistic and discursive process (Fairclough, 1994, p. 253). To begin with I will examine perspectives on the relationship between language and meaning-making, a bond which I regard as a paramount prerequisite to grasping the notion of discursive impact. In turn, I will demonstrate how by means of discourse a market ideological perspective was disseminated in Western societies. I will round off this chapter by emphasising the action-orientation of discourse.

5.1. An introduction to language and meaning

The purpose of my work is to investigate the influence of language and discursive practices on the reality perception, attitude building and behaviour of drug reps and doctors. In this respect, the relation between language and meaning needs to be understood. This relationship has been investigated for a long time and has resulted in various perspectives. In the early part of the 20^{th} century the logical positivists aimed for an ideal language whereby each term has a clearly defined, objective meaning which is also verifiable. The verifiability criterion of meaning (verification theory) asserts that a statement is meaningful if and only if it is either analytically or empirically verifiable.

Wittgenstein – initially a follower of logical positivism – later broke with the positivistic view of assigning one specific meaning to each word. For Wittgenstein the meaning of a word is its use in language (Wittgenstein, 1984, PU 43). To him linguistic meaning only and exclusively evolves out of 'language-games' which are considered to be simple forms of language, consisting of language and the actions into which it is woven. Language-games are forms of language that, for example, a child employs when it begins to make use of words. The concept of language-game was intended to bring into prominence the fact that the speaking of language is part of an activity, or a form of life (Wittgenstein, 1984, PU 23). With this statement Wittgenstein denies the

existence of a 'semantic hereafter', a metaphysical space of eternal meaning. To him "language must speak for itself" (Wittgenstein, 1974, p. 63). This means that a word or a sentence does not have a meaning assigned to it by an independent power. It is not possible to conduct a scientific investigation to find out what a word really means. Instead Wittgenstein notes that a word has the meaning that someone has given to it (Wittgenstein 1984 in Bezzel, 2000, p. 33). This statement implies a dynamic of use that allows meaning to be in a process of constant renewal. It also stresses the fact that there is not only one meaning (of a word) at any point in time. Instead there can be a multitude of meanings existing in parallel assigned by a multitude of "someones" existing and experiencing the world. In practice these "someones" are likely to be a social group that creates meaning as part of e.g. creating social conventions. With this view Wittgenstein fundamentally breaks with the philosophical concept of essentialism which acknowledges the existence a finite idealistic form or meaning.

Wittgenstein's view clearly differs from Chomsky's linguistic theory of a formal grammar generating language. While Chomsky promotes a generative formalism where grammar becomes a logical and mechanistic "device" (Chomsky, 1957) of infinite creativity, Wittgenstein emphasizes the practical dimension of social interaction. To Wittgenstein differences in meaning are not classifiable in a mathematical sense but must be evaluated qualitatively. The key difference from Chomsky's view is that Wittgenstein postulates that language fundamentally rests on (pre-linguistic) action, which determines thinking rather than is a result of thinking. Wittgenstein puts this very simple by stating that at the beginning there was action (Wittgenstein, 1984 in Bezzel, 2000, p. 28). In contrast to this, Chomsky postulates that each human being possesses a genetically determined mental system of rules and principles to generate representations through language (Chomsky, 1986). To Chomsky language is like a 'mental organ' (Chomsky, 1981) and as such part of the human genotype.

The conflicting positions of Wittgenstein and Chomsky display two ways of approaching and understanding language: either as a social or as a biological / psychological concept. While for Chomsky the knowledge of language is a state of the individual mind, for Wittgenstein it is the result of a community of (language) users. I prefer to agree with Wittgenstein's theory of language and meaning whereby meaning is the result of dynamic social interaction. His approach is particularly convincing with

regards to changes in meaning-making. Following Wittgenstein, it is the flexible interplay of social perception, action and language that one is able to understand the inherent powers of change. Therefore, a central conclusion of Wittgenstein's concept is that if language-games change, so will the words, and with the words the meaning of the words. To put it in another way, if we come to re-experience the world we will denote it differently and consequently perceive it differently.

Importantly, this position assumes that discursive practices have a strong impact on the meaning-making and action of individuals. Considering the fact that social interaction is not so much a random undertaking but frequently is the result of a deliberate move, discursive practices are likely to be motivated by particular interests as well. Thus constructing and shaping discourse in e.g. institutional encounters like drug rep – physician interaction is ultimately a means of exerting power. In the following I like to address the formation and impact of a particular discourse with regards to disseminating a market ideological perspective in Western society.

5.2. The marketization of discourse

5.2.1. Of becoming dominant

I am generally following the idea of discourse as a means of exerting power. From this perspective, social life is seen as hegemonic struggle among multiple discourses for dominance and survival (e.g. Gramsci, 1971; Fairclough, 1992; Keenoy, et al., 1997). It is argued that 'past-modern' times (Stones, 1996) are determined by increasingly paradoxical, fluid and contradictory accounts of social and organizational realities. The 'dialogical' perspective (Keenoy, et al., 1997) of parallel and competing discourses (realities) is convincing if one considers social life as a dynamic blending of subsystems. However, in today's prevailing interpretation of social reality there is a monological aspect to be detected. The term monological implies the reading and interpreting of social reality "as one story, usually viewed from the perspective of a dominant group" (Boje, 1995, p. 1029). In contrast, from a dialogical perspective a hierarchical ordering of discourses is not evident. Yet it seems that the interpretation of social reality is increasingly done from a market ideological perspective. Keenoy et al.

note that "we have all been ensnared by the behemoth of 'globalization' and subjected to the moral order of an indiscriminate totalizing 'market'" (Keenoy, et al., 1997, p. 147). However, if one thinks about discourse in terms of hegemony, it must be stressed that this is unlikely to be a stable condition. Fairclough emphasises that "hegemony is a more or less partial and temporary achievement, an 'unstable equilibrium' which is a focus of struggle, open to disarticulation and rearticulation" (Fairclough, 1993, p. 137).

The inherent dynamism of hegemony in discourse can be observed at present. While at the outset of my project in 2005 the discourse of marketization seemed to be incontestable, the current financial and economic crisis has brought strong rivalling discourses to the fore. Facing the chasms of individual and public wealth erosion suddenly people throughout the social and occupational spectrum are tuning in to a discourse of 'state control' and 'protectionism'. This development is nicely reflected in a newspaper article:

The death of neo-liberalism does not mean the death of international capitalism. Neither does it mean that workers and the poor will now get the fruits of their labour, that economic justice will now reign. What it means is that the ideological hegemony of neo-liberalism is finished, that the main thrust of ongoing discussions, regulating finance capital and government stimulus plans, run counter to neo-liberalism.

(International Herald Tribune, Jan 2 2009, p. 14)

Reviewing the dynamics behind the current economic crisis, Joseph Stiglitz referred to the protagonists of neo-liberalism as 'capitalist fools' (Stiglitz, 2009). Stiglitz' counter discourse – notably put forward in a magazine traditionally addressing the beneficiaries of neo liberalism – is disenchanting the ideology of neo liberalism and free market economy. At the end of the article Stiglitz presented the following revelation:

The truth is most of the individual mistakes boil down to just one: a belief that markets are self-adjusting and that the role of government should be minimal. Looking back at that belief during hearings this fall on Capitol Hill, Alan Greenspan said out loud, "I have found a flaw." Congressman Henry Waxman pushed him, responding, "In other words, you found that your view of the world, your ideology, was not right; it was not working." "Absolutely, precisely," Greenspan said." The

embrace by America—and much of the rest of the world—of this flawed economic philosophy made it inevitable that we would eventually arrive at the place we are today. (Joseph Stiglitz in Vanity Fair, January 2009)

Time will tell to which degree such counter discourses will flourish and prevail in Western societies. With respect to my research undertaking I consider marketization and discourse of marketization still to be the ruling phenomena. Looking at the vast complexity as well as the cost of today's disease management and warming to the idea of health becoming the leading code of the future (Bauch, 2000), some argue that economization and discursive marketization of medical work is likely to continue. It is particularly expected to continue in Germany where both buyers and providers of healthcare are publicly complaining about lack of information, organizational inefficiencies and an impeding sectoral opaqueness. I acknowledge that this statement is promotional discourse in its own right.

The hegemonic power of one discourse is questioned by critics like Davies & Harré (1990) who claim that different discourses will compete which each other as they create distinct and incompatible versions of reality which members of society can choose from. They clearly recognize the constitutive force of discourse and discursive practices but they also recognize that people are exercising choice in relation to those practices. In that they assume that people are exposed to various discourses in parallel and are able to compare and weigh off the competing concepts (represented through discourse) on offer.

This theory would be convincing if different discourses were equally available (dispersed) to people and if all discourses were 'pure' in the sense that they are a pure combination of speech and writing. However, it is argued by Zizek (1989) and Laclau (1990) that discourses should always be understood as a dimension of material practices, with material conditions of emergence and effectiveness (DuGay & Salaman, 1992). DuGay & Salaman underline this in their reaction to critics who doubt people's conscious identification with the aims and objectives of enterprise. They note that those who believe in people's continued attachment to the concept of equality rather than excellence simply overlook the fact that "the dominance of that discourse (i.e. discourse of enterprise) is not so much inscribed in people's consciousness as in the

practices and technologies to which they are subjected" (DuGay & Salaman, 1992, p. 630). Surprisingly, with this statement DuGay & Salaman weaken the discursive powers of meaning construction and instead strengthen the role of operational constraints. Zizek (1989) puts it more bluntly when stating that people "know very well how things really are, but still they are doing it as if they did not know" (Zizek, 1989, p. 32). In other words, they are still reproducing the discourse (e.g. of the market) through their involvement in the everyday practices within which market is inscribed.

This argumentation assumes a situation where the material practices have already progressed in one distinct (conceptual) direction and are now producing realities (in the sense of facts or constraints) that cannot be ignored. It does not assume a situation of pure deliberation where people are given the opportunity to critically compare various discourses on offer in order to position themselves. In my opinion, the latter represents a rather idealistic point of view that ignores the fact that a) there never is a state of just deliberation without practise and b) that various discourses are never equally dispersed and neutrally presented by those in power.

Leys (1990 in DuGay & Salaman, 1992) gives yet another spin to the discussion by arguing that in order for a discourse to be considered hegemonic it is not necessary for it to be loved. Instead, Leys notes, "it is merely necessary that it have no serious rival" (Leys, 1990, p. 127). If potential rivals (competing discourses) are kept out by powerful gatekeepers in form of politicians, corporate leaders, management gurus, scientists etc. a person's process of positioning is very unilaterally driven. Interestingly, this totalitarian attack on diversity and difference (DuGay & Salaman, 1992) is often not conceived of or represented as such. The consumer is imagined as an empowered human being and portrayed as the moral centre of the enterprising universe. These consumers "seeking to maximize the worth of their existence to themselves through personal acts of choice…" (DuGay & Salaman, 1992).

Irrespectively of how a personal positioning came about, also Davies & Harré acknowledge its binding powers. They realize that once having taken up a particular position as one's own a person inevitably sees the world from the vantage point of that position and in terms of the particular images, metaphors, story lines and concepts which are made relevant within the particular discursive practice in which they are

positioned (Davies & Harré, 1990). As presented earlier, it probably takes drastic events or radical system failure to shake people's ideological position.

5.2.2. *The patterning of marketised discourse*

Habermas (1984) postulates a progressive colonization of the 'lifeworld' (*Lebenswelt*) by the economy, leading to a displacement of communicative practices by 'strategic' practices, which embody a purely instrumental rationality (Fairclough, 1993). Following this thought, Fairclough identifies three interconnected developments in discursive practices. One is the need to constantly negotiate relationships and identities through dialogue. This is necessary because fixed relationships based on authority – which have been typical of traditional society – are in decline. Negotiating relationships between people and groups means negotiating differences. In context of healthcare, it can be argued that the erosion of doctors' professional autonomy and authority is requiring a renegotiation of their relationship with drug representatives. At the same time, doctor and drug rep identities are actively constructed and negotiated in everyday conversational interaction (Hall, et al., 1999). Any discursive contribution to an encounter both responds to what precedes it, and affects what follows. The sequential structures in an interaction thus provide the means by which participants jointly construct a particular social order and come to a shared interpretation of what is going on (Drew & Heritage, 1992). Importantly, it is not only the discourse between the two institutional actors that shape the respective identities but also the intra-institutional exchange, i.e. the discourse held among doctors and among drug reps respectively. Fairclough states that the discursive construction of identities is a multidimensional process. He further argues that institutional identities cannot be separated in an institutional context, but have to be regarded as mutually dependent (Fairclough, 1992). For example, it is through the construction of the drug reps' identity that medical work is shaped.

Second, a growing reflexivity within contemporary society is leading to a 'technologization' of discourse (Fairclough, 1992, 1994). Technologization implies the strategic construction and rigorous training of discursive practices with the intention to exert influence over others. This entails detailed research of existing discursive

practices, followed by a redesign of those practices according to the criteria of institutional effectiveness (Fairclough, 1993). Fairclough states that "many workers in service industries whose labour has an 'emotional' character have experienced such institutional attempts to dictate how they should interact with members of the public" (Fairclough, 1993, p. 141).

Giddens (1991) further suggests that the systematic use of knowledge about social life subsequently allows its transformation. This leads to a growing number of experts in the field of marketing, communication and social psychology. In pharmaceutical companies, sales and marketing management today are enforcing a rigid detailing guide on drug reps, specifying product messaging and dramaturgical conduct of each visit (see e.g. Oldani, 2004). In addition, all sales force members are regularly undergoing discourse training ranging from product presentation to pre-empting the physician's objection. Medical anthropologist Michael Oldani – having worked as a drug rep for nine years himself – speaks of the pharmaceutical industry's mastery in 'spin selling' or 'spin doctoring'. He notes that every objection by physicians can be turned around to become a positive selling point, something to be valued and sold for the patient's benefit (Oldani, 2004).

Third, Fairclough describes contemporary discursive practices as 'promotional' in kind. To him these are the cultural consequences of marketization and 'commodification' of all facets of social life. Promotion becomes the general communicative function (Wernick, 1991) and discourse is "a vehicle for 'selling' goods, services, organizations, ideas or people" (Fairclough, 1993, p. 141). In a knowledge-based economy, Fairclough postulates, knowledge becomes a commodity. This commodity comprises of two key elements: knowledge as actual 'know-how' and knowledge as 'know-that' discourse (Fairclough, 2002). A growing emphasis of the 'know-that' element can be observed in the various attempts to converge pharmacological know-how in a few key messages. The ultimate 'know-that' statement today is the brand, which is increasingly determining the economic success of a drug as much as the pharmaceutical company behind it (see e.g. Blackett & Harrison, 2001).

Relating it to the world of today's pharma business, I would argue, that detailing talks by drug reps are overtly promotional while the aspect of providing impartial

information or service is rather ornamental. This view was previously expressed by German health economist Rainer Rohrbacher (1988) who remarked that as long as the act of detailing – ideally through a standardized presentation routine – is driven by the drug rep and as long as this results in prescriptions the pharmaceutical industry is interested to maintain and even strengthen the drug rep - physician relation. However, should the doctor determine the content of the consultation instead and should he rather reluctantly prescribe the drug, Rohrbacher argues that the interaction becomes asymmetrical and as such loses its discursive power to influence the physician. It is not two actors any longer who contribute to the successful execution of a service. Rather it is a self-service situation by which the active doctor requests information, samples etc. on demand. Rohrbacher concludes that a relationship by which the drug rep takes on a reactive role is not in the interest of the pharmaceutical industry because it does not control the prescription process any longer. As a consequence, Rohrbacher suggests, the pharmaceutical company must alter or even discontinue the direct interaction with the doctor (Rohrbacher, 1988).

Oldani (2004) argues that drug companies increasingly revert to indirect measures to pave the way for dominant promotional discourses at the doctor's office. Many pharmaceutical companies advertise directly to patients to make them request information about a particular drug next time they enter their doctor's office. Physicians – feeling pressured to react to patients' demands – contact the respective local drug rep for detailed information. This allows the drug rep to be welcomed into the office by allegedly doing the physician a favour. Oldani conveys that this is a critical step because the opportunity arises for the drug rep to talk about other products. The doctor is compelled to return the favour and listen to the drug rep talk about these other products. Oldani accounts that "you were to hold out, if you will, on the requested information because you had the upper hand and the physician was forced to be a captive audience" (Oldani, 2004, p. 329).

To Fairclough (1999) such promotional discourse has major pathological as well as ethical implications. He foresees society's general distrust in discursive practices because of people's growing inability to recognize authenticity in communication. With reference to doctor detailing, physicians are expected to meet drug rep talk with cynical scepticism and disbelief. Furthermore, a prevailing promotional discourse is

fostering self-promotion making it become an integral part of identity. I believe that when medicine is succumbing to market ideology, the professional complex is equally seized by the notion of self-promotion.

Change towards marketization is not done by discourse alone. Marketization is not just a new discourse which is ideologically motivated and which people – after being permanently exposed to it – eventually adopt in practice. Customization, profit orientation, flexibility are real features of contemporary economies. In the second half of the 20^{th} century, the advances of knowledge, the rise in productivity, the accumulation of wealth met with people's desire to break with a predictable and standardized life. This led to a genuine structural change in the economic system, namely the move from Fordism to post-Fordism. While this is a fact which is largely supported by scientific evidence, discourse has been nevertheless an irreducible part of this becoming reality. Fairclough (1999) remarks, that the change from Fordism to post-Fordism is unthinkable without the change in economic discourse. To Fairclough the changing economy is the place of a struggle between the old and the new, and the discourse of e.g. flexibility and profitability is an important symbolic weapon in that struggle. Bourdieu (1998 in Fairclough, 1999) denotes this form of coalition a 'strong discourse', by which he means a discourse that is supported by the strength of the economic and social forces (e.g. multinational pharmaceutical companies) which are trying to make the new economic structure even more a reality than it already is. In pharmaceutical companies the new strong discourse of 'being a market driven organization' has completely replaced the old 'being a research driven organization' discourse. The new discourse is dispersed throughout the organization as set down ways of acting and interacting affecting all aspects of corporate activity, including for example internal communication, brand planning and, in particular, drug rep training. The marketised discourse is ultimately becoming part of the organization's identity. Fairclough denotes this process as the weakening of the boundaries between 'orders of discourse' (Fairclough, 2002), implying that the differences of discursive practices of the market and those for example of healthcare are gradually dissolving. The rate, at which this is happening, as noted earlier, depends on the vigour and viability of any rivalling discourse (see for example Leys, 1990; Keenoy et al., 1997).

5.2.3. The wellbeing discourse

There is in fact a rivalling discourse present in the German healthcare system. This discourse is strongly based on the medical ethics demand of 'the wellbeing of the patient' ('aegroti salus suprema lex') which frequently culminates in a 'question of life or death' talk. The 'wellbeing' discourse is strongly employed by the professional associations in their publicly aired defence against e.g. organisational or budgetary changes connected with health care reforms fostering marketization. Public buy-in is easily won as nobody would really oppose such a noble plea for life in general. The question, however, why ethical objectives like patient wellbeing cannot be pursued with the help of the economic principle remains largely unanswered by the medical community. This sparks the question whether the underlying motive behind this counter discourse is truly ethical.

In this context, Eugen Münch, the former CEO of Germany's largest private hospital group reports that in his interaction with representatives of the medical profession he has never even tried to question the ethic principle of patient wellbeing coming first. He was therefore perplexed to hear how aggressive and poisonous economization was attacked. How it was denied any reason for being, and that it was classified as a parasitic instrument of the time that destroys the future of humanity (Münch, 2005, p. 2). While such a single report may be dramatizing the representatives' reactions, it nevertheless exemplifies that there is a strong rivalling discourse in Germany that I believe is slowing down the colonization process of the medical domain by market discourses (Fairclough, 1994). For this reason any orchestrated dispersion of marketization ('market driven organisation') at the pharmaceutical company level needs to carefully differentiate between internal and external communication. While the inbound discourse is overtly marketised the outbound discourse must watchfully consider the popular 'wellbeing for patient' argument. I presume that (in Germany) the detailer's actual discourse will differ from the 'technologised' discourse he has been instructed with. In other words, the detailer is unlikely to discursively transmit his company's marketing & sales strategy. Why is that unlikely? Because the drug rep has to react on-site to a powerful counter discourse presented by a powerful counterpart that is enjoying high social prestige? Yes, maybe. It surely is a challenging task to spin the doctor. Yet with plenty of training and growing experience the detailer should be

well equipped to master this task provided that he believes in the marketised discourse altogether. It is here where I suspect conflict. As outlined earlier in the document, it is the detailer's year long exposure to representatives of a rivalling discourse that could lead to a conflict of identity.

5.3. Discourse is action

To me it seems obvious that investigating drug rep – physician encounters fundamentally implies the use of analysis of discourse. It is obvious because – and this is particularly valid in the area of service work – discourse and action are intertwined to the degree that discourse is action and action is discourse (Oswick & Keenoy, 1997). However, one regularly comes across a very different perspective that assigns discourse a subordinate role.

The ideological dominance of the economy with its focus on promotion, rationalisation and profitability has led to a privileged status of action over discourse. Oswick & Keenoy (1997) argue that in Western societies the mantra of productivity, the hymn of achieving results is predominantly associated with action and not with talk. This is indicated for example by commonplace sayings such as 'talk is cheap' or 'actions speak louder than words'. According to Oswick & Keenoy discourse is wrongly considered to be a "reflexive and passive activity while 'doing' is regarded as purposive and active action" (Oswick & Keenoy, 1997, p. 5). Furthermore, the prevailing belief is that 'discussing' and 'doing' is happening consecutively rather than concurrently. Discourse and action are regarded to be discrete activities that refer to clearly delineated domains.

This idea is still surviving in management practice, indisputable a pivotal function in the economic complex. Oswick & Keenoy point to the ignorance of discourse in traditional management theory, where management was boldly defined as the art of getting things done through people (Follett, 1941). With reference to Follett's definition Oswick & Keenoy pose the rhetorical question whether it is possible to get things done through people other than discursively. They regard discourse and discursive activity as vital elements of organisational life. They claim that discourse

and action are mutually implicated and intertwined and exemplify this with knowledge work done by e.g. lawyers, sales representatives or lecturers. "Much of the routine work and occupational activities undertaken by these actors – defending clients, selling products or giving lectures – is comprised of discursive activity; 'doing means talking'. Alternatively, their actions can be construed as 'discursive events" (Oswick & Keenoy, 1997, p. 6). As many goods today are services – and as such are dependent on the talk of those providing it – language becomes part of the service, part of the goods (Fairclough, 1999). Creating a commodity quite obviously implies action. Lyotard aptly concludes that when commodities become semioticised, discourse becomes commodified (Lyotard, 1986/7 in Fairclough, 1999).

5.4. Summary

In this chapter I have presented key perspectives on the relation between language and meaning. In particular, I have supported the view – which was initially postulated by Wittgenstein – that meaning is constituted by language, which in turn is shaped by social interaction. In other words, the way we experience the social world around us is determining the way we denote that world in discursive terms. Against this background I have argued that self-interested construction of discourse will influence the way individuals perceive the world. Thus discourse is a means of exerting power.

Further to that end, the role of discourse in mediating a market ideological perspective was discussed. Emphasis was placed on the hegemonic character of such discourse in present day Western societies. In turn, key perspectives on the patterning of marketised discourse were presented. Important in this respect, was the Faircloughian notion about the strategic construction ('technologization') and dissemination of discourse with the aim to influence others. This was related to practices of modern day drug detailing. Last not least the operational dimension of discourse was highlighted, by which discourse is regarded the central activity of organisational life (e.g. Oswick & Keenoy, 1997).

Leading over to the next chapter, I like to highlight the two notions of the term discourse in my study. From a research methodology point of view, discourse can be

seen as a source of accessing individual meaning making. Thus by e.g. listening to accounts (discourse) of drug reps I can obtain insights about their values, feelings and motivations. On a second note – in line with Fairclough's idea of discourse technologization – discourse is portrayed as an instrument for power exertion. This dual meaning of 'discourse' is vital to the concept of my research project which is – methodologically speaking – analysing discourse about discourse. In the following chapter I will describe my approach to the empirical investigation in detail.

6. Methodology

I will begin this chapter with outlining the research context which essentially is a brief summary of the previous chapters. In doing so, I will demonstrate how my research questions have emerged out of the research context. Subsequently, I will show how the overall research concept is grounded in theory before I move on to outline individual research methods and their concrete application. The order of presentation is thereby following my initial evolution of concept rather than the sequence of its actual implementation. In other words, the structure is reflecting the process of how I have initially conceptualised the empirical research. This implies, for example, to first advance the methods of data collection before concerning oneself with the approach to sampling.

6.1. Research context

The research project investigates the impact of marketised discourse in drug detailing from a physician, drug rep and also management perspective. To prepare for this context I have looked into both the medical profession and the pharmaceutical industry. Particular emphasis was placed to convey the developments and interpretations on medical professionalism in general. I have presented the cultural and sociological shaping of the profession which lead to the idealisation and extraordinary positioning of physicians in Western society. Yet we have equally learned about the various academic critiques on the implementation of medical work in practice. In this respect the accusation of self-interestedness on part of physicians was brought to the fore. At the same time, the review has displayed key factors responsible for a declining influence and autonomy of physicians. Most notable factors were the exponential growth of medical knowledge followed by rationalisation and standardisation of medical work. Thus I have provided several points of reference to profoundly assess the individual attitudes and perceptions conveyed by physicians in the empirical research part to come.

Next to introducing various theories on medical professionalism, I have provided background on the pharmaceutical industry. It became evident that the industry is

experiencing an innovative slow-down which is manifested by a large number of highly similar drugs being on the market. To compensate for its diminishing innovative return the industry has largely shifted its activities to the marketing of drugs. In this respect, we have learned that the average budget for marketing and sales is approximately twice as high as the one for research and development. The key marketing instrument is drug detailing, whereby representatives of drug companies are visiting physicians in their practices or hospital wards. We have been introduced to the origins of drug detailing as well as to the main theoretical stances with regards to the purpose and effects of drug detailing. The majority of theories support the view that drug detailing is not about informing but about promotion and selling of drugs. This view stands in contrast to the official, legally bound, job definition in Germany which strictly limits the role of drug detailing to scientific and technical informing.

In the previous chapter, I have presented theories on the role of language and discursive practices in shaping attitudes, identities and promoting change. I have further introduced ideas about the patterning and power of marketised discourse in particular. It was argued that the marketization of life in general and of healthcare specifically is to a significant degree a discursive process. Crucially, I have presented the notion of technologization of discourse – which entails the self-interested strategic construction of discourse – and related it to the promotional discourse practices of present day pharmaceutical companies.

Thus by combining existing theories on language and discourse with contextual data (e.g. on the pharmaceutical industry) I have shown that discourse is a highly relevant and critical research object in the area of drug detailing. This leads to the central aspect of my research project, which concerns the manifestation of marketised discourse in drug detailing and its impact on the attitude, identity and behaviour of those involved. In other words, I am interested to learn if and how marketised discourse is taking control of the act of detailing and what kind of responses it brings about. In answering these questions I expect to provide a better understanding of the idiosyncrasies of drug detailing discourse. Furthermore, I would like to provide a concept of how discourse is designed, implemented and received in today's detailing context. Based on these outcomes I hope to contribute to the advancement of quality and productivity in modern drug detailing.

6.2. Research questions

Following the research context outlined I will try to answer the following specific questions through empirical research:

Against the background of drug detailing in Germany

1. Is there discursive construction of marketization in drug detailing?
2. If there is marketised discourse how does it manifest in discursive terms?
3. How does such discourse impact the roles and attitudes of drug reps and physicians?

The term 'marketised discourse' is to be understood in a Faircloughian sense in that it is "a vehicle for 'selling' goods, services, organizations, ideas or people" (Fairclough, 1993, p. 141). In a drug detailing setting such discourse could e.g. expose or exaggerate certain beneficial product features while concealing others. It could mean to oversimplify the product's mechanism of action or to reduce information in order to reflect the drug's single 'benefit positioning' (Kottler, 1997). In short, marketised discourse is aimed at promoting commercial interests rather than at transferring impartial knowledge. Against the background of low product innovation marketised discourse is to advance drug sales more by means of tactical messaging than on the grounds of scientific facts.

The term 'physician' or 'doctor' refers to a medical doctor either working office-based or in a hospital setting. In Germany, the majority of office-based doctors are self employed although there is a growing trend towards salaried work to be observed (Preusker, 2008). Office-based doctors generate approximately 80% of their income through the statutory health insurance system. Continuous cost increase in that system has led to tight cost control measures induced by the government. These cost containment policies indirectly interfere with the therapeutic autonomy of physicians in that certain therapies and drugs are not (fully) reimbursed any longer. Office-based physicians are regularly visited by drug reps. High prescribing doctors receive up to seven visits by detailers per day.

Hospital physicians generally work as salaried doctors. By matter of organisational setting, hospital doctors are used to division of medical labour as well as to departmental orders and procedural guidelines. Their structural work setting thus resembles that of industrial organisations. Cost explosion and oversupply in the hospital sector have equally led to cost containment programmes. In order to increase efficiencies and therapeutic quality, medical work in hospitals today is primarily guided by evidence-based treatment policies. Hospital physicians are visited by drug reps for two reasons. First, they typically apply a lot of high value (expensive) drugs which is attractive to the industry. Second, their medication or prescription behaviour has a guiding function for office-based doctors. Thus hospital doctors are important leverage points to the industry. Formally, a hospital's drug portfolio is centrally determined by the hospital pharmacy. Yet physicians (head doctors) largely influence the listing of drugs in the hospital pharmacy.

The term 'drug rep' describes the pharmaceutical sales representative who regularly visits office-based doctors and / or hospital physicians to present drugs that require doctors' prescription to patients. Drug reps easily make up 20% of the workforce and 30-40% of the costs of a company. In Germany, drug reps come from educational backgrounds such as the natural sciences, pharmacy or nursing but also can come from a business administration environment. As by the German medicines law (*Arzneimittelgesetz*, AMG) drug reps are defined to pass on scientific and technical information to the physician and report any adverse effects caused by the drug back to the company. However, as by most sources in the literature (e.g. Rohrbacher, 1988; Greene, 2004; Oldani, 2004) as well as my own professional experiences, drug reps are seen as instruments of marketing that are employed to induce prescriptions. With 5-10 doctor visits per day drug reps spend a large part of their working lives in a medical environment. In fact they have more contact to physicians than they have to their managers and colleagues.

6.3. Theoretical framework

Having presented the project's contextual setting, subsequently it is important to relate the project to its ontological foundation. In the following I will discuss the theoretical framework the actual research is embedded in. This needs to be done in order to understand how the researcher approaches the study of social phenomena like drug rep – physician encounters. Unveiling the perspective subsequently implies to justify the criteria that guided the collection and analysis of data. The reader may altogether refuse to see the world through the investigator's lenses. In that case research findings will be ignored regardless of the methodological and argumentative rigour employed to extract them. Yet if the reader is able to see things from the researcher's perspective it largely depends to methodological relevance and consistency whether the findings will be received or not. At the same time, presenting the theoretical structure means that the researcher is conducting a plausibility check to detect and hopefully eradicate inconsistencies.

In the next section I will present the ontological base the research project is resting upon. Afterwards I will link the ontological base to the research methodologies that have been employed. The applied methodologies will be delineated before I turn to presenting the actual research process and content.

6.3.1. The ontological foundation

The world as we perceive it is our invention. (Heinz von Foerster, 1981)

My research project is based on the belief that social phenomena are socially constructed. It implies that social actors like physicians or drug representatives generate meaning about what happens in the world through their interpretation of social practices.

The interest of a social constructionist researcher is to discover how individuals and groups create their perceived reality. Importantly, differing from the radical constructivist perspective social constructionism does not believe reality to be an

individual construct of an operational closed cognitive system. Social constructionism proposes that all meaningful reality is socially constructed.

American literary theorist Stanley Fish illustrates the process of construction by emphasizing that all objects are made rather than found. In his view, they are made by institutions which 'precede us' and in which 'we are *already* embedded' and 'it is only by inhabiting them, or being inhabited by them, that we have access to the public and conventional senses they make' (Fish, 1990, p. 186 in Crotty, 2003, pp. 52-53).

Anthropologist Clifford Geertz further specifies Fish's description by simply applying it to culture. Geertz in turn defines culture as 'a system of significant symbols' and regards the meaningful symbols that constitute culture as an indispensable guide to human behaviour. Without it we would be 'unworkable monstrosities' (Geertz, 1973). Geertz underpins his view by stating that without culture human beings could not function. He argues that we depend on culture to direct our behaviour and organise our experience. Importantly, Geertz does not see culture as the result of behaviour patterns like customs, usages, traditions etc. Instead, he suggests that culture is best seen as the source rather than the result of human thought and behaviour (Geertz, 1973).

Social constructionism emphasises the hold our culture has on us: it shapes the way we see things and gives us a quite definite view of the world. Crucially, this shaping of our minds by culture is also seen critically. According to Crotty we tend to take 'the sense we make of things' to be 'the way things are'. This way, Crotty proposes, we become 'victims of the tyranny of the familiar' (Crotty, 2003). He further suggests that by stacking layers upon layers of interpretation 'we become further and further removed from those realities, our sedimented cultural meanings serving as a barrier between us and them' (Crotty, 2003, p. 59).

Social constructionism is fed from three main sources: sociology, post-modern philosophy and psychology, the latter primarily from the work of psychologist Kenneth Gergen.

In sociology the initial impulses were given by the work of Berger & Luckmann (1966) as well as by the school of symbolic interactionism. Interactionists focus on the

subjective aspects of social life, rather than on objective, macro-structural aspects of social systems. One reason for this focus is that interactionists base their theoretical perspective on their image of humans, rather than on their image of society. For interactionists, humans are pragmatic actors who must continually adjust their behaviour to the actions of other actors. Importantly, they can only adjust to them because they are able to interpret them, i.e., to denote them symbolically and treat the actions and those who perform them as symbolic objects. For interactionists

Society, conceptualized as a web of symbolic interaction, creates the person; but it is persons who through interaction create society. Thus society and person are reciprocally related in a most fundamental way: They presuppose one another in that neither exists except in relation to the other.   (Stryker & Statham, 1985, p. 314)

From post-modern philosophy (e.g. Foucault, Derrida) social constructionism has borrowed the refusal to accept the existence of an ultimate truth and that the world can be understood with the help of a few great theories ('grand narratives'). According to post-modernism the purpose of science is not about finding 'true' and rejecting 'false' theories but to portray the complexity of the world from different perspectives and allow different theories to co-exist.

The work of psychologist Kenneth Gergen was largely focussed on the role language plays in the reality construction of the individual. According to Gergen (1999, 2001) communal discourse is essential to reality construction of the individual. Communal discourse creates scripts for behaviour and thinking (inferring) based on which the individual plans, experiences and reconstructs social interactions. These communally produced scripts determine a person's role-specific behaviour. Gergen regards the linkage between communal discourse and the individual as the main focus of social constructionist research. Hence, he proposes analysis of discourse to be the key instrument for investigating this connection.

In summary, for the social constructionist the world does not present itself objectively to the observer, but is known through human experience which is essentially influenced by language (Burr, 1995). Language, in turn, emerges from social interaction within a group of people and as such reflects all the past experiences of that group.

The search for meaning in social action implies investigating its language. That is because, as Fairclough proposes 'language is a form of social practice' (Fairclough, 1989). This linguistically based practice can also be referred to as discourse. In other words, discourse is a way of constituting a particular form of social reality. By analysing discourse we can obtain an understanding of the world of meaning of social actors like physicians or drug reps.

6.4. Applied methodology

6.4.1. Introducing discourse analysis

Language and language use is ever more recognised in social and organisational research. According to Oswick, et al. (2000) the study of discourse has become one of the most important means of analysing complex organizational phenomena. Since the late 1980s there has been sharp increase in discursively based studies of organisations (e.g. Potter & Wetherell, 1987; Fairclough 1993, 1995; van Dijk, 1997; Grant, et al., 1998). Acknowledging that organisational events are discursively constructed has considerably strengthened the value of discourse studies. This development is aided by the fact that language is highly accessible for empirical investigation and that altogether social research is increasingly regarded as an empirical activity. By means of interviews or observations the social researcher can get access to a rich array of linguistic (inter)actions thereby learning how people use language as much as how language shapes people (Alvesson, 2000). Appreciating the significance and accessibility of language in that way has added to the growing interest in discourse.

Discourse analysis is grounded in a constructionist epistemology that sees language as constitutive and constructive rather than reflective and representative (Wood & Kroger, 2000). Parker defines discourse as an interrelated set of texts, and the practices of their production, dissemination, and reception, which brings an object into being (Parker, 1992 in Westwood & Clegg, 2003). In other words, social reality is produced and made real through discourses. The key task for the discourse analyst is to explore the relationship between discourse and reality. Discourses are embodied and enacted in a variety of texts which may take a variety of forms, including written texts, spoken

words, pictures, symbols, artefacts etc. However, "texts are not meaningful individually; it is only through their interconnections with other texts, the different discourses on which they draw, and the nature of their production, dissemination, and consumption that they are made meaningful" (Phillips & Hardy, 2002, p. 4). Discourse analysis is interested in the ways texts are made meaningful through these processes and also how they contribute to the constitution of social reality by making meaning (Phillips & Brown, 1993). The connection between discourses and the social reality they constitute makes discourse analysis a powerful method for studying social phenomena. That is, discourse analysis emphasizes the way versions of the world, of society, events and inner psychological worlds are produced in discourse.

Discourse analysis as a methodology had to gradually win through in the social sciences. Its assertion in the field was aided by a growing trend towards subjectivity in the post-war period. Since the 1960s the linguistic revolution had ultimately reached the social sciences. The term 'linguistic turn' – created by Bergmann (1953) and popularized by Rorty (1967) – described a new approach that broke with the traditional notion of language's representational character. Originating from the work of linguistic philosophers such as the later Wittgenstein (1953) and Austin (1962) the idea that language is constitutive of social reality became increasingly accepted. Their preparatory work strongly influenced sociologists Berger & Luckmann (1966) and anthropologists such as Geertz (1973), whose ideas in turn formed the foundation of a constructionist view of social phenomena. Subsequently, researchers in organization and management theory began to see language as important to their field. The idea, for example, that organisations are socially constructed and exist primarily in language was becoming increasingly accepted within the organisational research community.

6.4.2. What is meant by 'discourse'?

Discussing types of discourse analysis must be preceded by clarifying what is exactly meant by the term 'discourse'. This connects to the previous discussion on discourse in chapter five. However, in context of applied methodology the debate to follow has a clear definitional objective. In this section, I am essentially defining the unit of research analysis both in technical as well as qualitative terms.

The traditional outlook on discourse sees it as being a form of spoken dialogue standing in contrast to written text (Sinclair & Coulthard, 1975 in Oswick, et al., 2000). A decade later the definition was broadened by referring to discourse as a combination of spoken as well as written text (Gilbert & Mulkay, 1984; Potter & Wetherell, 1987). According to Oswick, et al. (2000) the outlining can be even further extended to include cultural artefacts such as music, art or fashion. All these definitions have in common that they are defining discourse by means of its carrying devices. Such a framework is helpful to identify and justify the technical unit of analysis. With regards to interviewing drug reps, it helps me to define whether to analyse just spoken words or also e.g. marketing brochure texts referred to during the interview. I could even go as far as analysing the interviewee's dress because – following Hodge & Kress (1988) – it is discourse in a broad sense as well.

Since the 'linguistic turn' discourse has basically become an ontological category by being regarded constitutive to social reality (e.g. Berger & Luckmann, 1966). Habermas (1988) for example vividly embraced the linguistic turn when stating: "Today the problem of language has taken the place of the traditional problem of consciousness" (Habermas 1988, p. 117). Coming from a critical theory perspective, Habermas assigns discourse a politically motivated character. He is carefully differentiating discourse from uncritical communicative action that takes place in everyday life. Discourse in the Habermasian sense describes a rather unusual form of communication in which individuals subject themselves to the force of the better argument (Crotty, 2003). Ideally, discourse is meant to achieve a universally valid normative system, constituting the basis of a more just society. From a critical perspective, discourse is seen as a vehicle for oppression – a condition in turn to be revealed by the critical inquirer – as much as a means to overcome oppressive structures through acts of untwisted communication. As such discourse is related to power.

Power is the guiding force also behind Foucault's interpretation of discourse. Discourse, according to Foucault, arranges and naturalizes the social world in a particular way, creating social practices. In turn these practices constitute particular forms of subjectivity in which individuals are managed and shaped (Foucault, 1976, 1980 in Alvesson & Karreman, 2000). Essential to Foucault's position is that practices

are systematically shaped through discourse by those in power. To Foucault, power is the ultimate principle of social reality and individuals are constituted by power relations (Sarup, 1993). Discourse is hence situated within societal relationships. Simply put, Foucault believes that power is producing reality through discourse.

I prefer to define discourse as less controlling and more in line with the reading of Phillips & Hardy (1997), drawing on Fairclough (1992) and Parker (1992), namely as concepts "through which we understand the world and relate to one another" (Phillips & Hardy 1997, p. 167 in Oswick et al., 2000). I clearly admit to the power element behind discourse. However, I feel that its effect on subjectivity is overrated by the Foucauldian school of thought. Here I am close to Alvesson & Karreman (2000) who state that reproducing a certain discourse is not automatically indicative of a specific cognition. "People may produce politically correct opinions in interviews or conversations without any particular feelings or convictions being involved (Alvesson & Karreman, 2000, p. 1132). From this perspective, discourse and meaning can be separated or only loosely coupled. Individuals must not automatically become victims of power discourses but can stay resistant. Or as Alvesson & Karreman put it: "The ways in which subjects relate to discourse may be Teflon-like; the language they are exposed to or use may not 'stick'" (2000, p. 1132). Individuals' opposition may come in various forms. Some resist openly by e.g. displaying a militant counter discourse. Others may revert to feigned adaptation practicing hypocritical talk. In any case, subjects are not always fragile and naively accessible by hegemonic discourse. Seeing them this way may ascribe too much power to discourse (Newton, 1998).

With respect to the technical unit of analysis (carrying device), in my study I like to concentrate on the spoken word as uttered during the course of qualitative interviews. This does not imply a disbelief in other vehicles presented (e.g. written text, artefacts) but simply is done to ensure operational focus.

6.4.3. Types of discourse analysis

There are various forms of discourse analysis differing primarily by theoretical assumptions that underpin the empirical work and that produce different styles of

research. Phillips and Ravasi (1998) have developed a framework (Figure 3) which provides a tool for understanding the diversity of theoretical approaches. The framework categorizes these differences according to two key dimensions: the degree to which the emphasis lies on individual texts or on the surrounding context and the degree to which the research focuses on power and ideology as opposed to processes of social construction (Phillips & Hardy, 2002).

The vertical axis in Figure 3 below shows the continuum between text and context. The text – or proximate context as Schegloff (1992) calls it – refers to the immediate features of an interaction like the sort of occasion or the capacities in which people speak. The context – or distal context (Schegloff) – includes things like social class, ethnic composition of participants or institutions or sites where discourse occurs. The horizontal axis of Figure 3 reflects the choice between constructivist approaches that produce detailed explorations of the way in which a particular social reality has been constructed, and critical approaches which focus more explicitly on the dynamics of power, knowledge and ideology that surround discursive processes.
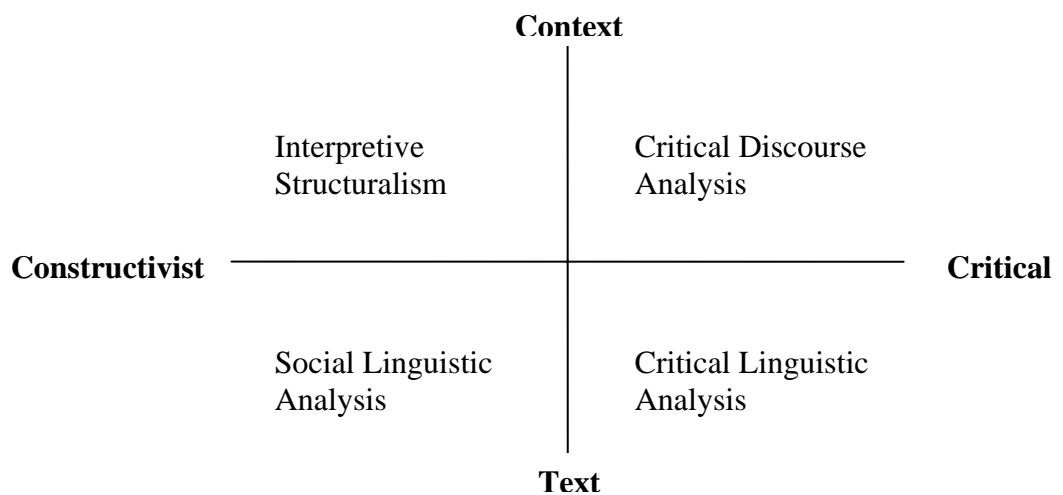
Phillips & Ravasi (1998)

Figure 3:   <u>Different approaches to discourse analysis</u>

Which type of discourse analysis is most applicable to address the actual research questions? To recapitulate: I wish to understand how presumably 'marketised' discursive practices during the detailing encounter are perceived by each party and how this perception (meaning construction) impacts role conceptions and attitudes. Therefore I am looking at discourse as social context rather than focusing on the text per se, which would imply treating the material as if existing in a contextual vacuum (Keenoy, et al., 1997). Conceptually this means analysing discourse about discourse. In doing so, I spark and interpret subjects' reflexive thinking on social systems, in line with Luhmann's prominent notion of 'communication about communication' (Luhmann, 1995, p. 450).

My central research task is to investigate how the context of marketization, both as a factual development and as discursive practice, is cognitively translated and reacted to by drug reps and physicians. Hence, the type of analysis is primarily interpretive in kind because it is concerned with interpreting how context is interpreted. In using the term 'interpreting' instead of e.g. 'extracting' I acknowledge the fact that from a social constructionist perspective the notion of objectivity in respect to reading accounts does not exist.

In chapter five the phenomenon of marketization of discourse was frequently looked at from a critical discourse perspective (e.g. Fairclough). By highlighting the power-laden aspect of such discourse I have set the scene for the actual research project. Clearly, I am of the opinion that marketised or promotional discourse is about one group trying to exert influence over another. At the same time I have made the point that although power interests are discursively spread they do not necessarily have to win through. In that sense I am following the critical perspective only to the extent to which it keeps acknowledging subjects' capacity for resilience. I am not prepared to view discourse simply through the lenses of latent oppression. My analysis of discourse therefore is equally about interpreting respondents' world views as it is about deciphering power games or revealing acts of oppression. With reference to the framework given by Phillips & Ravasi (Figure 3, p. 95), I would position my approach to discourse analysis as being contextual, interpretive and critical. As such my approach is overarching in kind and is not analysing discourse by means of a single specific method (e.g. via

critical discourse analysis). Hence, I prefer to call my method 'analysis of discourse' instead of 'discourse analysis'.

The matrix by Phillips & Ravasi is just one way of looking at types of discourse analysis. Aggregated at the level of methodology, I would argue that it is mainly helpful as a means of general positioning one's approach. It is not able to display, for example, the various relational options existing between discourses and meaning. It also does not sufficiently account for the distance the analysis is done from. Is discourse understood as being highly local or rather seen as an overarching grand story? All this can not be explained using the matrix of Phillips & Ravasi.

A more precise and augmented proposal for pinpointing one's analytic approach is presented by Alvesson & Karreman (2000). Their matrix (Figure 4) allows us to set the adhesive strength between discourse and meaning as well as the focal distance of analytic relevance.

Close-range interest
(local-situational context)
MYOPIC

Discourse
Determination
MUSCULAR
(discourse/meaning
collapsed)

Discourse autonomy
TRANSIENT
(discourse/meaning
unrelated)

GRANDIOSE
Long-range interest
(macro-system context)
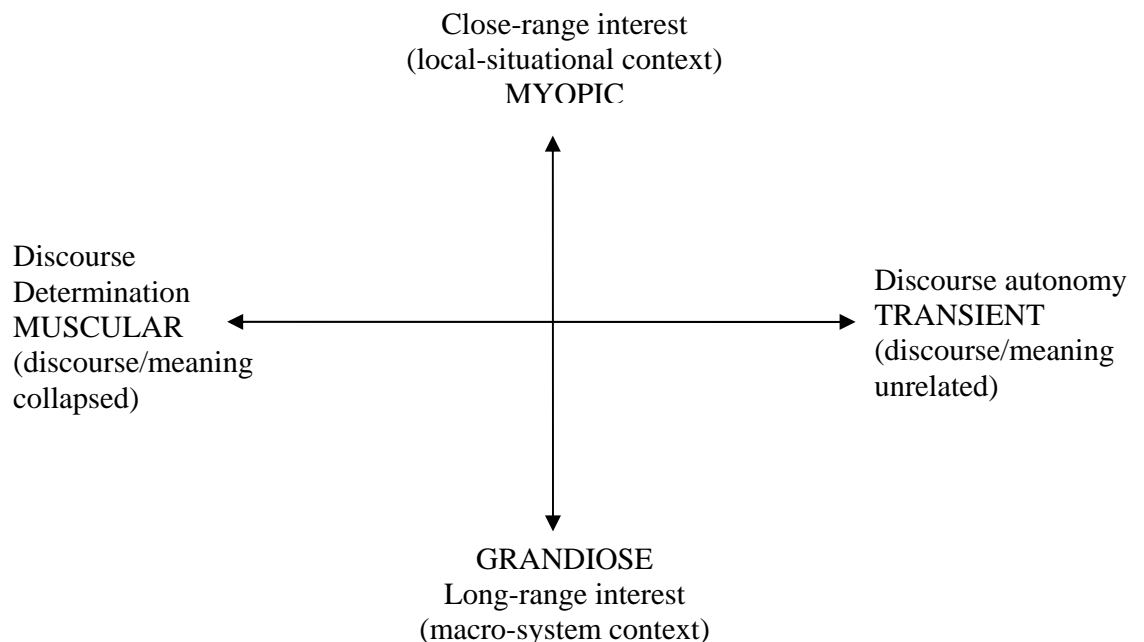
Alvesson & Karreman (2000)

Figure 4:   Matrix for the analysis of discourse studies

On the horizontal axis the association between discourse and meaning is defined. The relationship between discourse and meaning can be viewed as inseparable or strictly overlapping. It can be thought of as coupling, ranging from tight to loose, or it can be understood as nearly uncoupled. The various options refer to the degree by which one imagines discourse has an impact on a subject's meaning constitution. If the researcher is expecting discourse to significantly drive subjectivity (feelings, thoughts, orientations) he will assign his study a 'muscular' character. However, he could equally assume that the discourse under investigation will have a rather weak cognitive impact. Consequently, he would assign his study a 'transient' note. This relates to my earlier point of power-laden discourse being resisted to by some individuals. Should I adhere to an 'a priori' belief that promotional discourse is significantly manipulating physicians' subjectivity (e.g. their conception of a particular drug or treatment), I would, according to Alvesson & Karreman's model, follow a strong 'muscular' approach to analysis of discourse. Now that I prefer to assume that promotional discourse will not necessarily 'stick' with every physician, my approach will rest on a more loosely conceived coupling of discourse and meaning.

The second dimension determines the formative range a particular discourse and its analysis will have. At one end stands the analysis at the micro level. Emphasis is placed on local and situational context. Discourse in this context is regarded to have a very specific, almost unique character. From a methodological point of view the degree of transferability to other contexts is rated low. Due to the highly specific nature of the discourse, its predictability with respect to the interpretive outcome is likely to be low as well. Narrow range approaches thus tend to be less 'a priori' and more 'emergent' in style. Detailed analysis of discourse at a particular practice in connection with a patient specific event (e.g. mistreatment) would be exemplary for the 'myopic' type of analysis. The close range investigator would be interested to carve out the details of the particular situation but would not primarily assume the discursive event to be typical.

At the other end, discourse is assumed to have a broad, almost universal relevance. The same or similar discourse is expected to appear at many incidents and sites, thus being common in type. Empirical material will be treated in a standardized way, looking for

similarities rather than differences. Researchers analysing discourse from this perspective aim to link the variations at the local levels, assembling them under an over-arching theme. According to Alvesson & Karreman (2000) followers of this approach tend to start from a well established 'a priori' understanding of the phenomenon in question. I would assume that promotional talk is widely spread across practices & clinics. Subsequently, I expect the underlying concept of marketization to be conceived in a similar manner by the respondents. Having a macro-system interest, I would locate my analytic approach more towards the 'grandiose' pole of the scale.

Following a broad-range analytical approach has certain drawbacks. When entering the research with firm conceptions one risks to prematurely allocating the empirical material to one or the other grand discourse. Feeling almost relieved when recognizing one's 'a priori' patterning in the material, one sometimes fails to look more precisely. Gross categorization thus threats a variant interpretation of discourses. Let me illustrate this using an example borrowed from Fournier's (1998, in Alevesson & Karreman, 2000) study of career discourse, now translated to drug detailing: seeing drug reps' accounts about marketization only through the dichotomous patterning of e.g. affectedness vs. unaffectedness may suppress other motives. A drug rep may present himself as being morally righteous by adhering to scientific objectivity in his detailing talks. While this can be read as resilience to immoral power interests, on closer examination it could be interpreted as the respondent's frustration for not having advanced to the management ranks. Alternatively, it could be seen as simply currying favour with the interviewer. In Fournier's study, for example, one respondent was suspected of having been critical of management's immoral conduct, simply because he wanted to support the interviewer's presumably anti-managerial position.

All this is not saying that discourse analysis should be done by constantly changing the scope of investigation (e.g. iteratively moving between broad and situational level) in an attempt not to miss any interpretative variations. No, because such flexible approach would probably miss the analytical objectives & benefits of either school. It rather is a reminder to the long-range analyst to occasionally keep a watchful eye on the local or situational context.

Alvesson & Karreman's matrix to me is a methodological compass as much as an invitation for discourse analytical precision. In particular it is reminding the macro-level researcher to remain sensitive to language. Importantly, the authors point to the risk of 'jumping over' language in the course of making broad statements about discourse. Therefore, any researcher's attempt to impose a discursive framework should be checked against not running counter to the very idea of discourse studies. Alvesson & Karreman's warning is not about theoretical purity but about conceptual applicability and thus about effectiveness. Hence, the authors conclude:

> *In many cases, employing this label* (**discourse**) *does not add anything new and simply brings confusion to the study of topics that can be addressed through the use of other, although perhaps less fashionable, concepts like, for example, ideology.*
>
> (Alvesson & Karreman, 2000, p. 1145)

6.5. Data collection

The term data collection may sound like a technical and plain exercise that either precedes or follows the critical process of conceptualisation and evaluation. While this might be true for some projects, it does not apply in my research case. In a qualitative study like mine which philosophically rests on a constructionist perspective data collection is a central task. In contrast to counting events or measuring objects, data in constructionist qualitative research is hardly sizeable in a positivistic reading. This is because relevant data is seen as being individually constructed, none being objective or absolutely or truly generalizable (Crotty, 2003). From this perspective, how does one seize something for which no agreed measure exists? It requires to say goodbye to the notion of measuring and instead to embrace the concept of ascertaining meaning. Thus collecting data in a constructionist fashion necessitates provoking representations of individual meaning-making. In bringing about traces of personal sense making the researcher tries to burst through cognitive shells of habituation, fear, vein or cultural scripting. Sometimes the armour cannot be overcome, sometimes the shell is found to be empty. Yet even in these cases, the resulting data can still provide valuable knowledge to the constructionist inquirer. However, if such data is simply the product

of poor 'collecting' skills, its research value immediately drops to zero. Data collection is therefore a crucial part of my project which needs extensive preparatory dealing.

My empirical research is concerned with accessing individual meaning-making about discursive practices in drug detailing. In that I wish to understand how physicians, drug reps and managers perceive, value and respond to the discourse that they are experiencing. Based on the existing literature as well as my own work experience, I assume that discourse is heavily marketised which means that it is strategically shaped – in line with Fairclough's notion of technologization of discourse – to serve the commercial interest of the industry. With my research I like to obtain the protagonists' views with regards to that assumption of mine. Further to that point, I wish to get their perceptions on the idiosyncrasies of marketised discourse. Central to my research endeavour, I wish to understand how this discourse is impacting their role perceptions and attitudes. In order to do that I need to learn how they make sense of their worlds in discursive terms. As such I am interested to analyse discourse about marketised discourse. In the previous part I have already provided my project specific definition of discourse, namely the traditional outlook on discourse as 'spoken dialogue'. Given that definition I regard qualitative interviewing as a suitable method for data collection. In the following, I will present and discuss this method. Subsequently, I will address the crucial matter of sampling, introducing the chosen methodology as much as its specific application in the research. I begin with outlining the method of qualitative interviewing.

6.5.1. Qualitative interviewing

> **The interviewer wanders along with the local inhabitants, asks questions that lead the subject to tell their own stories of the lived world, and converses with him in the original Latin meaning of conversation as 'wandering together with'.**
>
> (Kvale, 1996, p. 4)

On a general note, in qualitative interviewing the researcher wants rich, detailed answers and is highly interested in the interviewee's point of view. He wants to obtain

insights into what the interviewee sees as relevant and important. As a result qualitative interviewing tends to be flexible, responding to the direction in which respondents take the interview and perhaps even adjusting the emphasis in the research as a result of significant issues that emerge in the course of the interviews. In contrast, interviewing in quantitative research is highly structured to maximize reliability and validity of measurement of key concepts (Bryman, 2004). A set of clearly defined questions is put to the respondents because the investigator wants to test a pre-conceived theory or seeks objective explanation for a particular occurrence. Structured interviewing is a method reflecting a positivistic position.

In qualitative interviewing the respondents are seen as active meaning-makers and not as reactive sources from which investigators can retrieve information. The aim of qualitative interviewing is to gain interpretations – but not to discover facts or laws – from respondents' talk. It is all about understanding the meaning of respondents' experiences and life worlds (Warren, 2002). Likely to come from a social constructionist stance the qualitative interviewer expects to obtain a broad spectrum of perspectives. To Warren broadness of perspectives is not only looked for across the total set of participants but also within a single interview. He exemplifies his point by noting that "during an interview, the perspective of the respondent may shift from one standpoint in her experience to another, as she speaks, say, as a former child, then as mother, as a care-giver, then as an employee, or even as one that watches the local news" (Warren, 2002, p. 84). I have equally found this kind of multiplicity in my interviews with drug reps and physicians. Office-based doctors, for example, never just argued as medical experts but also, for example, as employers or as tax payers. Drug reps sometimes spoke as fellow-scientists, as employees, as patients or as friends of the doctor.

The qualitative researcher's acknowledgement of what Luff (1999) called 'fractured subjectivities' must be further extended to his own person. Warren (2002) basing his argument on Luff's notion remarks that both researchers and respondents do not speak from stable and coherent positions but from varied perspectives. Reflecting on my role during interviewing I remember that my own position frequently changed during the interview. I conducted the interview partly as a social researcher, then again as a patient and at other times as a former industry manager.

Qualitative interviewing needs to be differentiated from ethnographic fieldwork like observation in that it provides a different angle of looking at the world. Warren (2002) comments that ethnography's lens of looking at the world is that of 'lived experiences' that are set in an 'eternal present'. Warren sets it apart from qualitative interviewing by stating: "The lens of the intensive interview is verbal – what people say and mean – but its temporal range is biographical extending into the past and the future" (Warren, 2002, p. 85).

Once qualitative interviewing has been selected as the method, the actual course of action according to Kvale (1996) is a systematic process that encompasses seven stages: thematising, designing, interviewing, transcribing, analysing, verifying and reporting. I will address the first four stages within the scope of this section.

Thematising implies narrowing down on the topic of interest and checking if interviewing as a method is appropriate with respect to research objectives. In my study, for example, I wish to understand how physicians, drug reps and managers make meaning of their working environments. Crucially, I like to get their readings of the phenomenon of promotional discourse and gain perspectives on how this discursive practice impacts their role conceptions. Given the sense-provoking properties of the qualitative interview method, these research objectives are most likely to be met.

Warren (2002) remarks, that the qualitative researcher resting on a constructionist position naturally is sceptical of rigid design structures. In this context I like to point out the difference between completely unstructured and semi-structured approaches to interviewing. Burgess (1984) compared unstructured interviewing to a conversation where the interviewer poses a single question or prompt and lets the respondent answer freely, with the interviewer only following up on topics of relevance. Bryman adds that unstructured interviewing is preferred by researchers who embark from a rather general research idea.

Investigators, who already have a fairly clear focus in mind, choose to conduct their interviews along a semi-structured framework of questions and prompts (Bryman, 2004). Right from the outset I had a reasonably clear conception of the

phenomenological arena I wanted to investigate. Given that I was able to articulate key themes rather precisely, a semi-structured design became most suitable to my project. Further to defining research focus, comes the aspect of comparability. Bryman (2004) notes that those researchers who, like myself, are doing multiple-case study research will prefer to have some structure in order to ensure cross-case comparability.

Last not least the notion of interview design also applies to quite practical concerns like the time available to finish the study, access to respondents and the associated financial cost (Rubin & Rubin, 1995). With altogether one year, the time available for empirical work has been sufficient to allow for some considerable number and variety in cases. Having worked in the pharmaceutical industry in Germany for some years has helped me to gain access to doctors, drug reps and managers. Access was won through existing contacts, recommendation and word of mouth. My current status as an independent consultant has helped to avoid any conflict of interest as it sometimes happens when researchers study their own organisations. Financial aspects did not discriminate the research design as interviewing resulted only in minor expenses for travel as well as purchasing professional recording equipment. No gratifications were demanded by or given to respondents.

The actual interviewing provides a social context in its own right that the qualitative researcher needs to make use of (Warren, 2002). Generally speaking, if subjects have agreed to be interviewed it is to be expected that they are willing to give insights about their views and experiences. Rubin & Rubin remarked that "people like to talk about themselves: they enjoy the sociability of a long discussion and are pleased that people are interested in them…" (Rubin & Rubin, 1995, p. 103). Yet Warren (2002) explains that respondents are always situated in the present moment with anticipatory notions what an interview might entail. The respondent's reaction to the actual social context of the interview may at times be surprising the interviewer. The qualitative interviewer, Warren argues, "must treat the unfolding social contexts of the interview as data, not as something that, under ideal conditions, can be eliminated from the interview process" (Warren, 2002, p. 91).

Audio or video recording of the interview will affect the respondent to a certain degree. Bryman notes that recording may disturb respondents, who become too self conscious

or alarmed at the prospect of their words being preserved (Bryman, 2004, p. 330). Warren reports about respondents continuing to speak once the recorder has been switched off. Interviewees apparently do this either because they wish to speak about a topic of their own interest or because they do not want to address a subject 'on the record' that they rate to be potentially harmful to them (Warren, 2002). During my field work all but one interview had been audio taped. One respondent cited confidentiality as a reason for not wanting to be audio-taped. At several occasions respondents continued to reveal insights relevant to the topic after the recording device was turned off. On one occasion, from the very moment the recorder was switched off the respondent switched to a personal accounts mode while before he had reported from a rather distant general perspective typical of 'cultural scripting' (Alvesson, 2003).

6.5.2. A critical outlook on interviewing

Interviews and the process of interviewing are commonly looked at from a rather technical perspective. The very notion of interviews being a useful empirical method is seldom questioned. According to Alvesson (2003) this is symptomatic of a traditional belief that knowledge can be produced from interviewing. This conception is not restricted to a particular school of thought. From a positivistic stance, for example, researchers expect interviews to generate facts about a particular situation or object being 'out there'. Contrary to this, social constructionists, rejecting the notion of an objective truth, aim to uncover the individual's inner world of meaning-making. Despite their fundamental differences, representatives of both ontological schools believe that access to respondents' knowledge – whether perceived as being 'objective' or 'subjective' in kind – is essentially a question of procedural rigour or adaptive refinement. By means of e.g. standardized questions, repeated interviewing or alternating inquirers, positivists try to minimize researcher influence and other sources of bias. The social constructionist researcher on the other hand, wants to establish an atmosphere of trust between him and the interviewee, getting as close to a 'natural' conversation as possible. In pursuit of this goal it is suggested (e.g. by Fontana & Frey, 1994) to strip the interview situation of any asymmetric features, for example, by encouraging the interviewer to voice his personal opinion. This way the respondents

are thought to convey their emotions more freely, contributing to the richness and authenticity of the interview data. Altogether, interviews are seen as a productive source of empirical research.

This position is challenged by a stance that conceptualises interviewing simply as an empirical situation in its own right. Interviews are not regarded to be any different from other local, situational events like serving customers or talking to the neighbour. In his paper on interviews in organizational research, Alvesson (2003) has termed this outlook on interviews 'localism'. Key to this perspective is the belief that an interview can be studied as an empirical event, yet it should not be treated as a tool for collecting data on something existing outside this particular event (Alvesson, 2003, p. 16). From a localist point of view, respondents are doubted to reveal their inner worlds because in a compulsive desire to give morally adequate accounts they are bound to a culturally pre-patterned discourse. The interviewee is thus preoccupied to establish a functioning micro-order rather than providing the researcher with productive accounts. Negatively phrased, localists see respondents as fragile and opportunistic subjects. On a more favourable note, one could argue that the interplay between researcher and respondent, potentially affected by complex issues like gender, age, professional background or appearances, is believed to put heavy imprints on the accounts. So to avoid that a culturally charged situation like this will gloss over any traces of subjective reality, localists prefer to draw on naturally occurring interaction for their empirical studies (Alvesson, 2003). Altogether, I rate this outlook on interviews as one-sided and over-critical because it disqualifies respondents from having any independent judgement and moral rectitude.

Partly in response to the radical view of the localist school, Alvesson (2003) is suggesting an alternative way of dealing with interview data. Although being less confident about the knowledge production qualities of interviews, Alvesson does not wish to discard the method altogether. Instead, he is advocating a multifarious challenge based on cross-checking accounts with interview context. This concept termed 'reflexive approach' shall be briefly outlined as it is an impetus for more thoroughly contemplating on interview data. To directly connect the model to my research context, I will illustrate it using key observations made during the interviews.

According to Alvesson's model the investigator using interviews should be aware of eight types of perturbations (e.g. disturbances to a system; see Varela (1974) potentially affecting the knowledge-producing interview 'system'. The first disturbance concerns the issue of complex interpersonal relations (interviewer vs. interviewee) leading to staged behaviour on part of the respondent. To give an example with reference to the actual research project: my professional background as a consultant had one respondent mistake me for a management spy. Although the issue could be solved during the event, clearly for a while it had reduced his willingness to offer criticism.

A second type of irritation relates to the problem of misinterpretation. People may simply assume the research to have a different objective, subsequently addressing themes in line with that objective. For example, one respondent kept presenting the technical details of various marketing plans without referring to the topic of language use. My direct questions regarding the mode of discursive presentation were just used as plugs for further elaboration on the programme's technical structure. Obviously, the key word 'marketization' or 'commercialisation' has led the subject to conclude that the study is about improving drug marketing skills.

The third type relates to the previously presented point by Warren (2002) regarding the multiplicity of identities displayed during the interview. In line with Warren, Alvesson highlights the need to account for participants changing their identities, hence arguing from different perspectives in the same interview. In my study, I observed that e.g. doctors were arguing from changing perspectives such as physicians, tax payers or employers.

Interferences caused by 'cultural scripting' is a further issue to watch out for. Cultural scripts are strong discourses prevailing in a particular social system like an organisation or a professional group. According to Alvesson there is normative pressure on individuals to reproduce stories that have been institutionalized within the system. The 'physicians earn little money' story is symptomatic of a cultural script that is relentlessly reproduced by physicians although there is plenty of evidence (e.g. Destatis, 2009) that it is not in line with their actual income situation. 'Moral storytelling' is equally a perturbation to the knowledge-producing interview system. It

occurs because interviewees like to give a good impression of themselves. What makes a good impression, of course, is a highly relative matter. In organisational context, Alvesson points to the key virtues of rationality (efficiency) and morality. Let us stay with 'morality' and translate it to the simplistic claim of 'being honest'. Related to Goffman's (1959) concept of impression management, in social interaction it is not so much about being honest but rather about presenting oneself as honest. Drug reps' accounts about their striving to inform the physician objectively should thus not enter my findings without scrutiny.

Another disturbance may be inflicted on the interview because interviewees are acting politically. It entails that subjects are following a certain agenda when confiding themselves to the interviewer. For example, accounts may be given with the intent to communicate certain issues to management (Parker, 2000). Managers, who by nature of their task have to balance a large array of different interests, will almost habitually revert to a discourse characterized by political manoeuvring (Jackall, 1988 in Alvesson, 2003). In my study this effect was indicated by one respondent in management function, who (at times) was giving an ostentatiously balanced account of drug promotion.

In the process of linguistically constructing an account the respondent risks glossing over relevant knowledge. That is because according to some (e.g. Potter & Wetherell, 1987) language has a forward-oriented purpose. In crafting discourse people want to achieve something. However, purpose-orientation has already been covered in terms of interviewees 'acting politically' and 'making impressions'. Thus I like to give it a different spin, by arguing that at the very least respondents wish to produce comprehensible and credible accounts. This is easier said than done, in particular when subjects have embarked to deliberate on rather complex matters. Eventually, the crafting of a story will be driven by the desire to sound coherent rather than to transfer content. Thus in an attempt to 'bring home' the story people may cut corners by e.g. reverting to catchphrases and scripts.

Last not least, influences may come from the forming powers of discourse. It essentially relates to the Foucauldian critical theory perspective which sees discourse constituting subjects. From this perspective the respondent is shaped by the situational

discourse permeating him. Alvesson states: "It is not the knowing subject but language that takes the upper hand" (Alvesson, 2003, p. 23). In other words, during the interview, strong discourses are working on the subject to influence his conception of a particular theme in an unforeseen way.

Many of the perturbations introduced are somewhat sparked by the presence and discursive actions of the interviewer. Alvesson is addressing the concerns of the localist perspective but with a different conclusion: to use the cognitions about potential perturbations as a means to improve the interviewing as well as the analysis of data. Quite practically, it is suggested that the investigator should immediately challenge any irritations he notices during the interview. In case of cultural scripting, for example, the interviewer may ask the respondent to elaborate on the topic in other words, thus forcing him to leave the beaten path. Should this not lead an immediate improvement, the interviewer could re-address the issue at a later stage, preferably using a different entry-point.

In terms of data analysis, the investigator should be prepared to evaluate material more carefully, looking e.g. for situational clues during other parts of the interviews. In my view, particular scrutiny should be demanded with those findings that seem to perfectly match the researcher 'a priori' beliefs. In some cases, re-evaluation of the research findings may even trigger a revised approach to the research topic. Thematically, this could imply a re-phrasing of the research questions. Methodological, this could mean shifting some empirical focus away from the interviews and towards other forms of empirical inquiry. Observations, for example, would relieve the field work of its heavy relational burden.

6.5.3. The interview guide

Building on the discussion in the previous sections I now like to examine the interview guide. The interview guide is meant to gently escort the respondents along the lines defined by the overall research question. It can be a brief list of memory prompts or – like in the actual research case – a more structured list of questions to be asked in qualitative interviewing (Bryman 2004). I felt that a pre-set form of guidance is very

helpful to deal with e.g. lethargic candidates who provided too little cues for the interviewer to proceed from. It was equally helpful to lead back those respondents who have wandered way beyond the scope of the research subject. In any case, the interview guide has been an organisational but also a psychological support in sometimes odd or stressful interview situations. The reassurance provided by the guide also helped to flexibly incorporate new routes of stories the respondents went along.

The type of questions asked during the interview largely reflect the typology of Charmaz (2002) that distinguishes between initial open-ended questions (e.g. 'what has changed in your working environment?'), intermediate (e.g. 'how would you describe typical drug rep talk?') and ending questions (e.g. 'what would you change to improve communication with doctors?'). The three types of questions have appeared across the thematic sections of the interview whereby the intermediate type has been employed most frequently. Altogether questions were posed to derive different types of data in line with Kvale's (1996) typology namely about values, beliefs, behaviours, roles, relationships, places, emotions, encounters, stories.

The interviews were all conducted in German language roughly following a cohort-specific interview guide (see Appendix 1-3, pp. 231-236). All interviews were thematically structured to cover the following areas:

A) Situational background

The key element of this section is to gain access to respondents' experiences and attitudes regarding their working environment. This introductory part is concerned with gaining situational insights before the backdrop of key developments discussed in the literature. At one end, it entails reflecting on the notion of physicians' power and autonomy loss. At the other end, it evaluates the strong emphasis on marketing within the pharmaceutical industry.

B) Detailing visit

The second part focuses on the actual drug detailing encounter. Attention is placed on obtaining respondents' views regarding process and contents of the visit as well as on the changes experienced over time. This is to gain an understanding of the specific situational context of drug detailing in Germany. Crucially, respondents are asked to

comment on their motivations, roles and on any role shifts observed over time. Thus accounts can be related to existing perspectives on purpose and effects of drug detailing as presented in the literature review.

C) Detailing discourse

In this central section of the interview, subjects are to reflect specifically on the discursive practices employed during the detailing encounter, which includes the description and evaluation of discourse. This part informs about the construction and perception of detailing talk before the background of theories on marketization and technologization of discourse presented earlier.

D) Responses to detailing discourse

The final part of the interview is concerned with the subjects' behavioural responses to the discourse they are experiencing. Factually and dramaturgically this section is intertwined with the previous one. It is to gain insight about how drug reps and physicians react on presumably marketised discourse, given the negative reactions (by physicians) towards detailing confirmed by existing studies. Importantly, this and all other sections are to shed light on drug reps' attitudes and behaviour which have not been investigated before.

The interview typically ends with an invitation to bring forward any suggestions for communicative improvement in drug detailing.

Table 3 on the next page illustrates how research questions, interview questions and themes previously discussed in the literature review are corresponding. For the purpose of clarity, the interview questions listed in the table exemplify only core questions asked during the interviews. As a matter of course, the open and flexible character of qualitative interviewing allowed for a variable set of associated questions that are not included in the table. For an overview of additional interview questions put to drug reps, physicians and managers please see the respective interview guides in Appendix 1-3 (pp. 231-236).

Table 3: Integration of research questions, interview questions & literature

Research question 1: Is marketised discourse really happening during drug rep vs. physician interaction?	
Interview questions (examples)	*Corresponding themes discussed in literature review*
What have been key changes in your work environment over the past 10-20 years?	**Medical profession to counterbalance market economy** (e.g. Parsons, 1951; Freidson 1994, 2001) **Loss of professional power** (e.g. Haug, 1973; Mc Kinlay & Arches, 1985; Hoff, 2001, 2003)
How has the detailing visit changed over time?	**Focus on marketing and promotion in detailing** (e.g. Strang, et al., 1996; Lexchin, 1997; Greene, 2004; Oldani, 2004)
Have you noticed any changes in the detailing discourse employed?	**Marketization of discourse** (e.g. DuGay & Salaman, 1992; Fairclough, 1993, 1999, 2002; Keenoy, et al., 1997)
Research question 2: If there is marketised discourse, how does it manifest in discursive terms?	
Interview questions (examples)	*Corresponding themes discussed in literature review*
How would you describe the discourse of drug reps today? Could you name any typical features of that discourse?	**Technologization of discourse** (Fairclough, 1992, 1994) **Promotion is the general communicative function** (e.g. Wernick, 1991; Fairclough, 1993; Oldani, 2004) **Action-orientation of discourse** (e.g. Oswick & Keenoy, 1997)
Research question 3: How does such discourse impact the roles and attitudes of drug reps and physicians?	
Interview questions (examples)	*Corresponding themes discussed in literature review*
How do you rate this kind of discourse? How do you judge the role of drug reps?	**Manipulation of physicians** (e.g. Hemminki, 1977; Avorn, et al., 1982; Rohrbacher, 1988; Cleary, 1992; Strang, et al., 1996; Steinman, et al., 2006, 2007)
How is your reaction to these discursive practices?	**Distrust in (detailing) discourse** (e.g. Lagace, et al., 1992; Poirier, 1994; Lexchin, 1997 Fairclough, 1999)

6.5.4. Transcribing the interview data

Transcribing the interviews is not only providing the actual base for analysis but equally brings along the chance for a first in-depth analysis. Despite being a tedious, lengthy and at times monotonous endeavour it gave me the opportunity to screen the data at the single word level. This means paying attention to language as proposed by Alvesson & Karreman (2000) in the previous discussion on discourse analysis (see section 6.4.3., p. 94). I like to compare the task of transcribing to cleaning a house or a car whereby cleaning is always coupled with inspection. Particular attention must be paid to avoid transcribing errors which can significantly alter meaning (see Poland, 1995). Caution does not only refer to a word changing its meaning due to its misspelling. Words may also be wrongly referenced to, particularly during lengthy expert accounts where the speaker patently assumes the auditor's equal understanding of the subject. For example, at one point I have referenced the term 'they' to drug reps when later I discovered it could only have meant 'patients'. It is a borderline case though, because it relates to the issue of individual meaning-making. That is not what I like to address here. I am not referring to interpretational differences caused by differences in meaning construction. Instead I am pointing to the risk of inaccurately translating data due to informational shortage.

In terms of when to transcribe I am following Lofland & Lofland (1995) who recommend to transcribe at an ongoing basis and not to wait until all interviews have been completed. While Lofland & Lofland see it primarily from a motivational aspect, Bryman (2004) argues that ongoing transcribing allows the investigator to incorporate emerging themes into later interviews. I took advantage of that by including e.g. the emerging topic of 'drug reps' solidarity with physician' into the interviews. Likewise, I took emphasis away from such themes that showed to be little relevant to the respondents. After about 20 interviews I was progressively approaching theoretical saturation (Strauss & Corbin, 1998). In this context, theoretical saturation describes the point were no new concept or themes emerge from the data. Consequently, in the last phase I reverted to transcribing only those parts of the accounts that provided new insights to the matter.

6.5.5. Sampling of physicians, drug reps and managers

As previously presented, data has been obtained via qualitative interviewing. To begin with, I like to illustrate how the interviewees were selected. At the start of each sampling process stands the definition of the target population (Wilmot, 2005). In the actual case the initial target population have been physicians and drug representatives working in Germany. To proceed from the target population to the sample population the researcher needs to define what characteristics will have to be reflected in the sample to properly address the research question. For the doctor and drug rep interviews respondents were recruited to fulfil the aim of the study, namely to obtain doctors' and drug reps' perspectives on drug detailing. Furthermore, to get doctors' and drug reps' perception regarding the impact of marketised discursive practices on their attitudes, roles and behaviours.

The criteria for sample selection were specified the following way:

Drug Reps:
- Detailing prescription drugs (ethical drugs)
- Visiting office-based or hospital physicians in Germany for at least ten years

Physicians:
- Office-based or hospital physicians in Germany of any speciality
- Receiving drug reps on a regular basis for at least five years

The above stated sample selection criteria were chosen to recruit doctors and drug reps with substantial detailing experience which allowed them to account for contextual variety and change. Drug reps must detail prescription drugs and have been exposed to marketing-driven strategies in order to be able to reflect on the contrast between scientific information and sales promotion as outlined in the literature review. In other words, drug reps have to experience a marketised environment in order to react to it. This sample validity test was applied 'post selection', namely during the interview itself. All candidates showed to have had exposure to marketing-driven strategies. Office-based as well as hospital doctors were recruited to ensure contextual variety knowing that both types are strongly interacting with drug reps. Given the different

work settings of hospital and office-based doctors I presumed the two physician types to display different attitudes with regards to drug detailing. Physicians' previous exposure to marketing-driven business conduct was guaranteed by the many different drug reps (companies) they were receiving.

Based on the selection criteria I conducted 'purposive sampling' (Bryman, 2004). Bryman denotes purposive sampling as strategic in kind which has the aim to establish maximum correspondence between research questions and sampling. In other words, the investigator selects those respondents who are relevant to the research question. Purposive sampling stands in contrast to 'random sampling', where the selection of respondents – from a pre-defined target population – occurs completely by chance (Bryman, 2004). The aim of random sampling is to produce a probability sample (one that is free from personal bias) from which the investigator can then make inferences about the population. A probability sample allows generalizing the findings of the research to the population from which the sample was taken.

However, statistical inference is not of concern to the qualitative researcher. The qualitative researcher operates inductively in that he aims to generate theories rather then to test if an already existing theory can be applied to a certain population. The qualitative investigator wants to obtain in-depth understanding of the world as seen through the eyes of the people he is studying (Wilmot, 2005). In my research I want to derive patterns of meaning-making – i.e. ways in which doctors and drug reps interpret commercialization and marketised discourse – out of which I am eventually shaping a theory. Whether this theory is representative of e.g. all cardiologists in Germany or all drug reps from East Germany is not relevant to the actual research project. However, it could very well be subject to a quantitative follow-up study.

Although obtaining representative findings is not the aim of qualitative work, researchers nevertheless wish to cover as much variety as possible. Cloke, et al. (2004) remark that the qualitative investigator likes to talk to people who are representing a wider social group. Importantly, respondents do not 'represent' a certain population in the statistical sense but "spreading interviews across axes of differences" (Cloke, et al., 2004, p. 156) allows the researcher to get a broad range of meaning-making right from the beginning. Still, Cloke, et al. point out that the investigator must be cautious not to

expect respondents to 'represent' their category. In chapter section 6.5.6. (p. 117) I will present the key features of each sample group, indicating if and how they relate to the actual social group characteristics.

In order to obtain a purposive sample the investigator needs a recruiting strategy. In my research I reverted to a combination 'convenience sampling' (Ferber, 1977; Burns & Bush, 2002) and 'snowball sampling' (Becker, 1963; Bryman, 2004) to recruit respondents. Convenience sampling entails that recruiting of respondents is driven by their availability to the investigator. In snowball sampling, according to Bryman, the researcher makes initial contact with a few people relevant to the research question and then uses these to establish contacts with others (Bryman, 2004, p. 544).

One particularity of my sampling operation was that 'managers' only later emerged as a target group for empirical investigation. At the outset of the project my focus was set on drug reps and physicians alone because I was – wrongly – reducing the phenomenon of drug detailing to its immediate actors. With this end in mind, I had recruited four pharma managers solely with respect to their former role as drug reps. However, during the interviews it became clear that the respondents were mainly answering from a management position rather than from a drug rep perspective. This was manifested by a strong attitudinal divergence compared to the actual drug reps in the group. In their accounts managers were e.g. sketching a very different picture about the role of the drug rep. They furthermore proved to have a rather contrasting perception about discourse and its employment in detailing. When realising this I chose to expand the research scope to include managers' as a separate group for investigation. I regard this step as a significant improvement to empirical quality and theory generation. Yet due to managers' ex post inclusion, active sampling of managers did not really take place and consequently there is no sampling strategy to present in this regard. The 'managers' sample is essentially a by-product that turned out to be highly suitable for the modified research agenda. However, I would argue that its appropriateness is driven by my existing network contacts to relevant managers in the pharmaceutical industry. Thus the sample is a by-product yet not a random creation.

6.5.6. Interviewee sample characteristics

Empirical data has been collected through conduct of semi-structured interviews with ten physicians, ten drug reps and four managers between June 2008 and July 2009. Doctors were coming from two hospitals as well as five medical practices in Germany. Drug reps and managers interviewed came from three different German pharmaceutical companies, two of which are internationally active, while one mid-sized player is mainly focussed on the German market. All respondents interviewed had been working in the German market for many years. Interviews took place at several locations in Germany. The interviews lasted between 18 and 101 minutes with a mean value of 48 minutes. Interviews with physicians and drug reps had almost equal length (mean value of 44 and 45 minutes) while talks with managers lasted significantly longer (63 minutes). Tables 4, 5 and 6 on the following pages display the key characteristics of the respondents.

Physicians

Table 4: Characteristics of physicians interviewed

Individual Characteristics		Physicians (n=10)
Gender	Male	4
	Female	6
Age range	30 – 39	3
	40 – 49	6
	50 – 59	0
	60+	1
Work Setting	Office-based	5
	Hospital	5
Medical Speciality	Anaesthesiologist	1
	Dermatologist	1
	Internist	6
	Ophthalmologist	1
	Orthopaedist	1
Years practicing (mean value)		17.1

My physician sample is skewed towards female doctors (60%), which is not correctly reflecting the situation in the German market. In Germany only 40% of physicians are female. To my reading, the 'untypical' gender composition is mainly due to the 'snowball' technique employed for sampling, whereby female doctors proved to be more responsive towards invitations to engage in qualitative interviewing. My sample is mirroring the actual mean age values in Germany (hospital physicians = 41.0 years; office-base physicians = 51.1 years) quite well. In three interview situations, however, I found it inappropriate to ask the respondents for their age. In these cases, I had to make an educated guess based on the number of years the respondents had reported to have spent in medical practice. The even split between hospital and office-based doctors in my sample is reflecting the situation in Germany quite precisely. In terms of speciality distribution, the sample approximately mirrors the actual balance between the five speciality types covered. However, it is slightly skewed towards internists and it is understating the share of anaesthesiologists in Germany. Given that my research approach does not require samples to be representative, methodologically speaking the above mentioned skews are not important.

Drug reps

Table 5:   Characteristics of drug reps interviewed

Individual Characteristics		Drug reps (n=10)
Gender	Male	3
	Female	7
Age range	30 – 39	1
	40 – 49	3
	50 – 59	6
	60+	0
Target market	Mass Market	3
	Specialist Market	7
Company turnover (Euro)	0-99 million	3
	100-999 million	4
	1'000+ million	3
Years experience (mean value)		18.7

At approximately 50 years on average (the age of two respondents was estimated) my drug rep sample is older than the average drug rep in Germany (45 years). The reason for this variance is that by means of purposive sampling I was recruiting candidates with long time experience in detailing. This was done to ensure that the candidates were able to reflect on the changes in the industry. Acting as a second point of reference, the majority of physicians in my study reported that most drug reps visiting them are between 40-55 years of age. In terms of size (turnover) of employing company my sample is roughly mirroring the market situation, whereby in absolute terms drug rep employment is quite evenly distributed over company sizes. This balance is achieved by the fact that a few big companies (Top 10 companies account for 35% of market turnover) employ a large number of drug reps.

Managers

Table 6: Characteristics of mangers interviewed

Individual Characteristics		Managers (n=4)
Gender	Male	4
	Female	0
Age range	30 – 39	0
	40 – 49	2
	50 – 59	1
	60+	1
Management function	General Manager	1
	National Sales Director	2
	Regional Sales Mgr.	1
Years experience (mean value)		23.5

Managers in my sample showed the highest mean value of work experience of all three respondent groups. This is not surprising considering the fact that – in a traditional branch like the pharmaceutical industry – experience and long term proof of operational success is (still) a critical measure for becoming a senior manager. The apparent shortcoming that no female manager was included in the study is strongly due

to the fact that with 17.5% the share of female managers in Germany is very low (Hoppenstedt, 2008). As such, an all male sample group (given a sample size of just four people) it is almost representative again. Unfortunately, no dedicated marketing manager could be found to take part in the study. To make up for this weakness, I have supplemented the findings in patches with my own experiences as a former national and international marketing manager.

6.5.7. Respondent coding

All respondents were anonymised to ensure confidentiality. Each respondent was assigned a code. The list below (Table 7) is matching code with respondent type on a category level only. Further specification of the respondents was avoided to warrant anonymity especially for those candidates belonging to the same organisation.

Table 7:   Respondent coding

Code	Respondent Type		Code	Respondent Type
P1 – P5	Hospital physicians		D1 – D10	Drug reps
P6 – P10	Office based physicians		M1 – M4	Managers

6.6. Data analysis
6.6.1. Template analysis

Analysing the data obtained via qualitative interviewing I have decided to employ template analysis because this method allows to structure the outcome of individual meaning-making in a highly flexible manner. In the following the key facets of template analysis will illustrated.

In template analysis, also referred to as thematic coding, the researcher is producing a list of codes called the 'template' that represent themes that have been identified in textual data (King, 2004). A code can be descriptive like 'standardisation of detailing' or interpretive in nature such as 'triviality of discourse'. Given the underlying

interpretive character that fosters the use of template analysis the majority of codes tend to be interpretive (King, 1998). Template analysis is a flexible technique in which the researcher is not limited by a precise modus operandi. In that, template analysis can be made to measure the researcher's individual demands. Analysis of text will frequently start based on a few 'a priori' codes but they will be added to and modified during a continuous process of reading and interpreting. It is an iterative process that eventually leads to a final construct. I have experienced and realised this conduct likewise in my actual data analysis. Based on my ingoing assumptions I initially looked for accounts both confirming and describing promotional talk. I was furthermore screening the data for signs of physicians' rejection and frustration with promotional discourse practices. Here I found a considerable amount of empirical evidence to carry my 'a priori' beliefs. Yet at the same time, new themes emerged. I was surprised to learn how negative drug reps rate promotional talk. I was amazed to discover that drug reps circumvent management's instructions for promotional talk in order to serve the physician according to their own ideas of detailing. I was astonished about the degree of empathy and solidarity drug reps showed to have with their physicians. All these discoveries lead to new or modified codes which gradually transformed the initial template into the final template.

Template analysis has both an analysing but also an organising dimension. The template is ultimately to present the themes in a way so that their relationships become clear. In most cases the final template will comprise of two or more hierarchical levels. A few rather general top level codes are rebased by lower level codes representing a finer analytical granulation of the accounts. King notes that most templates fall into the two to four level range and warns that "too many levels can be counter-productive to the goal of attaining clarity in organizing and interpreting the data" (King, 1998, p. 120).

Surprisingly, King regards template analysis to be hardly suitable for a discourse analyst. He argues that attaching of codes to segments would limit the discourse analyst to fully explore the diversities and ambiguities of meaning constructed through language (King, 2004). To King template analysis is not producing enough detail to meet the requirements of a discourse analytical approach. In my view, King reads discourse analysis too narrowly here and I am contesting his position both on

conceptual and on operational grounds. From a conceptual point of view, discourse analysis can be highly interpretive in kind given that the investigator is focussing on context (Phillips & Ravasi, 1998) and his study has a long-range focus (Alvesson & Karreman, 2000). These interpretive types of discourse analysis have been presented and discussed earlier in section 6.4.3. (p. 94). Against this background and given the fact that I am following an interpretative approach I consider template analysis to be an appropriate method in my case. This is essentially confirmed by King (1998) when he states that template analysis is quite suitable for the interpretative researcher. From an operational perspective and my own research experience I like to add that segments to which codes are referring to are hardly ever linguistic monoliths. In most cases they are a rich source of text and it is up to the researcher whether to make use of it or not.

Template analysis is typically used in qualitative research where the epistemological position is interpretative. Yet it can also be applied in a qualitative research endeavours that are based on a realist position. In such cases the researcher assumes an objective position and aims to 'discover' the underlying cause of a particular social action. In contrast to that the contextual constructivist looks to understand a particular phenomenon but accepts that there are multiple interpretations to be made depending on individual perspective and research context (King, 2004).

Altogether, King notes, that template analysis is placed somewhere between content analysis and grounded theory. The former is operating with pre-determined codes of which their distribution in text can be statistically analysed later. Grounded theory on the other hand completely relies on evolution of theory during analysis. The spectrum of use of template analysis allows some degree of leeway depending on the researcher's position. To me template analysis is the most suitable method for examining my interview data. Using it I can follow a structuring research framework without losing interpretative flexibility. In my study, the notion of 'marketization of discourse' joins up a large array of themes (meanings, feelings, opinions, experiences). Reflecting this notion with three very different groups of subjects has produced additional variety and altogether a lot of data. Over 300 pages of single spaced text have been produced transcribing the audio data. The strong organising properties (i.e. level coding) of template analysis made it possible to handle these large amounts of interview data and themes in a consolidated yet undistorted manner. By

conceptualising and re-arranging the codes and coding system I was given interpretative freedom and flexibility. The combination of 'a priori' and 'emerging' codes – e.g. the emerging perspective of managers – allowed me to recognise, find and transform themes. Thus it aids to the need for reflexivity in analysis (Alvesson, 2003) as discussed earlier in the chapter.

6.6.2. 'A priori' codes

'A priori codes' (King, 2004) are codes or themes that have been developed before the data was analysed. These codes essentially go back to the original idea that sparked the research project altogether. The view that qualitative research is mainly about generating theory and not about testing existing theory does not imply the absence of a foundational belief or various assumptions on part of the qualitative investigator. Phillips & Pugh (2003) state that all scientific work, be it of experimental or exploratory nature, starts with some expectations about the outcome. Given a growing marketization of the pharmaceutical industry, I assumed that marketised discourse would occur extensively during drug rep vs. physician interaction. Furthermore, I believed that promotional discourse practices would lead to a growing communicative friction as physicians would ideologically oppose such promotional behaviour. Based on these assumptions I approached the data analysis with the following 'a priori' codes:

- Marketization of detailing discourse
- Marketization of medicine
- Selling
- Role of physician
- Role of drug rep
- Asymmetrical communication between doctors and drug reps

Reading through the transcripts I looked for accounts that matched the above stated themes. The a priori codes helped to focus during the initial analysing process, where otherwise I would have been overwhelmed by the sheer quantity and diversity of data. Soon after the initial data structuring was done the base template became subject to modifications. With every re-reading of the interview data and with every new

transcript entering the analysis new themes emerged and structural focus changed. The template construction particularly changed when amidst the empirical stage I decided to include managers' accounts into the study. After half a dozen revisions the final template was crafted.

6.6.3. The template

Based on the 'a priori' codes I have developed a template over many stages of structuring, coding and recoding. Upon detailed inspection the reader will notice that most of my 'a priori' codes – in an adapted format – have entered the ultimate edition. The template (Table 8) displayed on the next page is representing the final version emerging from the process of analysing the data. The various level codes shown in the template translate into specific concepts, overarching themes and aggregated dimension that will be presented and analysed in chapter 7 to follow.

Table 8: <u>Template for analysis</u>

1. Situational Background
    1. Physicians' perception of marketization of medical work
        1. Loss of professional power and autonomy
            1. Cost control
            2. Yielding responsibility to non-physicians
    2. Drug reps' perception of marketization of drug detailing
        1. Shifting focus to selling
        2. Standardisation of detailing

2. Motivations for Drug Detailing
    1. Driving Sales
        1. Managers meeting market expectation
        2. Managers controlling outcomes
    2. Serving Physicians
        1. Drug reps providing scientific information
        2. Drug reps empathising with physicians
    3. Seeking impartial information
        1. Physicians seeking impartial information

3. Marketised Discourse
    1. Management's instruction
        1. Simplification of discourse
        2. Leading the physician
    2. Drug reps' translation
        1. Triviality of discourse
        2. Embarrassment
    3. Physicians' reception
        1. Value of contribution
        2. Manipulation
        3. Being sold to

4. Response to Marketised Discourse
    1. Drug reps' transforming marketised discourse
        1. Sabotaging marketised discourse
        2. Constructing new discourse
    2. Physicians avoiding marketised discourse
        1. Inhibiting marketised discourse
        2. Escaping from marketised discourse

6.7. Summary

In this chapter I have demonstrated that my study rests on a social constructionist position which argues that individual meaning-making is constructed through social interaction. Language in turn emerges from social interaction or – as Fairclough (1989) has put it – language is a form of social practice. I have argued that this linguistically based practice can also be referred to as discourse. In other words, discourse is a way of constituting social reality. Consequently, by analysing discourse one can obtain access to the world of meaning of social actors like drug reps, physicians and managers. Further to that end, I have confirmed that my research is about analysing discourse about marketised discourse in drug detailing. Against this background I have discussed various approaches to analysis of discourse, indicating that the approach I have adopted is contextual, interpretative and critical in nature.

Subsequently, I have introduced and discussed qualitative interviewing as my selected method of data collection. With regards to interviewing, I have highlighted various kinds of disturbances like misinterpretation, cultural scripting or moral storytelling that can potentially obstruct the interviewing process. In addition, I have indicated how some of these disturbances have affected my interviewing process in reality.

In turn, I have put forward my purposive approach to sampling, displaying the key characteristics of the respective samples of drug reps, physicians and managers. I have then discussed my approach to analysing the data, demonstrating that template analysis is an appropriate method to be employed in my case. It is particularly suitable because it combines operational flexibility with firm data structuring properties. I have ended this chapter with presenting the final template that has emerged out of several rounds of analysing, transforming and structuring the data. The final template will play a key role in informing the overall theory model as well as structuring the presentation of findings in the results chapter to come.

7. Results

7.1. Introduction

In this part I will report on the findings of my qualitative study examining the impact of marketised discourse on drug rep vs. physician interaction. It provides answers to how drug reps, their managers and physicians make meaning of the phenomenon of discourse in drug detailing. It sheds light on how the protagonists conceptualise developments in the healthcare field as much as it shows their attitudes and responses to the central issue of marketised discourse. Bringing all this together a model is emerging that reflects the impact of marketised discourse in today's drug detailing in Germany. The model explains how marketised discourse produces tension between the actors. Centrally, it displays the tensions drug reps are experiencing and producing when trying to balance the world of business with the world of medicine. Importantly, I have decided to present the model at the beginning of this chapter (p. 128) to provide the reader with a crucial point of reference with regards to the detailed findings that will follow in turn.

At this stage I also like to revert once more to the different connotation of the term 'discourse' employed in my work. In chapter five I have outlined that I use of respondents' accounts (i.e. discourse) as source for accessing their worlds of meaning. Thus discourse as 'source' is one connotation of 'discourse' in my research work. In a second sense, I refer to discourse as an 'instrument' employed in drug detailing. In that sense, discourse is the way drug reps' detailing talk is performed, received or instructed. Referring to 'marketised discourse' or 'promotional talk' implies reading discourse as an 'instrument' of drug detailing.

As indicated I will start this section with the end product in mind, namely with presenting the overall framework model (Figure 5, p. 128). Subsequent to this, I will decompose the model, laying out the various themes and sub-themes. I will demonstrate how and why initial concepts emerging from the empirical data were gathered into higher order themes responsible for driving the overall model. Ultimately, the various themes will be discussed using illustrative quotes to substantiate the argument. As a point of orientation to the reader, I will draw on a key data table (Table 9, p. 133) in which my findings have been structured for order and

comprehension. Altogether, the mode of presenting and discussing my results has been very much inspired by the approach of Corley & Gioia (2004) in their study on identity ambiguity.

7.2. Conceptualising the impact of marketised discourse – A theory model

To illustrate how marketization of discourse is influencing the drug detailing encounter in present day Germany I have compiled a model which is displayed below (Figure 5). The model is showing the process of discourse production in detailing in a consolidated manner. However, it goes beyond pure process description in that it is presenting new findings regarding the impact of discursive practices.
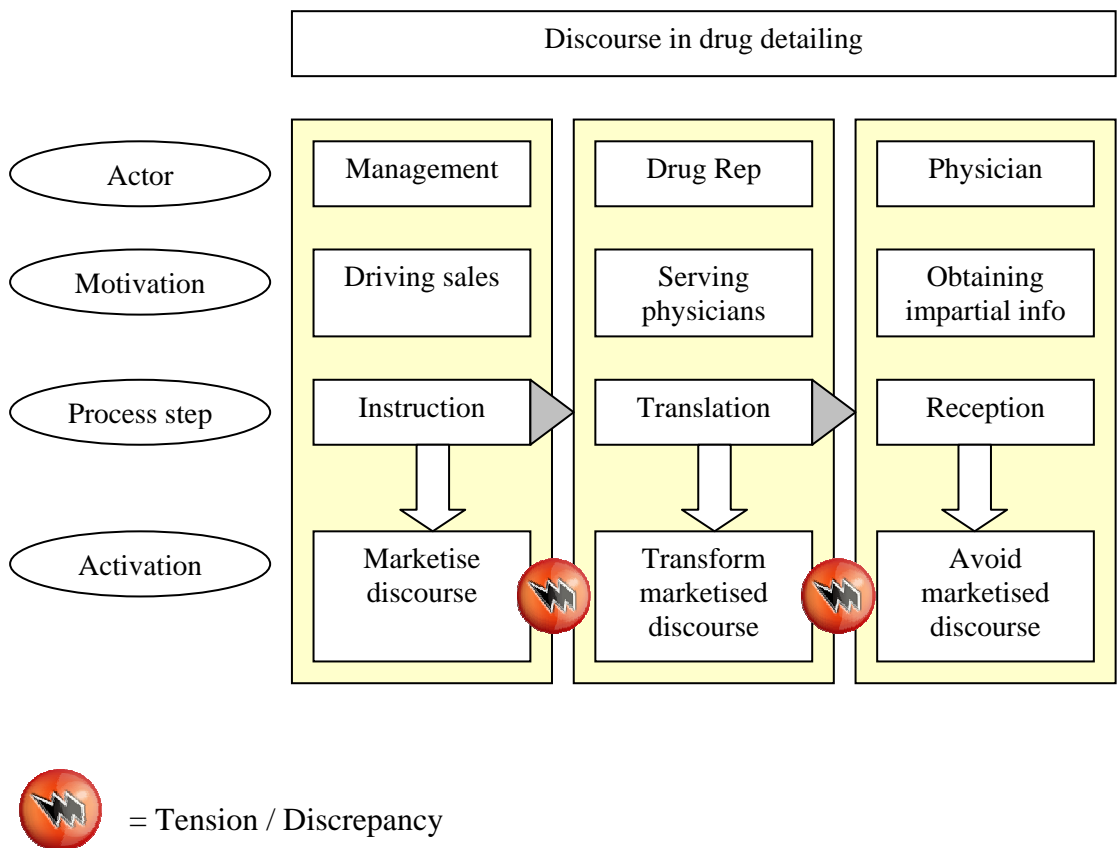

Figure 5:   Discourse in drug detailing model

In the following paragraph I like to briefly explain the model as well as the main research outcomes that it reflects:

Discourse in drug detailing is shaped by three actors, namely pharmaceutical company management, drug reps and physicians. From a management perspective, the three parties are linked together the following way: management, which comes in form of marketing, sales and general management, is strategically and tactically determining how drugs are marketed versus physicians. This involves deciding which products are presented to which doctors with which kind of messages. Management considers drug reps to act as transmitters of management's marketing ideas to physicians. Out in the field, drug reps are visiting physicians in order to discursively disseminate the marketing brief. Physicians are the key arbiter between pharmaceutical companies and the patients. Physicians use pharmaceutical drugs as a key component of medical therapy. They therefore need to be informed about the properties of the drugs they are prescribing to patients. Physicians turn to representatives of drug companies to obtain the relevant information.

The above description illustrates an ideal interaction between the three parties coming from a management perspective. Yet my research conveys that the three actors have quite distinct motivations with regards to the act of detailing. Management, standing for the viability of an economic system in form of a pharmaceutical company, ultimately aims to enhance sales and profits. Physicians, on the other hand, enter the detailing talks with the aim of receiving impartial information about drugs. Being low on time and faced with large amounts of data, physicians value this channel of information mainly for its practicality and convenience. Physicians' interest to engage is hence rather pragmatic. According to my findings drug reps primarily see themselves as agents to the physician by acting as scientific consultants. Their motivation is to serve the informational needs of their doctors. Their serving ambition has three main causes: (1) the traditional role conception of drug reps is still affecting holders of the occupation today. In the post war decades, which were characterised by economic prosperity, pharmaceutical innovation and national bound economies (in contrast to the global economy of today), the role of drug representatives was conceived as being scientific consultants to the physician. Pressure to sell hardly existed because direct

market competition was relatively low. (2) Predominantly well-trained drug reps seek to engage in stimulating and meaningful tasks. As such drug detailing must address the intrinsic need of self-actualisation at work. (3) Drug reps' all day exposure to physicians make them highly receptive for doctors' needs. Altogether, the protagonists have dissimilar motives for engaging, whereby drug reps and physicians are clearly showing greater commonalities.

The model shows that when activating their distinct motivations by means of instruction (management), translation (drug reps) and reception (physicians) the actors ultimately arrive at a stage of conflict. Management instructs drug reps to engage in a discourse aimed at boosting prescriptions. Such discourse is characterised by letting the particular drug stand out positively against competitive products primarily on the grounds of informational disfigurement. The primary intention is not to present an objective account about the drug's advantages and disadvantages but to construct a convincing argument for doctors to recommend the drug to their patients. By strategically employing discourse in this manner, management is urging drug reps to use a marketization discourse to spin the physician. Drug reps are trained accordingly and provided with prefabricated blocks of promotional talk (catchphrases, key words etc.) to use with their physicians.

Management's instructions run counter to drug reps' motivation to serve the informational interests of physicians. Thus drug reps in my study are facing a conflict of interest between their employers' demands and their customers' concerns. Furthermore, drug reps perceive the rather trivial character of marketised discourse as a devaluation of their ideal role as consultants. In their response to this situation drug reps are changing and even sabotaging management's instructions. In the very context of detailing, drug reps are not translating discursive targets as directed. They revert to selectively employing promotional discourse or reducing it to a bare minimum. They said to preferably voice their personal judgment with their customers instead of any prefabricated talk. Respondents further revealed that occasionally they would unmask or ridicule directions for promotional discourse in front of physicians. Justifying their destructive practices drug reps typically pointed to the need of protecting physicians from any misinformation.

Surprisingly, drug reps' attempts to protect their customers from marketised discourse is hardly recognised and appreciated by physicians in my study. On the contrary, many physicians are rather critical of drug rep work stating that it culminates in quite superficial and decrying information about drugs. Many pointed to the promotional character of the talk which they rate as easy-to-see-through attempts of manipulation. The majority of physicians in my study thus see drug reps adding little value to their work as medics. Many physicians stated to realise that drug reps are subjected to their management's policy and instructions. This is largely provoking a pitiful disrespect for drug reps on part of physicians. It ultimately results in physicians increasingly rejecting to engage in detailing encounters.

Drug reps' behaviour is thus producing a paradoxical outcome. Drug reps disrupt the transmission of management's strategy with the intention to serve physicians yet without meeting the requirements of physicians. While detailers in my research vividly pointed to the strain of being 'stuck in between' they were not aware that their efforts towards physicians are not met with appreciation. Overwhelmingly, drug reps are of the opinion that their interaction with physicians is symmetrical in that it is largely addressing what the physician really wants. So we have a situation where management is fostering a discourse that is neither appreciated by drug reps nor by physicians. We have drug reps covertly altering this discourse apparently without improving the outcome for the physician. What is essentially left is that all three actors fail to achieve their objective respectively. Management spends vast resources to develop and mediate communicative strategies which are not implemented by drug reps. Instead, drug reps are eagerly trying to cushion the marketised discourse they are instructed to employ yet nevertheless fail to satisfy physicians' objective of obtaining relevant and impartial information. While drug reps claim not to notice they still pay a high price by experiencing a conflict of interests: they constantly have to balance between organisational objectives and customer needs. Altogether, the model reflects a condition of incompatibility resulting in unproductive action. Marketised discourse as devised by management is thus not fostering collaboration between industry and profession.

7.3. Generating findings

My marketised discourse theory model (Figure 5, p. 128) is summarising the research findings on a highly consolidated level. It was placed at the beginning of this chapter to brief the reader early on in the process and provide a point of orientation with regards to the detailed presentation and discussion to come. The model has made use of key themes, each of which have been fed by several underlying concepts emerging from the interviews. I will explore these first order concepts explaining why I think they are relevant in the first place and why I chose to link them with certain other concepts to form overarching themes. In this respect, I will embrace two further themes that have not been used in the model due to demands for simplicity and comprehension. These themes are concerning the actors' perceptions of marketization with regards to their own professional sphere. As such they represent vital background conditions shaping the protagonists' attitudes with respect to their role in drug detailing. To facilitate my presentation and discussion of concepts and themes I have created a data organising structure which is shown in Table 9 on the next page. The structure is reflecting the final template (Table 8, p. 125) which emerged out of my data analysis. Thus final template, theory model, and data presentation structure are related the following way:

```
                        ┌─────────────────────┐
                        │   Final Template    │
                        └─────────────────────┘
          configurates     ╱              ╲      informs
                          ╱                ╲
                         ▼                  ▼
          ┌──────────────────────┐   ┌──────────────────────┐
          │  Data Presentation   │◄──│     Theory Model     │
          └──────────────────────┘   └──────────────────────┘
                              drives
```
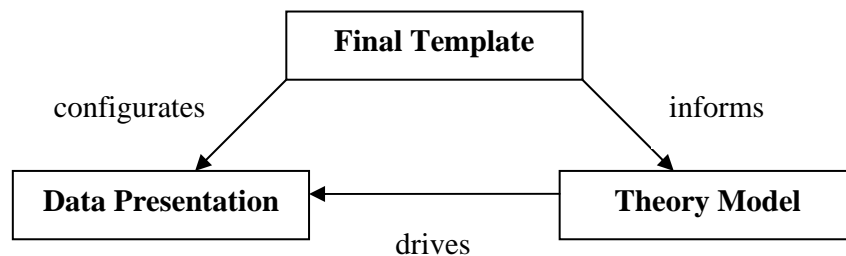
The structure and content of the final template is feeding my theory model. Subsequently, the template's architecture is used to structure my data presentation. As such my data presentation strategy is theory driven. Following Chenail (1995) I will lay out the data in a way which allows me to progress from one concept to another just as a narrator arranges details in order to best relate the particulars of the story. Each concept will be supported by one or more illustrative quotes. Adhering to the strategies of theory guidance and storytelling, the presentation of findings is always revolving around the central research question of 'What is the impact of marketised discourse on drug detailing'.

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Table 9: Data structure

1st Order Concepts	2nd Order Themes	Aggregate Dimensions
• Cost control • Doctors yielding responsibility to non-physicians	Loss of professional power & autonomy	Situational background
• Shifting focus to selling • Standardisation of detailing	Marketization of detailing	
• Managers meeting market expectations • Managers controlling outcomes	Driving sales	Motivations
• Drug reps providing information • Drug reps empathising with physicians	Serving physicians	
• Doctors seeking impartial information	Seeking impartial information	
• Simplification • Leading the physician	Management's instruction	Marketised discourse
• Triviality • Embarrassment	Drug reps' translation	
• Contribution • Manipulation • Being sold to	Physicians' reception	
• Sabotaging • Constructing new discourse	Drug reps transforming marketised discourse	Response to marketised discourse
• Inhibiting • Escaping	Physicians avoiding marketised discourse	

7.4. Findings

7.4.1. Situational background

I begin with participants' accounts on how they perceive their actual occupational sphere. As previously highlighted, the aggregated dimension 'situational background' was not built into the theory model purely for reasons of model simplification. I like to point out that during the interviews respondents were initially asked to comment on their actual situation with regards to key changes they have noticed. If the issue of marketization was not dealt with, respondents were directly asked if and how marketization / commercialisation have influenced their area of work. I will start with presenting physicians' key associations followed by those of drug reps.

7.4.1.1. Loss of professional power & autonomy

Loss of professional power & autonomy is an overarching theme that was fed by two emerging concepts: 'cost control' and 'yielding responsibility to non-physicians'. 'Cost control' is the dominant and more widespread concept of the two. The frequency of storylines fitting to the matter of cost control altogether indicated its high relevance to physicians. As we will see there are different readings of this notion across the sample spectrum, namely between office-based and hospital physicians. Still, both subgroups' accounts strongly revolve around this topic. The second concept, 'yielding responsibility to non-physicians', is of relevance only to office-based physicians. Yet within this subgroup it has played such an important role that it could not be overlooked. Each of the two concepts has a connotative dimension of its own. The notion of cost control is dealing largely with operational constraints to medical work while 'yielding responsibility to non-physicians' is interpreted rather emotionally, namely as an assault to social order and status. At the same time, both notions are intertwined in that cost containment is attributed to bureaucratic measures issued by non-physicians. This link is making the two first order concepts to support the higher order theme of 'loss of professional power & autonomy'. Let us now take a closer look at the two concepts, starting with the notion of cost control.

Cost control

When asked about key changes in medical work subjects first of all pointed to increases in cost containment measures. Cost containment in medical work is experienced differently by doctors, depending on whether they work in an office-based or a hospital setting. I first like to address the perspectives brought forward by office-based physicians in my study. All but one office-based physician stated that cost containment measures are impairing their work as medics. Four out of five office-based respondents said that budget controls on medical therapies are reducing the time they can afford to spend with the patient. Furthermore, that budget restrictions on drugs are producing conflict of interests as the quota must be balanced among the whole set of patients without too much compromising the quality of care. One office-based physician remarked:

Resources are getting low. We increasingly become administrators of shortages. Yes, that is actually the key factor. More and more of my working time or my spare time is absorbed with trying to squeak through without too much compromising my own demands as a physician. (P6, Office-based physician)

On first reading I rated this statement as the physician's inability to deal with healthcare provision in a utilitarian fashion. In other words, his struggling to balance the normative ideal of unconditional healthcare, associated with an altruistic and collectively oriented professional ethos (Parsons 1951, 1963), with the economic realities of limited financial resources. However, in the course of the interviews other motives came to the fore. Office-based physicians are afraid to lose income or to work much harder for the same level of income. Most evidently, however, was their panic to be held financially liable for exceeding their individual drug budget. In Germany, the efficiency of drug prescription in the system of statutory health insurance is monitored by boards of inquiry. A doctor may be liable if the total amount of money spent on drugs he prescribed exceeds the cost guidelines. The issue of financial regress is thus a rather prominent theme among self-employed physicians. As one physician put it:

You really like to do it to the best of your ability and knowledge but you are scared away because you fear that you are held liable with your personal assets.

(P10, Office-based physician)

This statement brings attention to the fact that office-based doctors essentially are small business owners who have to generate income. In Germany, the vast majority of office-based doctors are relying on the statutory insurance system for income generation. As presented in the introductory chapter, approximately 80% of their earnings are generated through the system by which the individual physician is balancing accounts directly with the Association of Statutory Health Insurance Physicians. For each quarter of the year physicians are assigned an individual budget calculated by combining average treatment cost rates per professional speciality with the physician's individual treatment and prescription profile of the previous year period. This method was issued to increase overall efficiency and to stop physicians to enhance income through applying expensive procedures to their patients. Against this background, office-based physicians are highly susceptible to any budget decreases as well as to sanctioning threats coming from the board of inquiry.

It must be mentioned that these cost control policies also have a legal conflict dimension. As by the German social security treatment contract, physicians belonging to the statutory insurance system are obliged to apply state of the art medicine to their patients. Cost control measures as outlined above can eventually compromise this obligation. However, in my study arguments of morale or contractual service obligation have been clearly displaced by signs of economic self protection.

Office-based physicians' attitudes reflect the critique by Freidson (1970, 1986) who argued that members of the profession have compromised their collective calling by being primarily concerned with securing their own living. This is not to say that respondents in my study like to subject their patients' interest to their personal interest of maximising income. None of my subjects gave evidence in this direction. To my interpretation physicians rather like to retain a status quo ante in which remuneration via the statutory system came generously and largely without any efficiency audit. This is referring to a time and condition that previous generations of physicians have experienced and that is now progressively vanishing. Yet physicians, either by personal

experiences or collective memory, cannot resist orientating themselves at the benchmarks of the past thereby sensing a loss in professional standing. This is how the issue of cost containment is feeding the overarching theme of loss of professional power and autonomy.

Hospital physicians in my study have a different access to the issue of cost containment. Before I present their perceptions I like to mention that four out of five respondents came from a very large, state-of-the art university hospital. Being one of the leading hospitals in Germany it assembles many of the best doctors in the country. For years this hospital has been undergoing restructuring programmes to boost efficiency and quality.

Five out of five respondents said that they understand the necessity of tighter cost controls to the benefit of greater operational efficiencies. They were generally supportive of their employers' position that non-evidence based procedures shall be dropped and measures that are just nice to have are to be reduced. In terms of resource management two out of five physicians spoke about their obligation to the whole body of the insured. In that they clearly took a utilitarian position which I like to reflect by the following statement of one physician:

As a physician I am also committed to the general public. If you talk resources you must ensure that there is enough left for the treatment of every potential patient. You cannot say one particular patient gets everything that is possible without knowing if this is financially feasible. I think you have to keep a close eye on this.

(P3, Hospital physician)

The respondent further revealed that he developed this perspective along with the establishment of a large controlling department in his hospital. Efficiency measures, a key element of economisation, thus did not have a deterring effect on the physician. On the contrary, it helped to develop a new perspective on the issue of funding healthcare. Hospital physicians' general openness to critical economic evaluation can be explained with their ongoing exposure to organisational management. As Hoff found in his study with HMO physicians, being part of a large bureaucratic organisation, which is e.g. promoting cost efficient patient management to its members, increases the doctor's

likelihood to conform to the organisation's objectives (Hoff, 2003). A second argument is that hospital physicians feel a greater deal of economic protection. Different from their self-employed colleagues in private office, they do not bear the commercial responsibility of the operation. Instead, hospital physicians are integrated in a system of hierarchical control but do not have to worry about making a living. Hence they appear to be less threatened by efficiency audits and cost containment measures. This interpretation again relates to what Hoff (2001, 2003) found. Hoff discovered that physician-employees felt at ease with their situation because they viewed their organisation (in Hoff's 2003 study it was a large HMO organisation) as insulating them from the business pressures of the marketplace rather than controlling or deskilling them.

Hospital physicians are nevertheless concerned about the potential effects cost control may have on patient care. Four out of five respondents explicitly mentioned this issue. Different from their office-based colleagues they shed light on the issue from a patient's perspective. That is to say, they did not employ the topic of patient wellbeing as a means drawing attention to their own - apparently miserable - position in the German healthcare system. Instead, they seem to have an intuitive interest in what cost control could ultimately lead to with regards to their patients. Yet I could not refrain from noticing that despite all their voicing of concern the issue was dealt with on a rather theoretical level. Respondents talked about critical compromises to patient care more in terms of an eventuality in the distant future rather than as an immediate threat. Storylines like *'we have to mind the cost but if it is really needed we do everything'* (P4, Hospital physician) were typical of their rather unagitated approach to the issue. To my reading, this perspective is clearly influenced by the structural particularities of the hospital four out of five of my respondents were coming from. The very hospital is a leading institution which is sufficiently supported to operate at the highest standard. Compromises to patient care are probably not occurring at any significant level.

In summary, hospital doctors in my study experience cost control as a necessary step which they do not believe is putting their patients at any immediate risk. Furthermore, none of my respondents indicated that cost containment measures would deprive them of their professional autonomy and power. At first glance this is a surprising outcome. Yet on closer inspection it seems a quite understandable reaction. All hospital

physicians in my study have spent their careers in a large organisational setting. As a matter of size and function, hospitals operate by means of rationalised division of medical labour. No single physician holds or has ever held holistic control over his work. Pointing to the theory of McKinlay and Arches (1985) hospital work is essentially organised in an industrial fashion. As with large industrial organisations the personal element is minimised to avoid individualistic – at times esoteric – decision-making. Preferably, decision-making happens via pre-existent set of rules. Physicians who grew up in a hospital environment naturally take less issue with rules and procedures influencing their medical work. This is how I make sense of my hospital physicians' laid-back reaction to cost control measures.

To summarise the key findings with regards to cost control: cost control is a major topic for all physicians in my research. While it is of great relevance to all of them, it is judged very differently between office-based doctors and those working in a hospital. Office-based doctors conceive cost control primarily as a threat to their economic fundament which in turn is seen to impair their power and autonomy as physicians. Hence, office-based physicians in my study are very critical of efficiency audits and cost containment measures. By contrast hospital doctors generally approve of cost reduction programmes to the benefit of a more efficient and more just allocation of resources. Hospital doctors are more concerned that cost containment could eventually compromise their patients' health, yet they see it as a rather distant threat.

Yielding responsibility to non-physicians

'Yielding responsibility to non-physicians' is the other strong concept that emerged out of the data. As mentioned at the beginning, this concept is limited to the subgroup of office-based physicians. Within this group, however, it has a very emotional character, that is to say it is not rational grounded but is largely dealt with on the emotional level.

All five office-based physicians in my study were self-employed and did not have to subject themselves to a supervisor or managed care organisation. All five subjects nevertheless felt non-autonomous in their work as medics. Four out of five physicians were agitated about the fact that they are patronised by non-physicians. Thematically it

is about politicians and representatives of health insurances increasingly determining their treatment and prescription schedule. I have discussed the issue with regards to cost control in the previous paragraph. However, I have found that the question of autonomy has just another context to it. Office-based physicians in my study were particularly disturbed by the fact that control was exercised by people coming from outside the medical profession. Typically these people were referred to as 'bureaucrats' or 'economists'. Interestingly, physicians in their critique only marginally addressed the actual policies these people are responsible for. Instead doctors were simply vexed about being ordered certain terms by a non-physician. In their reaction physicians showed a high degree of sulkiness:

Then let these paper pushers prescribe drugs to the people…this is not my idea of being a physician. As a doctor I decide what is good for you. And I prescribe the drug for you. […]. And now they are telling me what I should prescribe. This cannot be. For a doctor this is hardly acceptable. (P8, Office-based physician)

This relates to the findings of Warren et al. (1998) who suggested that the strongest challenges to physician satisfaction came from doctors having to yield their clinical judgement to non-physicians. Furthermore, sentiments of resistance to outside control are mostly strong among self-employed physicians as presented in Hoff's study on physician adaptation (Hoff, 2003). These findings appear plausible particularly if the office-based physician has been working in a self-employed setting over many years. In my study aversion to outside control was remarkably stronger among those three subjects who had been in own office for a long period of time. The other two respondents, who had been self-employed for less than ten years showed a lesser degree of cynicism with regards to outside control by non-physicians.

Three office-based physicians painted a very gloomy picture with regards to their professional autonomy. One subject was expressing her fears that control by non-physicians will further increase in the future. She predicted that eventually the physician in his own private practice will vanish completely. Instead, physicians will be forced into large interdisciplinary constructs run and controlled by non-physician managers. The topic of interdisciplinary work settings was assessed rather contradictory by the respondent. At one point during the interview the physician spoke

very positively about the effects an interdisciplinary setting would have on patient care. She also emphasised the benefits of sharing expensive medical equipment among many doctors. Yet, at a different stage she criticised the same model quite heavily simply on grounds that control would rest with non-physician managers:

The way this is organised…and politically intended…namely to set up some sort of ambulatory healthcare centres, not run by physicians, where we simply are instruments... to me is no alternative to professional freelancing. Although there is already little professional freedom left I would still not let me force into that. Only if there is no other way forward. (P6, Office-based physician)

To my interpretation this statement is indicative of a deeply rooted, ideological motivated, resistance to subject oneself to the primacy of capital represented by business management. In that the respondent's stance is essentially mirroring the analysis of Freidson (1994). Freidson argued that despite all changes in physicians' work environment the physician remains the authoritative spokesman of his body of knowledge and skill. Furthermore, the medical profession must keep an administrative or supervisory monopoly over the operational conduct of medicine. Non-physicians, according to Freidson, aid to this process through e.g. developing and operating instruments of information management. However, they are not controlling the medical work itself. Physicians in my study are clearly adhering to this ideal position, maybe only because they are experiencing a rather different scenario in reality. This would explain why their reactions are highly defensive and emotionally charged, showing comparably limited rational critique.

7.4.1.2. Marketization of detailing

In terms of situational developments at the company end the outstanding theme was 'marketization of detailing'. This overarching theme was carried by two first order concepts of 'shifting focus to selling' as well as 'standardisation'. Storylines feeding these two concepts were numerously produced in every interview of drug reps. As with physicians' assessment of their occupational situation, each of the two base concepts has a connotative dimension of its own yet the two notions are also interlinked. In

short, marketization of detailing is understood as moving from scientific consulting to upfront selling by means of regimenting the act of detailing. I will begin with presenting drug reps' perceptions on the notion of a shifting focus to selling.

Shifting focus to selling

When asked about the main changes in drug rep work all drug reps in my study pointed to the strong emphasis on selling in drug detailing. Interviewees expressed that over the past 10 to 15 years their work as drug reps has fundamentally changed. Previously, drug detailing was mainly about providing scientific product details to the doctor. Today, respondents report that detailing is largely about openly selling the product. This does not mean that before drug reps had not been aware of their companies ultimately wanting them to promote drugs. However, as one respondent described it, the approach taken in the old days was rather indirect, namely by inducing scripts through scientific consultation. Relationships with doctors were gradually developed and cultivated over many years. In most detailing talks the topic of promotion was never even touched but only implied. If the encounter went well it was a tacit consent that the physician would 'do something' for the drug rep in terms of prescribing or recommending his products. Yet the physician's support remained tentative altogether. Respondents explained that in the past doctors have been infuriated by any attempts to pressure them into prescribing. Three drug reps reported about being severely reprimanded by their physicians when putting only the slightest promotional pressure on them. Doctors' harsh rejection, one respondent conveyed, was cushioned by the fact that management was exerting comparatively little pressure in terms of sales targets. Against this background, drug reps could lose themselves in the role of a technical advisor carefully nursing his customer. Reflecting the situation of 10 to 15 years ago, eight out of ten respondents said that they conceived themselves as 'consultants' rather than 'salesmen'. Yet the same respondents admitted that today this self-conception is no longer sustainable.

I think the biggest change has been that when I started the drug rep's self-conception was such that he was there to inform the doctor. The selling aspect, in the sense that I also try to convince the doctor to prescribe my product, was almost seen

a little sleazy and disreputable. For this reason one's self-conception was more like: it is my job to inform the doctor about our product. And in the course of time it changed more and more towards sales and volume generation. The change was manifested when the field force was beginning to receive special trainings in selling and sales psychology […]. If before you had the sense of being a scientific advisor to the doctor and then suddenly the selling aspect took over…to many of us that was embarrassing.   (D1, Drug rep)

In their reflections about the underlying causes of this development drug reps vary considerably in quality. Four out of ten respondents remained at a very general level, pointing to phenomena like 'growing commerce' or 'changes in the market'. Essentially this group was treating the underlying reasons as a black box, broadly labelling it 'marketization'. Preferably, they were criticising the effects of marketization rather than penetrating the grounds for it. The most common criticism in this respect was that of having to subject service to sales pressure. To my interpretation, respondents' superficiality is not rooted in their inability to grasp the issue but in their unwillingness to deal with a matter which they actually despise. These respondents see themselves as casualties of the business world rather than as protagonists in it. The other drug reps in the group were pointing to selective events and developments for causes. While none of the respondents produced a coherent explanation of why focus has shifted to selling this group after all displayed a much greater willingness to explore the underlying causes. Typical explanations given were growing market competition, low product innovation, and rising shareholder expectations.

Regardless of their level of adherence to the notion of commerce, all drug reps in my study disapproved of the strong shift towards selling. All respondents said that growing sales focus makes it impossible for them to competently serve the physician. The topic of serving the physician will be intensively discussed at a later stage as it appeared to be the key motivator for drug reps engaging in detailing. I will now present the second concept carrying marketization in the drug reps' mind, namely standardisation of detailing.

Standardisation of detailing

The majority (7) of respondents mentioned that strong focus on selling is accompanied by standardisation of drug rep work. The concept of standardisation is interpreted as uniformity in terms of content delivery as well as loss of operational freedom. This situational account confirms Greene's (2004) disbelief in the notion of the drug rep being a sovereign actor. However, six out of ten drug reps emphasised that previously they were given considerable freedom to manage their own set of customers. All of them were largely left to decide which doctors to visit at which frequency. One respondent spoke about drug reps being granted the status of 'small entrepreneurs' within the organisation. As such they were able to adjust to the individual needs of the single doctor. The respondent affirmed that this was not only aiding the quality of service but altogether putting the drug rep in a position of controlling his own work process. Three subjects voiced that freedom to operate had been a prerequisite for them choosing a sales job in the first place. In that they pointed to the high salience of this condition within the set of needs of drug reps in general. Today, respondents said to experience a situation where customer management is centrally geared, resulting in firm instructions given by sales and marketing management regarding customer targeting and call frequency.

While interviewees expressed their frustration about losing control over tour planning, they were even more agitated about another kind of imposition. Drug reps in my study were particularly stirred up by the forced standardisation of their discourse with the physician. Many confirmed that they are no longer left to decide how to converse with the individual physician. During the interviews seven out of ten respondents emphasised that they are always given firm instructions by marketing to bring across mostly brand related catchphrases and storylines. Two respondents explained that the typical script is essentially following the brand's marketing positioning statement which includes key product advantage, target indication and preferred patient group. Furthermore, that this statement is required to be repeated over many visits until it is firmly embedded in the physicians' long-term memory. These discursive provisions are met with particular frustration on part of drug reps and are provoking rather cynical responses. The following quote is a characteristic account:

Actually the drug rep has moved away from individual consulting to becoming an accessory to marketing management. I once said it is like being marketing's talking parrot. […]You have firm instructions by marketing and you have to get them across – accident-free – via ten memorised catchphrases.   (D8, Drug rep)

Aims by management to regulate and standardise talk is judged as jeopardizing the drug rep's personal relationship with the doctor. One respondent remarked that entering the talk in a totally designated manner would not only offend the physician but also impair the drug rep's ability to pick up critical signals sent by his customer. In this respect all drug reps were of the opinion that success in drug detailing is essentially dependent on the personal relationship with the physician. In that all respondents showed to adhere to the traditional approach of detailing whereby scripts were induced indirectly. We have already learned in the previous paragraph when drug reps spoke about the focus on selling that this position is no longer supported by management. As we will see in the process of this presentation, this is to become the key conflict issue.

Already during the early parts of the interviews it became clear that drug reps are very critical of the developments affecting their occupation. Standardisation of detailing again is a key cause for this critique. Respondents are irritated by the fact that their work is subjected to extreme scrutiny and homogenisation. According to my observation, this is devaluating the occupation in the drug rep's perception. Equally important, however, becomes the fact that drug reps fear the loss of what they regard as the critical success factor of detailing, namely relationship-building with the doctor.

7.4.2. Motivations

My research shows that discourse in drug detailing is carried by different motivations. The three players involved – namely management, drug reps and physicians – engage in discourse to achieve quite distinct goals. Their ideas and perceptions have been collected under the aggregate dimension of 'motivations'. Motivations are critically stimulating the discursive process in drug detailing. Sometimes, as in the case of drug reps, motivations stand in contradiction to the assigned function. In the following section, I will present how the three groups conceptualise their respective ambitions

with regards to discourse in drug detailing. Storylines picked up from the respondents have been assembled to form three main themes. I have found the key theme for managers to be 'driving sales'. Among the group of drug rep respondents the overarching theme of 'serving the physician' emerged. At the other end, accounts by physicians led to the collective theme of 'obtaining impartial information'. The fact that I have structured motivations by type of actor is once more showing that my data presentation is theory guided. Based on my findings I have built a model (Figure 5, p. 128) that reflects how I believe discourse is impacted by the diverging motivations of the three actors. According to my theory motivations differ by actor. Naturally, motivations are never homogenously represented among a social cohort and I am fully aware of it. For example, drug reps in my study have also shown to be motivated by the prospect of augmenting sales. However, amongst my group of respondents this feeling was clearly overlaid by their wish to be of service to the physician. A reliable measure in this respect was the frequency and intensity of respondents dealing with a particular theme or concept. While assigning a set of motivations to a particular group is probably a simplification it is nevertheless for the most part reflecting the attitudes and feelings of that group. I will begin with presenting the overriding theme of 'driving sales'.

7.4.2.1. Driving sales

Accounts supporting the theme 'driving sales' came from a small group of four pharma managers. The sample consisted of one general manager, two national sales directors and one regional sales manager. I took the decision to include direct accounts by these managers rather late during the field work. Initially, I had planned to focus on drugs reps and physicians alone as they are the immediate actors involved in drug detailing. Therefore, I had recruited the four managers solely with respect to their former role as drug reps. During the interviews, however, it became clear that the respondents were mainly answering from a management position rather than from a drug rep perspective. In essence, they were reading drug detailing as sales promotion in line with Hemminki's (1977) notion of the task. When realizing this I chose to expand the research scope to include managers' perspectives instead of just relying on drug reps' interpretations of management's attitude and behaviour. I regard this step as a significant improvement to empirical quality and theory generation. The reader might

still have doubts to whether a former drug rep can credibly represent management because the respondent might be clinging to his drug rep perspective. I may dissipate these doubts by arguing – based on personal experiences and industry HR sources – that many managers in pharmaceutical firms started out as drug reps. Especially for those in senior marketing and sales management roles this is a typical and institutionally wished-for career start. To my conclusion, having a drug rep biography can thus be regarded as characteristic of pharma managers in Germany.

The overriding theme 'driving sales' is supported by two concepts that emerged out of the interview data. One concept is 'meeting market expectations' the other is 'controlling'. Clearly, the two concepts are interlinked in that expectations are met through controlling and optimising the resources available. Yet both concepts also possess an individual subtext. 'Meeting market expectations' is outside driven and as such largely dealt with in a reactive mode. 'Controlling', on the other hand, is more referring to an intrinsic need, namely the fascination to have power over processes and people. In terms of drug detailing it entails the attraction to optimise the sales call and lead the physician. I will start with presenting managers' views regarding the concept 'meeting market expectations'.

Meeting market expectations

Three out of four managers emphasised that the pharmaceutical industry is used to earning profit margins way above those of other industries. This fact by itself seemed to fill the respondents with pride. At the same time, all three interviewed regarded the industry's high achievements of the past as a major burden. Two managers spoke about their immense difficulties to hold the standards before the background of empty product pipelines, generic competition and reimbursement restrictions. To their perception the business has become much more finance driven and rigorous. Yet respondents made it clear that there is no way out of this other than finding new options for growth and efficiency gains.

Due to its high profits over the past 40 years the industry faces new challenges to meet these margin expectations in the future. And that is why every cog in the wheel

- in the area of sales and marketing - that is able to hold or enhance profits and efficiencies is put in motion.   (M2, National Sales Director)

From the seriousness and determination by which they presented their cases I got the impression that they were actually pleased by being given such a challenge. While this might be a misconception or exaggeration on my part, it was obvious that these managers perceived their task as a high-end venture. Interviewees used the term 'high pressure' very often when describing their challenges. One respondent pointed to the international capital markets causing these high pressures by raising expectations which they as managers have to meet. He thereby conveyed the impression that global market expectations are rather motivating him. Claims by respondents to accept and to withstand the market pressures, to a large degree are caused by cultural scripting. As by my own experience as a pharma manager, portraying the market forces as 'inevitable' is typical for keeping managers in line, motivating them to do the extra effort. Simply put, the discourse is suggesting that the global market economy is demanding permanent growth, total flexibility and self-reliance to which one can either adapt to or otherwise one will be marginalised. This discourse is not only coming from top management in the pharmaceutical industry but is produced and reproduced everywhere within the business community. As per DuGay (1991) it has even spread to the whole of Western societies paving the way for the self-interested ideology of neo liberalism. It seems impossible that managers who are permanently exposed to this cultural script do not pattern themselves on it. This was clearly the case with my respondents who prima facie were embracing the notion of marketization. While acknowledging that there are many hardships on the way – for example one manager conveyed that certain drug reps are not able to stand the pressure and (have to) leave – respondents still claim to support the overall idea.

Yet in the course of the interview two managers said that from their 'private' point of view they would have a different opinion on the subject. One manager revealed:

I believe the basic idea of wanting to combine medicine with business is conceptually wrong. Because the temptations and opportunities that the system offers to those who are clever ultimately reduces the patient to a commercialised object.

                    (M2, National Sales Director)

This statement signifies that managers' stories about marketization are largely inspired by cultural scripting. The very fact that two respondents in my study said to have a professional as well as a private stance on the issue is further indicative of this. Yet in terms of the leverage managers have on discourse it is only relevant what stimulates respondents in their role as professionals. In my study respondents were clear that they would transmit the expectations of sales and profit growth for the benefit of organisational viability. As such they were motivated by the growth beliefs of the market economy.

Controlling

The concept of 'controlling' reflects interviewees' interest to direct processes, contents and people with the aim to augment commercial performance. While controlling is a prerequisite for meeting growth expectations, it was also conceived as fascinating in its own right. Therefore, discursive strategies could be equally driven by managers' immersion to control and optimise the detailing encounter. Supporting this position, one manager explained that they try to reduce the intangible part in the detailing encounter as much as possible. He thereby referred to those drug reps who manage their physicians by means of individual esoteric skill, i.e. purely on the relationship level. Although this approach may bring commercial success it is nevertheless unwanted because it is neither replicable nor predictable on a large scale. By contrast, if a drug is marketed on the message level – whereby contents are highly standardised – it gives the company much greater control over the process of generating prescriptions. Ideally, the respondent explained, the drug rep should act on the physician strictly within the framework of preset messages. Individual relationship skills shall only be employed to get the physician's attention in the first place.

Another manager spoke a lot about professionalizing the detailing, which to him meant developing processes for further efficiency enhancement, quantification and benchmarking. He conveyed that he himself is rigorously measured by the rate of process innovation, implementation and yield. While this to him is tough and demanding he nevertheless is fascinated by pushing things further.

I see myself as a sales professional and I enjoy professionalizing things…focussing things, enhancing efficiencies...that's really for me. I love these processes. I am mainly paid for controlling these things.   (M2, National Sales Director)

This statement reveals how relevant it has become for drug companies to closely steer and monitor their marketing and sales efforts. Control is particularly relevant for companies with large institutional investors behind them. Based on my personal experience of working in pharma corporations, predictability of results has become as important as the result itself. If the company achieves its sales and profit targets precisely in line with the forecast it is demonstrating to its investors that it is in control of the business. Failing to do so – even in the case of exceeding targets – will raise doubts whether management is in control of things. This brings along another type of manager who is increasingly rewarded and thus motivated by the level of sales control he provides the organisation with. Unsurprisingly, managers' growing focus on control will affect the way drug detailing is imagined to be executed. As detailing is largely a discursive event it will impact the way discourse is practised on part of the drug rep.

7.4.2.2. Serving the physician

In terms of motivation, serving the physician is the overarching theme from the drug reps' perspective. The theme is fed by two underlying concepts that emerged out of the interview data. One concept is assembling all storylines about 'providing information' to physicians. This is mainly about being a technical or scientific advisor to the doctor. The second concept gathers all accounts dealing with 'empathising with physicians'. It includes drug reps' notion of understanding and identifying with physicians and their current situation. Furthermore, it refers to stories dealing with advocating physicians interests'. It contains drug reps' ideas about how and why the physician needs to be backed, in particular with respect to defending him against certain company interests. I begin with presenting drug reps' views regarding 'providing information'.

Providing information

Ten out of ten drug reps in my study said that informing the physician is to them the key reason for drug detailing. Informing is mainly understood as providing technical and scientific information about the drug and its associated clinical indication. In recent years, technical information about health economic issues such as drug reimbursement policies has been added. For the majority of respondents, information supply is ideally determined by doctor's knowledge demands. Six out of ten drug reps' see themselves as responding to what is really needed. Only if they have 'something new' or 'value adding' to offer they like to switch into an inserting mode. The subsequent quote is illustrative of a number of identical comments.

I see myself as a service provider to the physician, one that brings the essential information to him…as fast as possible. […] To do whatever makes life easier for him, that's how I see my role as a drug rep…to make life easier for the physician. But not trying to enlighten him with banalities. (D3, Drug rep)

The statement is signifying the respondent's somewhat agenda-free service attitude. This approach to detailing stands in contrast to many perspectives voiced in the literature. By not leading the talk and not actively promoting his products the drug rep is essentially foregoing the central objective of drug detailing (Hemminki, 1977; Rohrbacher, 1988; Greene, 2004; Oldani, 2004). Agenda-free service behaviour thus runs counter to the ultimate organisational goal of working the doctor in order to drive prescriptions.

Respondents in my study are not ignorant of the sales promotional effect of drug detailing. Yet they all see it as a consequence not as the purpose of detailing. Many drug reps conceived drug sales essentially as a by-product of advising the physician. Informing and serving the physician is regarded to be the actual purpose of detailing. Further to that end, three respondents pointed to the high level informational demands on part of physicians that in turn would require a sophisticated address on part of the drug rep. Providing scientific information on a high level was thus conceived as an indicator of occupational importance. During the interviews the three respondents used

the argument of providing scientific information to differentiate themselves from a salesman. One of the respondents defiantly ascertained:

I am a consultant…not a salesman…a consultant! I pass on scientific information.

(D2, Drug rep)

However, despite such poignant illustration of defending one's occupational territory, the majority of respondents conceded that the actual situation in the field is not reflecting their conception of drug detailing. In this respect, interviewees pointed to trivial informational contents that they are supposed to pass on to the physician. Furthermore, they said that they were obliged to press and lead the physician rather than respond to him. These issues will be discussed in context of 'marketised discourse' later on in the document. From a motivational perspective, drug reps in my study were interpreting detailing as a customer driven informational service. Advising and informing were thereby seen as a key source of occupational inspiration. In that, drug reps in my study were consciously idealising their occupation against the harsh realities characterised by increasingly uniform and self-interested demands on drug selling.

Empathising with physicians

At first glance, the concept 'empathising with physicians' seems to be rather a description of an emotional condition rather than supporting the overarching motivational theme of 'serving the physician'. Yet drug reps' stories about how much they feel for physicians entail the desire to do something for physicians. As such their stories have a motivational dimension and are also inducing accounts regarding advocating physicians' interests.

Nine out of ten drug reps interviewed expressed their empathy for the difficult situation the physician is in. Difficulties were perceived to come from two directions, namely government induced bureaucratic cost control and discursive manipulation by the drug industry. Regarding the first cause, respondents saw physicians unduly curtailed by governmental cost containment and efficiency programmes. Four out of ten detailers

interviewed pointed to office-based physicians facing near bankruptcy or gave similar accounts of doctors who are experiencing financial hardship. One respondent expressed such a high degree of empathy with her physicians that she reported to have advised one of her doctors to act against the maxim of treating patients equally:

Drug rep: *Then I said: Start cancelling out statutory insured patients…move them to the back! You have to do it! What's it good to your patients if you are not around any more…because you are financially broke in the end.*

Interviewer: *So you are promoting in fact a two class medicine?*

Drug rep: (Speaking in an agitated voice)*…well, but the patient also has to understand that the physician is in a quandary and that it's also no good to the patient if his beloved doctor is not around any more. It's no good to him either. You see, they (physicians) have to pay their staff; they have to pay off their practices…and all the running cost…electricity and so on. In fact, they cannot do it any more!* (D7, Drug rep)

The emotional involvement and support by respondents is striking, in particular because drug reps' stories and empathy levels do not reflect physicians' actual income situation. According to the German Federal Bureau of Statistics (Destatis, 2009b) the average income of office-based physicians (self-employed) was Euro 142'000 per year in 2007. This is three and a half times the average income in Germany and two and a half times the average gross salary of detailers. Against this background, voicing empathy with physicians' economic situation is indicative of drug reps' high identification and somewhat naive solidarity with the medical profession.

To explain this behaviour one has to turn to the discursive strategies of the medical profession's representatives. For many years talk about low physician remuneration or tales about financial bankruptcy are symptomatic of strategic discourse disseminated through the German media by representatives of the professional associations. Subsequently the talk has been taken over by a large share of practicing physicians. According to Lauterbach (2009), one of the leading health economists in Germany, this discourse has been constructed and dispersed to strengthen the representatives'

bargaining position versus government in their demand for higher budgets. As shown beforehand the grim picture painted by lobbyists is not at all reflecting the actual income levels of physicians in Germany. Nevertheless, as shown by the interview data, this discourse has been successfully adopted by detailers. Following Alvesson & Karreman's (2000) theory this particular discourse has a 'muscular' character. To my interpretation this is indicative of drug reps' emotional and ideological proximity to physicians and their worlds of meaning. This is likely to be caused by detailers' ongoing exposure to the world of medicine. The quotation below is characteristic of the respondents' sentiments expressed during the interviews.

We love our physicians. They are our family. We spend the majority of our lives with them… (D1, Drug rep)

With respect to restructuring studies on physicians becoming managers (Freidson, 1994; Hoff 2001, 2003) exposure time was found to be a critical factor for individuals' ideological adaptation to a contrastive work context. Although the particular studies were investigating a cognitive move in the opposite direction (i.e. from the world of medicine to the world of business) the findings can nevertheless be used to interpret the phenomenon of detailers' closeness to physicians.

The other cause of empathy with doctors' is concerning the discursive manipulation of physicians by the industry. Eight out of ten drug reps pity physicians for being exposed to promotional discourse which places them in a position of informational uncertainty. Respondents pointed to the fact that in their drug treatment decisions physicians are largely dependent on outside information. Yet according to one interviewee, doctors cannot be certain that the information they are getting is objective and correct. Further to that end, the respondent stressed that even at medical congresses physicians cannot be sure to receive an honest evaluation of drugs because most speakers are industry sponsored. On a different note, six respondents were very critical of the high pressures that are exerted on physicians by drug companies. Drug reps spoke mostly from a long range perspective, referring to the 'industry' rather than to themselves as representatives. Still, interviewees were not denying their personal share in the matter. As one drug rep stated:

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I often really feel sorry for them. I think they sometimes just don't know where they actually stand and they just don't have the time to thoroughly inform themselves. Actually, we should be partners who are informing them…but they cannot always rely on us anymore. […] You have to win them over, you have to convince them of your product…and often they just have enough of it. I sympathise with them. That's how it is. (D5, Drug rep)

While the above account is illustrating drug reps' empathy with doctors it is equally signifying that drug reps are not able to stick to their ideal role as disinterested advisors any longer. Yet by employing terms like 'you have to' they are indicating that this is happening against their conviction.

Altogether, I found the concept of 'empathising with physicians' to be a major determinant of drug reps engagement in detailing. It is partly because interviewees have so much attachment with doctors that they brace themselves against the act of discursive manipulation. Thereby it becomes less relevant how successful they really are in trying to keep a promotional discourse at bay. The important point is that they conceive serving the physician not only as a technical exercise but equally as defending a professional idea they feel emotionally bonded to.

7.4.2.3. Seeking impartial information

'Seeking impartial information' is both an emerging first order concept and an overarching theme. Despite searching for another data structural increment, 'seeking impartial information' proved to be the determinant concept / theme on each level. Storylines supporting the concept / theme were produced by office-based and hospital physicians in my study. All ten physicians interviewed said that they enter the talks with drug reps with the aim to receive scientific and technical product information. Scientific consulting is wished to be the key purpose of drug detailing. In that, physicians' understanding of the detailing encounter is perfectly mirroring the ideal conception of drug reps. This is not a surprising outcome. In chapter five I have already introduced the notion that – following Hall, et al. (1999) – doctor and drug rep identities are actively constructed and negotiated in everyday conversational

interaction. Furthermore, according to Drew & Heritage (1992), the sequential structures in that interaction provide the means by which participants jointly construct a particular social order and come to a shared understanding what is going on. Thus drug reps' frequent exchange with physicians has most likely aided to the identity-conceptual concordance that I have observed. While respondents from both sides report to have matching motivations, it remains to be seen whether there is also perceptual consensus in terms of activation.

Within the group of physicians, there has been a difference in informational detail required which is essentially driven by occupational setting. Four out of five hospital physicians mentioned that they wish to go into technical details with the drug rep. Overall, hospital physicians expressed a greater aspiration to know the scientific minutiae compared to their office-based colleagues in the study. One hospital physician described her expectations the following way:

The drug rep should inform me about new drugs on the market and about the advantages of his drug compared to other drugs. He should also precisely demonstrate why me of all people should actually use this new drug…for which indications. That should come across very precisely. […] Actually, I am always interested in the pathomechanisms. How does it originate and how does the particular drug act? What kind of interactions do I have to pay attention to? When can I apply it? I am also interested in doses, how to apply it, how long to apply it…do I have to reduce the dose or adjust the dose? (P4, Hospital physician)

This illustrative quote is demonstrating the informational scope and detail requested by hospital physicians. However, to my interpretation this quote was equally a demonstration of professional conceit. I got to this impression because the account came from a young physician who at many other occasions during the interview spoke about the importance of his/her task while belittling the contributions of non-physicians. The physician was simply not showing serenity and superior ease and hence his/her account may be a slight exaggeration. Still, by their statements hospital physicians in my study overall show they are very demanding in terms of scientific and technical information.

Unsurprisingly, all office-based doctors in the interviews expressed a greater need for application-oriented information. Nevertheless they all expected to receive scientifically sound updates. Yet, as by my respondents' accounts, the information has to be constructed and displayed to reflect the diversities and turnover rate of a busy doctoral practice. One respondent, who after spending the first part of his career as a hospital doctor had set up his own practice, aptly summarised the demands of practicing by saying:

I have done intensive care for ten years and now I am doing everything ranging from pulling rusty nails out of people's toes to treating heart attacks. Everything! And I have to come up with an idea for everything within five minutes.

(P6, Office-based physician)

Dealing with a broad diversity of cases is of course typical of family practitioners like the one quoted above. Nonetheless, the other four office-based respondents who all had a specialist area equally talked about high time pressure and huge variety of cases. They all pointed to the need of receiving technical and impartial information yet with a high practical relevance.

Differences in informational demand between hospital and office-base physicians can be explained by their differing work settings. Hospital physicians typically are specialists working in an organisational structure characterised by high labour division (McKinlay & Arches, 1985). Consequently, they count on detailed data to feed their work as specialists. The fact that they are surrounded by other specialists who rely on their input equally drives the level of informational sophistication. This is different with office-based physicians who largely communicate to lay-people. Office-based doctors altogether operate on a more holistic or broader clinical basis, much more in line with Parsons' concept of medical practice (Parsons, 1951). Naturally, their information needs are more general and practical oriented and in turn probably easier to meet by drug reps.

Why in their search for impartial information do physicians turn to drug companies? Are physicians unaware that drug companies are following a sales promotional agenda? None of the respondents in my study were unaware of that. I will present their

perceptions in detail at a later stage in the document. Yet at this point now I like to report my interviewees' motivation to engage with drug reps. The majority of respondents first of all pointed to the high convenience and low cost when receiving representatives of drug companies at their own work place. In the same breath, however, some of them remarked that their main source of information would be medical congresses and professional publications. This statement is typical and indicative of two things: first, subjects are contesting the disinterestedness of drug detailing, and second, they nevertheless believe they are in control with regards to the integrity of their informational supply. Yet research by Avorn, et al. (1982) pointed to the opposite fact. His study showed that doctors in fact heavily rely on commercial sources for information but nevertheless claim their influence to be minor. Irrespective of this, two young hospital physicians in my sample revealed that opportunities for them to visit relevant medical congresses are often few and far between, so that they sometimes turn to drug companies as an alternative source of information. On a different note, three office-based doctors remarked that in the solitude of their single practice mode they sometimes feel rather insulated from the rest of the medical community. Therefore, to them drug reps were a source of information yet also a point contact to other physicians in the network. When investigating the motives for physicians engaging with drug reps one major fact must not be overlooked: all physicians in my sample said that drug reps are often visiting them without notice, sometimes literally imposing themselves on them.

In summary, physicians in my study are primarily entering drug detailing talks with the desire to receive scientific and technical information about a drug and its application. Hospital physicians are demanding a high level of technical detail while office-based doctors wish for data to be very applicable. They all expect this information to be comprehensive and unbiased yet claim to know that this is not matching reality. Irrespective of this, the majority of respondents pointed to the convenience and low cost as a convincing reason for receiving drug reps.

7.4.3. Marketised discourse

As displayed in Table 9 on page 133, marketised discourse is the third of four aggregated dimensions describing the phenomenon of discourse in detailing. Marketised discourse is referring to how the protagonists conceive the act of detailing, always in reference of course to their underlying motivations. The whole component rests on three main themes, namely 'management instructions', 'drug reps' translations' and 'physicians' receptions'. These themes are assembling stories about how discourse is perceived to be instructed, how these instructions are interpreted and how the actual implementation of discourse is received. Different from the previous section on protagonists' motivations, accounts feeding the respective themes do not necessarily come from just one group of actors. I will begin with presenting respondents' views on the overarching theme of 'management's instructions'.

7.4.3.1. Management's instructions

The theme 'management's instructions' has emerged to reflect the input variables of marketised discourse. The theme is semantically carried by two first order concepts: 'simplification' and 'leading the physician'. Accounts gathered behind the concept of 'simplification' are dealing with the shortening, abridging or condensing of discourse. Furthermore the concept includes stories about repeating and memorising discourse because to my view it is sustaining the notion of simplification. The concept 'leading the physician' collects stories about the strategic character of discourse in detailing. It is referring to particularistic interests behind discursive practices. Simplifying discourse and leading physicians are strongly intertwined. By condensing discourse, for example, physicians can be directed in their prescription behaviour. I commence with displaying respondents' perceptions regarding the concept of 'simplification'.

Simplification

From a management's perspective discourse in detailing must be trenchant, concentrated and constantly repeated to have an effect on the physician. According to one senior manager the desired effect is that the physician takes in key messages and associates them with the drug's brand name. Presentations of technical and scientific details are missing the point because, although physicians may prefer them, physicians are unable to memorise the data or relate it to practice. The respondent further pointed to the risk of selective message intake on part of physicians which is potentially counter productive to the drug company. By that he referred to doctors remembering just one aspect of a large array of data and subsequently associating it exclusively with the brand. For example, if presented with a drug's full range of indications the physician in the end may only connect one rather economically unattractive indication with the brand. This according to the interviewee would be harmful to the company and must be avoided by focussing talk on productive indications only. This is a prime example for simplification of discourse becoming strategic.

Yet in my study simplifying discourse was typically sold as a benefit. Three out of four managers said that because physicians are flooded with information discourse in detailing must be simplified in order to be handled and retained by the physician. One senior manager phrased it the following way:

 You always think, Wow! Physicians are such intelligent people […] you can communicate with them on a very high intellectual level. Yes, you can. But they don't retain it. That's why I have to keep simplifying my detailing address to the doctor. […] Many drug reps are just too proud to express things in simple terms. Actually, physicians are just as everybody else and communicating with physicians is just like communicating with any other person. (M1, General Manager)

The manager is treating simplified discourse as something helpful and – by referring to 'everybody else' – implies that it is common practice. This quote is interesting because it points to the fine line between agenda-free discourse consolidation – which is principally helpful – and promotional discourse. While impartial discourse consolidation aims to strip discourse of informational ballast to the benefit of clarity,

promotional discourse aims to disfigure information to the advantage of particularistic interests. To my interpretation those in management function, deliberately or not, disguise promotional discourse as an act of message consolidation which is supposedly helpful to the busy doctor. However, if one looks to the technique of product positioning, as taught in every marketing textbook, it is all about competitive differentiation (e.g. Kotler, 1997). Simply put it means to carve out only those relevant product features that are either superior to or unmet by competitors. It is not about providing a comprehensive overview – neither detailed nor compressed – of product specifications and actions. On the contrary, the target audience is meant to receive just a unidirectional brief which stresses the relative advantages and cushions potential weaknesses. Experts in the field of advertising interpret positioning therefore rather defiantly as something that is done to the mind of the prospect (Ries & Trout, 1982).

I like to indicate however that if – as happened in my study – managers argue for simplified communication vis-à-vis physicians it does not automatically imply that they follow a hidden agenda. I am convinced that some truly believe promotional discourse is aiding to the process of informational clarity. I like to relate this optimistic interpretation of mine to what Angell (2004) called the effect of compartmentalization. Angell noted towards the end of her critical report *The Truth about the Drug Companies:* "In fact, it is my impression that most pharmaceutical employees, even at the highest levels, accept their own public relations. […] That is a testament to the effects of compartmentalization in big corporations; very few people know the full dimensions of the business. And it is also a testament to human nature. People want to be proud of their work" (Angell, 2004, p. 238).

As with simplification of discourse also constant repetition of talk is argued from the 'benefit to the physician' perspective. Due to physicians' busy schedules and vast information intake, messages have to be constantly reproduced. One respondent remarked that presenting the same talk just two or three times a year would be a waste of time. He conveyed that talk must be replicated at least eight times a year in order to be remembered by the physician. Assuming an average call frequency of four to six weeks (rate based on personal experience) the manager essentially requires the same talk to be presented all year round. As per the respondent's accounts, resistance to this practice is mainly coming from drug reps – not physicians – who long for presenting

new data to their customers. Drug reps' complaining and sensing of monotony is thereby seen as a typical reaction caused by what the interviewee called 'subjective perception'. The drug rep is under the delusion that because he is monotonously producing the same discourse his customer would be equally sick of listening to it. The respondent thought that this is just a misconception as from his own experience the very same message often is new to the physician time and again. Further to that end, the respondent was referring to insights stemming from 'modern communications science' that would substantiate his position. Unfortunately, at this stage I missed to press him further regarding the underlying scientific evidence he was suggesting.

Indeed, literature on communications (e.g. Petty & Cacioppo, 1986) is supporting the view that – initially – repeated exposure to a particular message is increasing the recipient's chances to remember it and to develop a particular attitude. Yet these insights have been viewed – and to my opinion must be viewed – in the context of persuading not informing. In my opinion, strategic repetition of discourse is not employed with the intention to enlighten someone but to promote a self-interested plan. My position connects to the critical stances of Wernick (1991) to whom promotion has become the general communicative function which has altogether led to a 'promotional culture', as well as to Fairclough to whom promotional discourse is "a vehicle for 'selling' goods, services, organizations, ideas or people" (Fairclough, 1993, p. 141). In the context of detailing, message repetition is thus sought to 'brand' a particular discourse in the doctor's mind. To my reading, by referring to insights of 'communication science' the respondent is only trying to legitimise his discursive plans and practices.

In summary, representatives of management in my study adhere to the notion of discourse simplification and message repetition in detailing. Respondents admit to the strategic character of this practice by providing examples of selective information supply aimed at maximising income. At the same time, they try to convey the image that these discursive provisions are aiding to informational clarity which in turn is meant to be beneficial to the busy physician.

Leading the physician

The concept 'leading the physician' has emerged from numerous accounts about discursively directing the physician instead of being led by him during the detailing encounter. It is different from the 'simplification' concept in that it concerns not the specific contents but the strategic conduct of discourse. All of the managers and also several drug reps reported that detailing talks are often scripted and that techniques to carry these scripts are regularly trained. Both, managers and drug reps referred to trainings in objection-management, conversation management, sales psychology and self-presentation. This by itself is nothing new and according to Oldani (2004) has been practiced for decades in the USA. As by my respondents, such trainings were introduced to their organisations in Germany during the first half of the 1990s. Since then they have been gradually intensified both in scope and frequency. Two senior managers conveyed that originally these technique were used 'covertly' by which they meant that physicians were guided indirectly, for example by means of knowledge implication ('I am sure doctor you know that…'). These accounts reflect what Fairclough (1992, 1994) referred to as 'technologization' of discourse which entails the strategic construction and precise training of discursive practices with the intention to exert influence over others.

Yet today, with higher pressures on managers and drug reps to succeed, discourse is also aimed at producing a tangible result already during the talk. Influence generation that remains undefined in terms of outcome is simply judged as insufficient. In this respect, manager-respondents frequently spoke about obtaining a 'firm agreement' or – in a more euphemistic tune – talked about reaching a 'common understanding' with the physician. As such, one respondent explained, the detailing address must convey a relevant benefit to the doctor but at the same time it must build up pressure for him to reciprocate immediately.

I simply believe that drug reps are trained to conduct the talk as efficient as possible. They must try to structure the talk in a way that they are possibly pre-empting the physicians' objections and then…and I think that is a very, very important point in a detailing conversation…that they come to a concrete agreement. Physicians tend to leave the conversation by saying: 'Yes, I do something for you. Yes…!' In the past

one was happy with that and said: 'Well, he said he would do something for me'. Today you immediately ask: 'What do you mean by that?'…and if he replies: 'Well, I will prescribe your product!'...then you ask: 'To how many patients?'[…] And you do it not so much in terms of a sales pitch but in order to better understand the collaboration with the particular physician. (M1, General Manager)

To my reading this statement is reflecting management's need for greater control in detailing. In that it relates to the concept of 'control' presented earlier in context of actors' motivation. In context of discursive planning, it further illustrates that management does not intend to let things slide. The quote displays that discourse is constructed to lead the physician to enter into a contract. This contract is equally about control ('to better understand') as it is about securing sales. At the end of the quote, the respondent is suddenly understating the sales aspect, stressing that agreements are mainly about improving the collaboration with the physician. I took it as a discursive reflex driven by a mixture of 'cultural scripting' and 'moral storytelling' (Alvesson, 2003). The respondent is perfectly aware that 'concrete agreements' are sought with the intention to push sales. In his role as general manager he was likely to be responsible for deploying or adopting this strategy in the first place. Nevertheless, towards the end he chose to present himself less aggressively and more in tune with the corporate image of being 'the physicians' partner'.

Overall, managers in my study revealed that they try to orchestrate discourse with the aim of leading the physician. This evaluation was also confirmed by some drug reps who pointed to various types of training ranging from objection management to sales psychology. Different from the past, however, today discourse is constructed to build up pressure for the physician to commit to a tangible result. Still, one senior manager claimed to conceive agreements with physicians mainly as contributing to a better understanding of the collaboration. Remembering the same respondent's motives with respect to 'simplification' of discourse, I took his claim as an institutionally scripted act of 'moral storytelling'.

7.4.3.2. Drug reps' translation

The theme 'drug reps' translation' is reflecting how drug reps perceive marketised discourse as designed and presented to them by management. The theme is pillowed by first order concepts of 'triviality' and 'embarrassment'. The concept of 'triviality' is assembling drug reps' accounts about the trifling character of discourse, while the concept of 'embarrassment' collects their feelings in response to the conceived discursive strategy. I will start with presenting drug reps' readings on the concept of 'triviality'.

Triviality

Nine out of ten drug reps in my study were criticising the trivial contents they are told to pass on to their physicians. Respondents typically defined trivial contents as topics that the physician is long familiar with and that are pre-packed into standardised phrases. These phrases are further described as 'loud' or 'slogan-like'. Two respondents even referred to them as 'vulgar'. Respondents thereby measured triviality against the high intellectual standards they assign to physicians. Remarks about the trifling character of the talk were frequently coupled with comments about doctors' sophistication and high educational level. Several drug reps said that neither the presentation mode nor the content of the talk would meet the intellectual standards and informational demands of their customers. Further to that point, two respondents said that the banality of discourse is indicative of the fact that management obviously thinks the doctor is 'plain stupid'. In terms of actual contents, drug reps stated that discourse is just delivering selected aspects of a drug's profile and indication spectrum in a highly compressed manner. Typical aspects presented are key indication, key benefit and key study outcome to support that benefit. All this is reduced to a chewable piece of talk containing a few sentences and one or two key figures. According to two thirds of the drug reps this oversimplification is offending their customers simply by assuming that physicians could be palmed off with this marginal input. The following quotation is symbolic of a number of equal statements.

It's highly compressed communication…and above all it has nothing to do with quality and aspiration. You could just as well send a postman who says: Listen doctor, please remember [product name]! And the postman could even do this at a much lower pay. (D8, Drug rep)

Triviality in discourse is further underlined by the requirement to constantly repeat the same subject. According to several respondents this makes discourse essentially self-destructive because any significance that was left is ultimately eradicated by replication. Following the demands by management to constantly repeat rather petty topics would make it very difficult to stay connected to the physician. As one drug rep phrased it:

They expect support from me in their in work as medics. But if I start talking in slogans I lose them. (D5, Drug rep)

Further to that end, one drug rep conveyed that 'losing' the physician due to irrelevance in discursive contribution is the worst thing that could happen to someone working in the field. This is typically manifested by the drug rep sensing that during the encounter the physician would be glad if the rep left his office. This, according to the respondent, will surely happen on a large scale if they keep on following the strategy the company expects.

To my interpretation of the respondents' accounts the notion of triviality has two dimensions. One is about disappointing or even offending the doctor by not delivering the information and service demanded. The other is about drug reps feeling devalued compared to their ideal role perception of being scientific consultants. A drug rep who – as illustrated above – is sarcastically comparing his task to that of postman is not conceptualising himself as a consultant anymore. During the interviews all respondents took to the first dimension when commenting on the effects of trivial content delivery. None of them approached the topic from a self-devaluation perspective. I got the impression that my respondents are truly interested in their physicians, nevertheless, their one-sided presentation also had a touch of 'moral storytelling' (Alvesson, 2003) to it. By advocating solely the physician's case they wanted to convey an image of selflessness which is not convincing. In my view, respondents judged discursive

triviality equally as an attack on their own self-conception. The level of sarcasm employed during their reports – using terms like 'regurgitating' or 'postman' to describe their tasks – is strongly pointing to personal frustration. Yet this was not addressed openly. When pressing them further on this on one or two occasions they kept arguing from the physicians' interest point of view. As with some of their superiors who 'sold' self-interested discursive practices as beneficial to the doctor, drug reps – in my view – also used the physician's interest as an excuse, this time to hide their feelings of being marginalised in their roles. This will become also apparent during the next section, where I will present drug reps' views on the concept of 'embarrassment' with regards to marketised discourse.

Embarrassment

Very early in the process of interviewing drug reps, one respondent stated – without prompt – that she felt embarrassed to talk promotionally. She claimed to be embarrassed to mention petty topics with her customer. Further to that end, she was ashamed to engage in twisted communication practices aimed at obscuring the scientific profile of the drug to the benefit of augmenting prescriptions. It was a very forceful statement and remained unique with regards to its frankness. This statement became the impetus for exploring the notion of embarrassment with respect to drug reps' reception of marketised discourse. In the course of the interviews I repeatedly came across reactions of bewilderedness with regards to demands for discursively selling something to the physician. Although statements were less outspoken and accusing they nevertheless could not be overheard. On some occasions, drug reps threw in comments like 'you cannot ask the physician to promote…' when e.g. describing the particularities of the detailing situation. In turn, I confronted the respondents with my impression that to them selling is something embarrassing. Indeed, half the interviewees voiced back that they feel embarrassed when asked to engage in promotional discourse. Inquiring further to the reasons of such feelings, I found that their rejection is largely based on the conviction that selling is not the focus of drug detailing. I have introduced this attitude earlier in this chapter with regards motivational grounds to engage in detailing. When now being directly asked to deliberate on the notion of marketised discourse, many interviewees expressed the

opinion that any promotion should be avoided because the doctor is unable to appreciate this concept at all. Again, respondents used physicians' attitudes or expectations to fend off promotional discourse. Irrespective of this, drug reps claimed to be aware that ultimately the company needs to generate sales. Yet in terms of internalising and implementing this objective most of the respondents imply to have stranger anxiety. This is exemplified by the following quote:

I mean we are not selling anything to the physician. The physician is not a buyer. The physician is a person who wants to help patients and therefore he needs drugs. Yes, of course, we have to make sales. Yet the physician has a different perspective: He wants to help the patient. And we have to make it clear to him that his patients can best be attended to when using our products. […] Yes, at the end of the day it's selling but…by another route. (D4, Drug rep)

To my reading, this quote is indicating that the respondent conceives sales promotion as convincing the physician on the basis of facts alone. More importantly, it implies that drug quality, performance and price are perfectly meeting requirements and that these facts simply need to be communicated. This is a scenario that may hold true in emerging drug categories or in markets which are under monopolistic control. Yet drug markets in Western countries like Germany are characterised by enormous competition and very little product differentiation. Given that, it seems unrealistic to assume that discursive practices in detailing can ignore that. Many other interviewees confirmed my assessment of the situation claiming that they are urged to promote rather aggressively. This is why I read the above statement mostly as the respondent demonstrating his unwillingness to engage on the dishonourable level of selling.

The guiding feeling expressed by many respondents was that of being embarrassed to market upfront. Drug reps frequently mentioned that physicians would disapprove of such practices which in turn are weakening their standing with the physician. Exemplifying this view one very experienced drug rep reported:

For years, I have never even mentioned the name of a competitor. That was not necessary, and that would have been out of place. I speak for my product and that's

it. And my doctors always appreciated that. Today, you have to do it […]. It's a different level now. Actually, this level is becoming increasingly rude. (D5, Drug rep)

To me this statement is showing several things: on the one hand, the respondent rates promotion through differentiation from other products as somewhat low-level and as such discomforting to her. Furthermore, the interviewee is inversely implying that upfront marketing is not appreciated by physicians and hence it is not aiding to a productive relationship between drug reps and physicians. Third, the underlying feeling of embarrassment is probably also originating in the perceived disrespectful treatment they are receiving from management. In other words, drug reps are not only embarrassed on view of physicians but equally because they are assigned a petty task that undermines their occupational self-conception. Criticising marketised discourse is thus not only a moral or ideological issue but also an identity issue. Drug reps in my study openly adhere to a collective interest yet I have reason to believe that their critique and embarrassment is also self-interested. Drug reps essentially want to protect their function as scientific consultants on which their occupational self-actualisation is based. Being a consulting partner to the physician can be regarded as a meaningful activity satisfying a higher order need such as expressing oneself through one's work (Marx, 1932). To my interpretation drug reps feel embarrassed because they sense to be professionally downgraded vis-à-vis the doctor.

Altogether, subjects have been found to be very critical of marketised discourse. Subjects have openly voiced moral as well as customer relational concerns to engage in promotional discourse. Morally, criticism was related to the deceiving character of promotional discourse, relationally, their disapproval was about fear to terminally offend and thus 'lose' the doctor. Though not having addressed it directly, respondents have still provided considerable evidence that they also have occupational identity concerns. To that end, many subjects expressed a feeling of being used mainly as a speaking tube of marketing which is seen as underrating their professional qualification and thus undermining their occupational self-conception.

7.4.3.3. Physicians' reception

The overriding theme 'physicians' reception' is reflecting how the discourse is perceived by doctors. Different from the previous section, these accounts are assessments of real discourse experienced. When before drug reps were commenting on the concept of marketised discourse as devised by management, now physicians provide insights about its implementation. The main theme is carried by three first order concepts which I will present in the following section. The concept of 'contribution' is gathering doctors' accounts about the functional value drug reps are providing during the talk. The concept of 'manipulation' assembles physicians' stories about how drug rep talk is trying to exert influence. Finally, the notion of 'being sold to' is collecting views expressed with respect to the selling aspect of discourse. I will begin with displaying interviewees' perceptions on 'contribution'.

Contribution

During the interviews physicians have been asked to reflect on the discourse as produced by drug reps and how they rate its value with regards to their work as medics. This question was embedded in the context of physicians commenting on their interaction with drug reps. Six out of ten physician in my study stated that drug reps are not meeting their scientific and technical information needs. Out of the six respondents who criticised drug reps' performance, four were hospital based. As shown earlier, hospital physicians by structure of their work setting tend to be more demanding in terms of informational detail. This attitude was clearly reflected in their assessments. The most prevalent point of critique was that of superficiality with regards to scientific contents presented. Further to that point, all six respondents referred to a situation in which drug reps were unable to competently answer questions more in-depth. Typically, doctors said to be interested in things like mode of action, side effects and the drug's interactions with other medications. They often prefer to flexibly address partial aspects of a subject in greater detail. In such cases, physicians wish to enter into a technical discussion with the drug rep. To their frustration, many drug reps are unable to rejoin proficiently; instead they are offering to pass the questions on to their central office. The following reference is illustrative of several similar comments.

They advertise their product, of course, but how the drug actually works that they do not know. Too little background knowledge…too little knowledge of the basics. I mean: how does the drug act, where does it intercept? How does it really work…in the cell? […] Drug reps do not know anything thereof…that's at least my experience. They come here, ask us if we want to take part in some sort of CME (continuous medical education) *event or they give us some nice looking brochures. Well, then you have to study the brochure in detail to get the information because the talks do not give me anything.*   (P4, Hospital physician)

As per the respondents' reports, all this runs counter to their ideal conception of a fast and competent knowledge update by the industry. The perception is further intensified by the high frequency of visits which causes the talk to lack novelty.

Feedback by office-based physicians with regards to drug reps' discursive contribution was altogether more favourable. Three out of five respondents said that they generally value the talks with drug reps. Respondents claimed that in most cases drug reps are providing helpful information with regards to the key features and uses of a drug. Furthermore, detailers' presentations were regarded useful for learning about new trends and developments in certain product categories which doctors otherwise would not always know about. Importantly, whenever physicians spoke positively about drug reps' talk they pointed to their long lasting relationship with them. Conversely, when expressing dissatisfaction with detailers' contribution they mentioned high (personnel) turn over rates. This became a noticeable feature during the field work. In the course of the interviews it became evident that office-based physicians in my sample primarily value the personal contact with the drug rep. Compared to their hospital-based colleagues, technical information was significantly less relevant to them. Challenging them further by asking what they would miss the most if their drug reps would not visit them any longer, three interviewees immediately pointed to the 'personal exchange' with the drug rep.

To my reading the more positive assessment by office-based physicians is mainly due to the following: office-based doctors' demands for high applicability of technical information are fostering the acceptance of compact information delivery. This is

strongly in line with the compactness of marketised discourse strategies as – according to my findings – devised by management. Even more important is the insight, that office-based physicians value, above all, the personal exchange with the drug rep. On that note, two respondents remarked that talking with the drug rep is a welcoming change in their daily routine with the patients. One office-based doctor conveyed that she regularly shares her sorrows with some of her drug reps. This would include talks about problems with health insurance policies as much as personal stories about family affaires. Value of drug rep talk is thus assessed very differently across the scope of the sample. Hospital physicians require functional contributions and are mainly disappointed by the quality of the delivery. As per my respondents, drug rep discourse to them is of very little functional value and often simply a nuisance. Office-based physicians, on the other hand, largely expect concise updates and look for relationships beyond functional matters. They value discourse by different standards and thus altogether come to a more favourable rating.

However, to my perception positive accounts by office-based physicians were partly determined by respondents acting politically. During the interviews two respondents quite obviously wanted to protect their drug reps from any negative consequences potentially developing from the interview. It became evident because respondents were eager to withdraw or relativise any negative statements they have made about drug rep performance. For example, one physician mentioned that 'talk appears to be memorised' yet quickly added that this is not the case with any of her regulars. Another one commented on drug reps' unpleasant assertiveness just to finish the story with how much she is altogether pleased with her detailers. In my view this was reflecting their suspicion that I was a management spy who could potentially harm the drug reps. It is what Alvesson (2003) referred to as disturbances emerging from interpersonal relations between interviewer and interviewee. Respondents' inner speculations about my true role probably lead to a politically manoeuvring in support of the drug rep. Assuming that I have interpreted this correctly, their political acting still provides a valuable insight in its own right. Namely, that the relationship between physicians and drug reps is important enough for the physician to engage in any politically motivated discourse with me.

Manipulation

While some physicians commented positively about drug reps' overall contribution, the majority of respondents were highly aware and thus very critical of detailers' methods to discursively exert influence over them. Hospital physicians expressed their disfavour quite vividly while office-based doctors were slightly more reserved. On a general note, more than half of the physicians said that drug reps' discourses are easy-to-see attempts to influence script writing. They asserted to recognise this right away and all but one claimed to be unaffected by it. In other words, promotional talk was argued not to influence their script writing. As mentioned before, this is a typical reaction and pretence of control which has little basis in fact as several studies have shown (e.g. Cleary, 1992; Rizzo, et al., 1999; Manchanda & Chintagunta, 2004). In terms of its form and mode of presentation respondent painted a quite homogenous picture. Promotional discourse was described by and criticised for its schematic and mechanic character of talk. One respondent referred to a 'standard loop of talk' that the drug rep is following through, yet missing to show any personal commitment or verve. Interviewees furthermore pointed to the designated character of promotional talk that did not welcome flexibility.

The typical drug rep presents a glossy brochure or shows five, six slides on his lap top […] and you notice that he wants to machine down his arguments exactly as written in the brochure. And he does not like to be interrupted by any questions in this phase of the talk. (P3, Hospital physician)

The respondent further voiced his anger about being virtually plastered with talk which makes the communication to him highly asymmetrical. Mechanical and designated talk as perceived by respondents is indicative of the sending character of promotional discourse. This is in turn is characteristic of hegemonic discursive behaviour as described by Gramsci and later by Fairclough. (Gramsci, 1971; Fairclough, 1992). It is hegemonic because the sender obviously has no interest to enter into a dialog with the receiver. Instead, he tries to subject the addressee to his interpretation of the world. Yet out in the field the sending status of drug reps is highly exposed and unprotected. Inconvenient questions by physicians are potentially destroying the sham integrity of promotional talk and thus are gladly avoided or ignored by the drug rep. Different from

e.g. print or TV advertising where discourse can not be directly responded to, promotional talk is vulnerable to immediate challenge and criticism. In particular, if the recipient has a knowledge advantage that the sender cannot possibly match (Greene, 2004). To my interpretation this is why promotional discourse is aiming for a coherent story that remains mainly at the surface of things. From my personal experience, the dramaturgy and content of the talk is designed so that everybody can agree to its logic. Yet by my respondents' accounts, smoothness hardly passes through with physicians. Altogether, the industry is not unaware of this and according to Oldani (2003) increasingly tries to address the patient directly in order to circumvent physicians' scrutinising the promotional argument. However, this type of consumer pressure building – which is typical of the US market – is very limited in Germany where the law on advertising in the healthcare system (*Heilmittelwerbegesetz*) is prohibiting any direct talk to the patient.

The other outstanding characteristic of promotional talk – according to many respondents – is its one-sided and often decrying presentation of contents. All physicians in my study reported to have experienced this. However, to three office-based doctors this was rather the exception than the rule. Their feedbacks largely connect to the insights obtained with respect to the concept of 'contribution' presented in the previous section. The majority of respondents, in particular the group of hospital doctors, revealed that biased promotion was rather a common phenomenon in drug detailing. Doctors were irritated and at times amused about the bluntness in which unilateral updates were presented. For example, one physician said that whenever the term 'better than' is mentioned he gets alarmed. Further to that point, several respondents criticised that drug reps always try to convey the impression that their product is invincible. They always attempt to differentiate their product pretending there are facts to support their case.

His product is the best, of course! All other products are blanked out. […] Or he brings along a table where his product always wins…more tolerable, less side effects…blah, blah, blah…and the other products are run down badly…all other products…which is simply incorrect! (P4, Hospital physician)

Next to an unpleasant feeling of deception physicians are vexed about the extra time and effort associated with 'disentangling' biased discourse. By that they meant researching the credibility of certain statements in the literature or tediously interrogating the drug rep to get to the bottom of things. Yet scrutinising is time consuming and, as per several respondents, sometimes just cannot be followed through. According to one interviewee, these circumstances are damaging the overall trust in the industry and its representatives. It corresponds to Fairclough (1999) who spoke about 'pathological effects' that promotional discourse is having on society. Fairclough argued that there will be growing distrust in discursive practices because of people's rising inability to recognize authenticity in communication. As per my results, although physicians are intellectually able to scrutinise the talk they still lack the time, manpower and endurance to do so.

Four out of ten physicians concluded that schematic and biased presentation is a sign of discursive prefabrication triggered by meticulous company training. When pressed further on this, respondents conveyed that some drug reps have told them about various rhetorical trainings they are receiving. Altogether, the majority of respondents claimed to know that discourse is essentially controlled by management. In this respect one respondent pointed to the hierarchical system within the industry that becomes quite obvious during medical congresses. At such occasion the industry usually shows with a lot of different people and – according to the respondent – it is easy to observe that drug reps are the least important of them all. All in all, respondents are consciously distinguishing between drug reps and their managers. Drug reps are typical conceived as simple agents who have to follow instructions. In turn, some (3) physicians expressed their empathy with drug reps' for being in a position of dependency and little intellectual challenge.

Being sold to

Last not least, I like to present physicians notion with regards to the concept of selling. It clearly connects to the notion of 'manipulation' yet it has a more general quality to it. For that reason I prefer to present it separately. As the act of selling is usually a discursive one, some respondents were inspired to comment on it whilst evaluating the

concept of 'manipulation'. Essentially, physicians wished to explain why to them selling or being sold to is an awkward experience.

Physicians took issue with the notion of selling on the representational as well as on the ideological level. At the representational end, some physicians were simply piqued by the improper intrusiveness associated with the act of selling.

If drugs are boosted I just think it's bad style…but that's probably just me. […] I believe physicians are generally not the type of people who respond well to such practices. Things should be presented with a certain integrity and dispassion.

(P6, Office-based physician)

Physicians' claims for decency in discursive practice may be explained with the bourgeois value system the profession is socially embedded in. Equally, demands for discursive decorum could be due to physicians' 'affectivity neutrality' (Parsons, 1958) which they are trained to develop during medical school. Both reasons surely play a prominent role in shaping an attitude like the one illustrated above. To my reading, the quote is furthermore demonstrating that the physician is used to be shielded from the market in which the concept of selling plays a fundamental part. In other words, one must be able to afford an attitude like this. It could be given by the fact that one's income supply is still largely independent from market forces.

This directly leads to the ideological aspect behind rejecting the notion of selling. Physicians in my study have barely been dogmatic yet several respondents made it clear that trading is something they do not wish to be involved in. They pronounced that medical work must not be influenced by any commercial interest. For example, they repeatedly voiced that they are not interested in any brands or brand related promotions but solely care for applying chemical or biological compounds. One older physician emphasised that she advocates social equity and therefore she 'cannot always do everything for money'. By this she was referring to constant price increases to the benefit of the industry and pharmacists which she was disapproving of. During the interview she further conveyed that she was rather critical of the market economy system in general. However, a system critical attitude like this was not typical among the other respondents in my study. Confronted with the direct question of why

physicians are reluctant to accept any sales promotional interest a young hospital doctor explained:

If the notion of selling shimmers through it becomes deterring for doctors. Doctors really do not see themselves as selling drugs to patients and therefore they have difficulties passing this concept along. I personally think that's why they handle it rather badly if one tries to approach them on this level.   (P3, Hospital physician)

Physicians expressing their scepticism towards the act of promotion and selling can be traced back to Parsons' interpretation of medical professionalism. In their role as safeguards of social cohesion, according to Parsons, doctors are to adhere to collective rather than particularistic interests (Parsons, 1958). From this perspective, promoting a particular drug on grounds other than therapeutic indication must principally be seen as an act of corruption. However, we have also learned that Parsons' concept was criticised for being a rather normative reading and – at no point in time – a realistic sketch of the actual situation. Along these lines many researchers have accused physicians of promoting their own financial interest quite vividly (Freidson 1970, 1986, Daheim, 1992; White, 2002). However, traces of such immediate particularistic orientation could not be found in my study. Naturally, I would think physicians were reluctant to admit to any commercial bias as it would be contradictory to their own self-conception based on the Hippocratic Oath.

7.4.4. Response to marketised discourse

The fourth overarching dimension as displayed in Table 10 (p. 140) is dealing with responses to marketised discourse. Different from the previous dimension 'marketised discourse' (section 7.4.3., p. 166) it entails insights about how drug reps and physicians operate in response to their perception of discourse. Thus the focus lies on accounts about action not on statements of evaluation. Importantly, the reader has to keep in mind that action taken by drug reps and physicians are following sequentially. Drug reps react to management's instructions concerning the design and presentation of discourse. Subsequently, physicians are reacting to drug reps' implementation of discursive practices originally conceived by management. Altogether, this is done to

display variances in goal attainment between management's instructions, drug reps effective implementation and physicians' actual reactions to marketised discourse.

The analysis of the interview data has brought about two main themes describing the protagonists' reactions, namely 'drug reps transforming marketised discourse' and 'physicians avoiding marketised discourse'. I will begin with presenting drug reps' accounts regarding how they transform marketised discourse instructions.

7.4.4.1. Drug reps transforming marketised discourse

The main theme is fed by two underlying first order concepts that both collect stories about how drug reps influence the discursive provisions received by their company management. In this respect 'sabotaging' is gathering all accounts about how detailers wilfully damage marketised discourse. On the other hand, 'constructing' is collecting stories about drug reps scripting their own discourse. The two concepts are also connected in that respondents use ridiculing of marketised discourse to introduce their own discourse versus the physician. I will start with presenting accounts on the concept of 'sabotaging'.

Sabotaging

The phenomenon of sabotaging came to the fore early during the interviews. Several drug reps who expressed their disapproval and frustration with instructions to talk promotional subsequently revealed how they dealt with it in practice. Four out of ten candidates conveyed that they engage in some sort of impairment of discourse. This ratio may even understate the actual situation, taking into consideration that some respondents may still have had doubts about interview confidentiality. In their accounts respondents have varied considerably in frankness but their degree of openness was not necessarily related to their level of frustration displayed. While all statements were reflections of dissatisfaction, none of them was uttered in a fit of temper.

Analysing the accounts of the four interviewees, tampering of marketised discourse is typical carried out in a combination of unmasking and ridiculing marketised discourse in front of the doctor. Unmasking is done by virtually announcing that promotional discourse is coming. According to one respondent this is sometimes performed in an ironic tune, which to my interpretation is done to bring criticism across rather smoothly. Asked for their motivations, subjects said that they always try to remain honest with their physicians. If prefabricated discourse is against their conviction or style they simply would not hold back on their disagreement. Acts of sabotaging is thus not a permanent mode replacing all marketised discourse. It is employed rather selectively whenever the drug rep feels that the talk is exceeding a particular level of triviality or mendacity. The exemplary quotation below indicates that this is done in a very direct fashion.

I convey to the physician: You know, I just had another marketing training and I have to present this to you now because tomorrow you will be called. There will be a day-after-visit study tomorrow and you will be asked about that. That's why I have to present it to you now. (D2, Drug rep)

This is a strong example of sabotaging because the drug rep is 'a priori' devaluating the contents to follow plus she is also influencing the mechanisms of control. Informing the physician about a day-after-visit study beforehand is like prompting the answer to a quiz. In fact, the drug rep enters complicity with the physician. Harming the actual message but nevertheless ensuring that feedback will be in line with management's expectations, the drug rep is covertly sabotaging the marketing strategy. The detailer is taking sides yet ensures that she is covered. Such form of feigned adaptation is understandable and also typical for subjects in a position of e.g. powerlessness and economic dependency (see e.g. Merton, 1949). Yet it also shows that there is a degree of self-interestedness on part of the detailer that she otherwise tried to play down in the interview. Her morally loaded claims of honesty and scientific service to the physician obviously are not as resilient to be defended openly versus management. My reading is less meant to be a reversed form of critical discourse analysis whereby I am now unmasking the discursive manoeuvres of the powerless in order to accuse them. It is much more to avoid any black and white thinking in the context of detailing by scrutinising accounts for disturbances like 'moral storytelling'. Irrespective of this, the

crucial finding is that some drug reps do not accept marketised discourse implicitly but strongly oppose it by undermining management's strategy in practice.

Constructing

The concept of 'constructing' emerged out of respondents' stories about how they circumvent marketised discourse by composing their own talk versus the physician. Seven out of ten respondents said that they would – at least in parts – put together their own contents and speeches. The concept is different from 'sabotaging' in that it is creative not destructive in nature. Although the revised discourse is not in line with management's directives, it nevertheless offers an alternative discursive product to the physician. Sabotaging and constructing are also intertwined in that drug reps first unmask discursive practices after which they continue performing their own format. However, construction does not mean that all contents and formats are changed. None of the respondents voiced that they would totally ignore discursive instructions. According to several interviewees it rather entails that new talk is added or that prefabricated parts are combined with individual ones. Despite taking the liberty of personal discourse construction, to some drug reps it is a highly stressful act because the talk must be at least half way balanced with the management brief. Furthermore, due to the triviality and quick wear-out of promotional messages, drug reps constantly have to come up with new mostly scientific themes in order to legitimise their frequent visits versus the doctor. The following quotation is illustrative of a number of identical comments.

I try to sidestep, I try to bring about different topics, and I try to weave something into the talk that might interest him. But then I am not always in line with what the company expects from me. (D3, Drug rep)

Construction of new talk is driven by what the drug rep believes the doctor is really interested in. As per my respondents, this implies providing impartial scientific and technical service as well as catering to doctors' wishes to talk about issues that bear down on them. The latter is typical for drug reps who have long-lasting relations with their physicians. Three of them said that they try to get the promotional bit out of the

way by mentioning just a few key points. Then they would quickly shift into a personal conversation mode sometimes initiated – as one drug rep reported – by the physician offering 'to have a cigarette'. Several candidates revealed that their talk then becomes comforting in nature and sometimes seems to have a therapeutic function to the physician. One of the interviewees found that this is emotionally burdening at times, still all of them expressed their satisfaction to be able to communicate with their physicians on this level.

Altogether, the notion of 'constructing' to drug reps means combining various types of discourse, namely promotional, scientific and personal discourse. Promotional or marketised discourse is thereby said to be kept to a minimum and if possible set apart from the rest of the talk. Drug reps are aware that they have to sell but none of them showed to identify with it. This differentiation was manifested in a dual role conception on part of respondents as the following quotation indicates.

I have two roles in this. One, I am the representative of [company name] and as such I have a clear mandate: I am supposed to generate sales…and I have to manage this somehow. And then I also see myself as a partner to the doctor giving advice to him.

(D2, Drug rep)

The above account is symptomatic of a drug rep who – defiant of a very different organisational goal – is trying to adhere to a role as an advisor that obviously satisfies her intrinsic need. To classic sociologists like Durkheim and Merton such behaviour is suggestive of anomie, a cognitive state in which the individual feels alienated due to lack of or disagreement with the normative system. In line with the slightly more contemporary perspectives of e.g. Seeman (1959), Blauner (1964) and Mottaz (1981), strong disagreement with organisational goals leads to social isolation, a variant of work alienation. In the particular case the respondent did not act in a pure fashion as defined in Merton's (1949) typology of defiant behaviours. Instead she showed a combination of rebellion and ritualism, a mixture of active opposition and feigned adaptation.

Organizational commitment theory (e.g. Reichers, 1986) provides an additional explanation for such conduct. In this context McGee & Ford (1987) spoke about

continuance organizational commitment, describing a condition of attachment where individuals simply lack an alternate employment opportunity and/or there would be high personal sacrifice associated with leaving a particular association (Angarwal & Ramaswami, 1993). Indeed, the majority of respondents in my study voiced that they see very little opportunity for a job change as they expect to find the same situation (marketization of drug rep work) prevalent across the industry.

7.4.4.2. Physicians avoiding marketised discourse

This main theme emerged from stories about how physicians react to discourse they are experiencing during the detailing encounter. In this respect, we have learned already that doctors perceive marketised discourse to be highly prevalent despite drug reps claiming that they try to reduce it to a minimum. I have reported that many physicians disapprove of the overt promotional character of the talk claiming that these practices are obvious attempts of manipulation. Furthermore, I have shown that doctors claim to have difficulties with the notion of marketing, both on representational as well as on ideological grounds. At this point now, I am interested to know how physicians handle marketised discourse in practice. The overarching theme of physicians avoiding marketised discourse is carried by two first order concepts, which I have called 'inhibiting' and 'escaping'. The first is collecting accounts about how doctors restrain promotional talk during the encounter. The second is gathering reports about physicians literally running away at the prospect of being talked to promotionally. I will begin with presenting doctors' perceptions on the concept of 'inhibiting'.

Inhibiting

Half of the doctors interviewed said that they prevent promotional talk to expand during the encounter. This was particularly the case in situations where drug reps produced overtly biased talk or kept repeating the same promotional messages over many visits. Respondents varied in their handling of the issue. Three doctors reported that they would simply display their disinterest with ostentation. This would include measures like asking the drug rep to hurry up or inviting him to 'skip this part'

completely. Two respondents declared that they voice their disapproval quite directly with the drug rep. To them this means criticising the drug rep on the spot for e.g. whitewashing the facts. Furthermore, to openly voice back to the drug rep that they do not want to be pressured into prescribing a particular product. Further to that point, one respondent said to be scorned by inquisitions about her prescribing pattern and stated that she would block this off immediately with those drug reps who try. Altogether, several respondents felt the need to inhibit any attempts to be directed or lectured by drug reps during the encounter.

Then there is the 'pointer' act…and I do not want this…that's really like them playing schoolmaster.   (P1, Hospital physician)

The quote points to the power aspect of marketised discourse. According to Greene (2004) physicians – based on their self-conception as autonomous experts – do not want to be lectured in their area of proficiency by non-physicians. This insight was also confirmed by one of my respondents in the study. To my interpretation the directing and goal attaining character of marketised discourse is seen as an inappropriate challenge to their position as experts. Thus if discourse becomes leading and demanding it seems to spurn physicians' resistance to that discourse. I suspect that inhibiting promotional discourse is equally done for power than for ideological reasons. This was confirmed during the course of the interview. As the respondent was further elaborating on the schoolmasterly treatment by drug reps, any ideologically or morally grounded critique faded into the background:

The general rule is that he wants to sell me something... […]…this means he wants something from me. And I would argue that this requires a certain behaviour… which is seldom the case. It's sometimes as if they had something to offer...and I do not see that!   (P1, Hospital physician)

Interestingly, the respondent is clearly acknowledging the trading character of the encounter. While several of her colleagues previously expressed to have an uneasy relation to the notion of selling, this respondent takes it all rather pragmatically. However, she is obviously agitated with the way matters are presented by drug reps. Yet to my reading the above quote is not only about missing or demanding respectful

behaviour. It is much more reflecting the respondent's consternation that drug reps are attempting to challenge the traditional role allocations. It becomes particularly evident in the last sentence in which the physician is denying drug reps to deliver any added value ('as if they had something to offer'). In its absoluteness her last sentence is probably an exaggeration. Still, the respondent is negatively reacting to a discursive strategy by which drug reps overtly demand support (e.g. prescriptions, endorsement or critical information) in return for their services. This observation connects to the practices as devised by the industry (see section 7.4.3.1. on page 159). According to accounts given by managers in my study, obtaining a firm tangible agreement with the doctor is a crucial objective in today's detailing. The above quoted doctor, however, takes a different perspective on the matter. To her view the industry has to provide extensive information and service and leave the physician to decide what to do with it. She contests the right of the industry to demand something in return, whereby in my opinion the issue lies with the notion of 'demanding'. Naturally, every physician in charge will eventually reciprocate to the industry be prescribing or recommending a particular drug. Yet, according to my study learning, many interviewees believe – or like to convey the impression – that this is done on the basis of objective analysis only. It must not be done on grounds of an individual 'quid pro quo' obligation to a self-interested commercial party. Physicians' attitude again can be ascribed to their ideal self-conception as 'affectively neutral' experts following a collective interest as portrayed by Parsons (1958). However, different from Parsons' idea but in line with Freidson's (1970) critique of it, those physicians obviously derive a claim to social power from their ideal self-conception. This claim, amongst other things, prohibits them being directed or pressured by non-professionals like drug reps.

Altogether, physicians in my study reported to stop any attempts by drug reps to spin or pressure them discursively. Doctors claimed to intervene either by displaying their indifference or by directly reprimanding drug reps on the spot for e.g. whitewashing the facts. To my interpretation, their reasons for stopping marketised discourse are equally motivated by critical market ideology as by fending off contests to professional and thus social power.

Escaping

The concept of 'escaping' is describing a situation in which the doctor is physically avoiding the encounter with the drug rep. Stories gathered under this concept are relating specifically to avoidance caused by dissatisfaction or enervation due to marketised discourse practices. This is an important specification, because in the course of the interviews I found that many encounters were said to be dodged simply due to time constraints caused by increased work loads. However, in some cases time constraints were obviously brought about by increases in drug reps' call frequency which is a strategic facet of drug marketing. Irrespective of this, I focussed my attention on those accounts clearly relating to escaping due to disapproval with marketised discourse.

Six out of ten physicians interviewed spoke about incidents where they escaped from drug rep visits. Out of the six respondents five came from a hospital background. For hospital doctors, characteristic modes of escaping were said to be e.g. changing one's course at the sight of a drug rep waiting in the hallway of the ward or by pretending to be busy with a patient. Two interviewees reported that they often pass the responsibility of having to meet with a drug rep on to another colleague. This is frequently done by delegating detailing talks down the hierarchy which to me is indicative of the event being rated as irrelevant or highly unpleasant. When asked directly about their motivations for escaping, the majority of hospital doctors confirmed my assessment. The subsequent citation is typical of several accounts given in this context.

The drug rep is mostly a disruptive element, you have to say it. […] And if you have to deal with him and he is not delivering quality than this is really annoying.

(P2, Hospital physician)

Although in this quote the respondent is not referring to marketised discourse directly he nevertheless implied it. Throughout the interview he kept complaining about the 'pushing and hyping format' of the talk that comes at the expense of quality information delivery. This, he declared, would let him avoid these encounters at any opportunity. To bring his point across, he equally kept referring to one exceptional

detailer who by means of sound knowledge and dedication was highly accepted and basically treated like a member of the medical team. However, this account was overwhelmingly contrasted by his stories about the irrelevant and distracting character of detailing encounters.

By matter of spatial setting, office-based doctors have little room to escape from drug reps. As per my sources, they handle the situation differently by simply refusing to see certain drug reps in their offices. According to one respondent, reception is now increasingly controlled and granted only against advance notification of the visit – a modus which used to be highly uncommon in Germany not long ago. Yet office-based physicians in my study were also torn between two needs. On one hand they liked to prohibit commercially laden talks, on the other hand – in their situation as single doctors – they longed for outside information and network contacts. Thus none of the office-based doctors reported about any severe measures against drug reps talking promotional. At the other end, one drug rep gave her view about how physicians escape the detailing encounter yet still manage to receive the drug rep. Her observation may act as juxtaposition here. The respondent reported that increasingly office-based physicians give her a short shrift at the front desk. Instead of being invited to enter the doctor's office or meet in the private setting of the lunch room, she is asked to remain in the public area at the entrance. To her perception the doctor is reverting to this 'public setting' modus to keep the detailer in check and – most importantly – to be able to retreat at any time. I read this behaviour simply as a covertly and flexible form of escaping from drug rep talk.

All in all, hospital physicians in my study conveyed to physically abscond at the prospect of having to meet with detailers. They typically delegate the responsibility to a colleague or simply hide away. Due to their different work setting, office-based doctors tend to take a different approach. According to my sources, they revert to either controlling access or engage in brief encounter under the screen of the public. When asked about their motivations for escaping, both groups of physicians in my study pointed to the informational irrelevance as well as discursive directedness of promotional talk which they wish to get away from.

7.4.5. Summary of representative quotations

In Table 10 below I have summarized the key representative quotations for each main theme that has been discussed.

Table 10: Data supporting interpretations of impact of marketised discourse

Main Theme	Representative Quotations
Situational Background	
Loss of professional power & autonomy	• *Then let these paper pushers prescribe drugs to the people…this is not my idea of being a physician. As a doctor I decide what is good for you. And I prescribe the drug for you. […]. And now they are telling me what I should prescribe. This cannot be. For a doctor this is hardly acceptable.* (P8, Office-based physician) • *The way this is organised…and politically intended…namely to set up some sort of ambulatory healthcare centres, not run by physicians, where we simply are instruments... to me is no alternative to professional freelancing. Although there is already little professional freedom left I would still not let me force into that. Only if there is no other way forward.* (P6, Office-based physician)
Marketization of detailing	• *I think the biggest change has been that when I started the drug rep's self-conception was such that he was there to inform the doctor. The selling aspect, in the sense that I also try to convince the doctor to prescribe my product, was almost seen a little sleazy and disreputable. For this reason one's self-conception was more like: It is my job to inform the doctor about our product. And in the course of time it changed more and more towards sales and volume generation. The change was manifested when the field force was beginning to receive special trainings in selling and sales psychology […].If before you had the sense of being a scientific advisor to the doctor and then suddenly the selling aspect took over…to many of us that was embarrassing.* (D1, Drug rep) • *Actually the drug rep has moved away from individual consulting to becoming an accessory to marketing management. I once said it is like being marketing's talking parrot. […]You have firm instructions by marketing and you have to get them across – accident-free – via ten memorised catchphrases.* (D8, Drug rep)

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Motivations	
Driving sales	• *Due to its high profits over the past 40 years the industry faces new challenges to meet these margin expectations in the future. And that is why every coq in the wheel - in the area of sales and marketing - that is able to hold or enhance profits and efficiencies is put in motion.* (M2, National Sales Director)
Serving physicians	• *I see myself as a service provider to the physician, one that brings the essential information to him…as fast as possible. […] To do whatever makes life easier for him, that's how I see my role as a drug rep…to make life easier for the physician. But not trying to enlighten him with banalities.* (D3, Drug rep) • *I am a consultant…not a salesman…a consultant! I pass on scientific information.* (D2, Drug rep) • *We love our physicians. They are our family. We spend the majority of our lives with them…* (D1, Drug rep)
Seeking impartial information	• *The drug rep should inform me about new drugs on the market and about the advantages of his drug compared to other drugs. He should also precisely demonstrate why me of all people should actually use this new drug…for which indications. That should come across very precisely. […] Actually, I am always interested in the pathomechanisms. How does it originate and how does the particular drug act? What kind of interactions do I have to pay attention to? When can I apply it? I am also interested in doses, how to apply it, how long to apply it…do I have to reduce the dose or adjust the dose?* (P4, Hospital physician)
Marketised Discourse	
Management's instructions	• *You always think, Wow! Physicians are such intelligent people […] you can communicate with them on a very high intellectual level. Yes, you can. But they don't retain it. That's why I have to keep simplifying my detailing address to the doctor. […] Many drug reps are just too proud to express things in simple terms. Actually, physicians are just as everybody else and communicating with physicians is just like communicating with any other person.* (M1, General Manager) • *I simply believe that drug reps are trained to conduct the talk as efficient as possible. They must try to structure the talk in a way that they are possibly pre-empting the physicians' objections and then…and I think that is a*

	very, very important point in a detailing conversation… that they come to a concrete agreement. Physicians tend to leave the conversation by saying: 'Yes, I do something for you. Yes…!' In the past one was happy with that and said: 'Well, he said he would do something for me'. Today you immediately ask: 'What do you mean by that?'…and if he replies: 'Well, I will prescribe your product!'…then you ask: 'To how many patients?'[…] And you do it not so much in terms of a sales pitch but in order to better understand the collaboration with the particular physician. (M1, General Manager)
Drug reps' translation	• *It's highly compressed communication…and above all it has nothing to do with quality and aspiration. You could just as well send a postman who says: Listen doctor, please remember [product name]! And the postman could even do this at a much lower pay.* (D8, Drug rep) • *They expect support from me in their in work as medics. But if I start talking in slogans I loose them.* (D5, Drug rep) • *For years, I have never even mentioned the name of a competitor. That was not necessary, and that would have been out of place. I speak for my product and that's it. And my doctors always appreciated that. Today, you have to do it […]. It's a different level now. Actually, this level is becoming increasingly rude.* (D5, Drug rep)
Physicians' reception	• *The typical drug rep presents a glossy brochure or shows five, six slides on his lap top […] and you notice that he wants to machine down his arguments exactly as written in the brochure. And he does not like to be interrupted by any questions in this phase of the talk.* (P3, Hospital physician) • *His product is the best, of course! All other products are blanked out. […] Or he brings along a table where his product always wins…more tolerable, less side effects…blah, blah, blah…and the other products are run down badly…all other products…which is simply incorrect!* (P4, Hospital physician) • *If drugs are boosted I just think it's bad style…but that's probably just me. […] I believe physicians are generally not the type of people who respond well to such practices. Things should be presented with a certain integrity and dispassion.* (P6, Office-based physician)

Response to Marketised Discourse	
Drug reps transforming marketised discourse	• *I convey to the physician: You know, I just had another marketing training and I have to present this to you now because tomorrow you will be called. There will be a day-after-visit study tomorrow and you will be asked about that. That's why I have to present it to you now.* (D2, drug rep) • *I try to sidestep, I try to bring about different topics, and I try to weave something into the talk that might interest him. But then I am not always in line with what the company expects from me.* (D3, Drug rep)
Physicians avoiding marketised discourse	• *The drug rep is mostly a disruptive element, you have to say it. […] And if you have to deal with him and he is not delivering quality than this is really annoying.* (P2, Hospital physician)

8. Conclusions

Over the last 50 pages I have presented my research results in detail and have structured them according to a conceptual model that aims to portray the phenomenon of marketised discourse in drug detailing. The model (Figure 5, p. 128) is inductive in kind because it is essentially the product of my interpretation of the data. Due to the research methodology I have chosen the model is thus only representative of my own cognitive grasp on the subject. However, in that it can eventually become the impetus for further research on the issue, some of it being also deductive in nature. What is left for me to do is to balance my findings against the research questions that drove this project. Furthermore, I wish to provide the reader with my conclusions drawn from the results, both on a theoretical and on an operational impact level. I will begin with comparing my results to the three research questions I have put forward at the beginning, namely

1. Is there discursive construction of marketization in drug detailing?
2. If there is marketised discourse how does it manifest in discursive terms?
3. How does such discourse impact the roles and attitudes of drug reps & physicians?

8.1. Balancing findings with research questions

In discussing the findings with regards to the research questions I equally provide a summary of the research outcomes as presented in chapter 7. I will approach this task by addressing the research questions in the above listed order.

Is there discursive construction of marketization in drug detailing?

Yes, according to my respondents marketised discourse is constructed in drug detailing. However, reports regarding scope and intensity of marketised discourse vary between the protagonists. To managers in my study marketised discourse is the essence of drug detailing. They confirmed that discourse is strategically employed to drive sales and profits. To that objective, discourse is sharpened with the intention to influence the physician's behaviour with regards to prescribing or endorsing a

particular drug. Managers revealed that drug reps are trained and briefed to employ promotional discourse in their daily encounters with physicians. From a management point of view, marketised discourse is said to be highly prevalent in today's drug detailing versus physicians.

All drug reps in my research confirmed that they are instructed to talk promotionally with their customers. At the same time they conveyed that they do not implement these instructions as devised. Instead, they claimed to reduce marketised discourse to the benefit of scientific information, a service that they regard to be the focus of drug detailing. Despite their noble intentions, drug reps admitted that they nevertheless have to employ promotional talk to a certain extent. This was said to be necessary as pressures by management for tangible results are high. Thus according to drug reps, marketised discourse is happening yet it is mainly presented in a reduced form.

Altogether, physicians in my study experienced marketised discourse regularly in their interactions with drug reps. Hospital physicians, in particular, confirmed that they are typically addressed in a promotional manner. Office-based physicians also reported about the spreading of marketised discourse yet painted a less dramatic picture compared to their hospital colleagues. I rated the differences between the two doctor groups to be essentially caused by different work settings which in turn had influence on physicians' accounts. In their need for highly applicable information, office-based doctors are less critical of the compressed (in fact disfigured) content delivery typical of promotional talk. Furthermore, in their often remote single practice setting, office-based doctors are torn between rejecting commercialised addresses and keeping connected to market information. As such they are experiencing a conflict of interest which also shun through in some of my interviews. To my interpretation this is why office-based physicians tend to understate the dissemination of marketised discourse. Nevertheless, all doctors in my study were confirming that marketised discourse is happening.

The fact that each of the three actor groups gave different accounts about the intensity and scope of promotional discourse is not surprising. First, the three groups were not subjected to the same experiences as only parts of them share the same work sphere. Furthermore, in case of managers interviewed, accounts are largely based on normative

ideas and secondary information whereas drug reps and physicians are experiencing the encounter first hand. Last not least, the protagonists' perceptions are driven by their motivations to engage in discourse. As such they compare their individual observations against their ideal objectives or self-conceptions. Naturally, this will result in different assessments, even in cases where the underlying situation is – in a positivistic reading – the same. If, for example, a drug rep is motivated by providing scientific information to his physicians, he probably is less open to admit that in fact he is just reproducing prefabricated commercial talk. Of course, reasons for interpreting a particular event are endless and many of them work both ways. For example, I could equally argue that precisely because a drug rep is seeing himself as a scientific advisor, he is particularly alert to any activities compromising this ideal. Thus in his accounts he should tend to overstate the spreading of promotional talk. In essence, reports about the prevalence and quality of marketised discourse are subject to individual interpretations. These interpretations are driven by structural as well as cognitive settings. To reflect these determinants appropriately in my analysis is the key task in my function as a qualitative researcher. Yet in parallel I have to ensure that the research design is constructed to allow for a clustering of similar interpretations. I have provided this by roughly outlining the definition of marketised discourse – as I read it – with every respondent. This way I have ensured that all my respondents had a similar point of reference to base their assessments on. As a constructionist researcher I have no interest to standardise meaning, yet I nevertheless have to ensure that respondents broadly align on the phenomenon they should comment on. In line with Alvesson (2003) this avoids interview questions to be misinterpreted which would otherwise lead to a rather inferior empirical outcome.

If there is marketised discourse, how does it manifest in discursive terms?

Since all respondents have confirmed that marketised discourse is happening I now like to review how according to their perspectives discourse is manifested. To managers in my study marketised discourse is seen as a helpful simplification of complex contents. As such it is valued altogether as an improvement in terms of clarity and data handling. Managers said to construct marketised discourse by means of translating key product features into relevant user benefits. Preferably, discourse is not to transport scientific

detail (e.g. active substance level built up in the blood) but should bring across the key practical advantage to the doctor (e.g. the patient can be released one day earlier on average). From a management point of view this is more helpful to the busy doctor than any complex sets of clinical information which the doctor is unlikely to remember. In my opinion the 'end benefit' focus of marketised discourse is characteristic of the utilitarian ideology management is governed by. Essentially, information is not used to describe something but to demonstrate a useful purpose. The interesting aspect is not that management operates from a utilitarian position. That is of little news value. The interesting point is that the utilitarian approach is used to shortcut the communication process. Marketised discourse is constructed to skip – or at least critically shorten – the information stage whereby a matter is first of all presented before it then gives rise to an argument which in turn leads to a particular position or recommendation. Promotional discourse, however, directly starts at the recommendation end, reducing or dimming the steps beforehand to a minimum. While this practice is typically sold as an act of simplification it is in fact an act of controlling. Marketised talk is to ensure that decisions turn out as planned by limiting time and information that would allow a critical deliberation by the recipient. Thus in my view promotional discourse has essentially a sending mission and its originators have no interest in a dialogical communication whatsoever. Instead they have an interest to dominate and control by discourse (Gramsci, 1971; Fairclough, 1992). This makes promotional discourse an instrument of power, thereby following Foucault (1976) who argued that discourse is systematically shaped to serve the interests of those in command.

Its utilitarian directedness is also causing marketised discourse to aim for a tangible outcome at all times. Managers revealed that detailing talks are designed to obtain a firm agreement from the doctors with regards to script writing or endorsing a particular drug. Furthermore, marketised discourse is characterised by constant repetition of key messages versus the doctor. As by my management sources, key messages are to be repeated over many months until the physician has truly memorised them. All these characteristics of marketised discourse have been largely confirmed by physicians as well as drug reps in my study. Yet with regards to the benefits and motivations of promotional discourse both doctors and drug reps come to a different evaluation compared to managers. Physicians perceive simplified talk as highly superficial and often not substantiated. To drug reps promotional talk is exemplified by its

informational triviality and non-scientific content. Both drug reps and physicians are annoyed by the constant replication of discourse and value it more as an act of indoctrination. Furthermore, doctors perceive promotional talk rather schematic, inflexible and little authentic. This means that marketing related product features are worked off rather monotonously and discussions are rather avoided. Thus many doctors see promotional discourse as prefabricated scripts that are centrally geared. Last not least, marketised discourse is perceived to be manipulative in that certain aspects of a drug are hidden, overstated, played down or wrongly represented altogether. The fact that doctors and drug reps are critically challenging and unmasking these practices is signifying the limitations of power driven discourses. Even if talk is designed to exert control over other groups it does not necessarily mean that it sticks with those who receive it (Alvesson & Karreman, 2000). People may stay resistant to promotional discourse on grounds of knowledge and access to rivalling discourses. Physicians, for example, based on their expert knowledge on the subject can scrutinise assertions made during promotional talk. Drug reps can look behind the scenes of discourse invention during sales trainings and interactions with management. Furthermore, they are constantly exposed to rivalling discourses as they spend a large part of their working lives in a medical environment. These factors are surely strengthening the subjects' resistance to marketised discourse.

However, marketised discourse in its compactness and intense penetration is still prone to leave its marks on doctors and drug reps. Many physicians in my study have reported that they have very little time to scrutinise the vast information influx thoroughly. One respondent revealed that although he knows that the discourse is manipulative, he is still happy to have a piece of information he can refer to in stressful situations. Drug reps who claimed that they do not wish to pass on trivial or deceiving talk to doctors, equally find themselves in a situation of operational pressure. Faced with tight schedules, internal monitoring and performance targets many adopt promotional discourse simply because they want (or need) to remain in the system.

Altogether, marketised discourse in drug detailing can be described on two levels, namely on a technical and a perceptual one. While there is largely agreement on the technical characteristics of promotional talk there are fundamental differences at the perceptual end. From a technical aspect, marketised discourse is said to be brief, non-

scientific, repetitive, and results oriented. From a perceptual level, marketised discourse has been found to be consolidating yet disfiguring, practical yet trivial, easy to memorise yet indoctrinating, helpful yet deceiving. Simply said, marketised discourse does manifest itself differently in different minds, which of course is not a surprise to a constructionist researcher. What is surprising though is that the divide does not run between industry and physicians, but mainly between management on the one side and drug reps and physicians on the other.

Finally, I like to deliberate on the question why, after all, marketised discourse as devised by management is suspected to be harmful. One could argue that promoting one's product is a legitimate act in a highly competitive market place. Moreover that unilateral presentation of facts is common to nearly all other markets and categories around the world. Given enough competition in the market, contending players will make sure that one-sided presentations are eventually balanced by rival discourses. Essentially, drug marketing could be treated as marketing of any other good, a thought that – to my experience – is prevalent on many executive floors in the pharmaceutical industry.

I am of the opinion that promotional discourse in the prescription drug business is to be assessed differently compared to promotional discourses employed in e.g. the consumer goods industry. Biased presentations of e.g. branded consumer or luxury goods can potentially trail financial disadvantages to individual consumers because market pricing is exceeding use-value. Although from a Marxist position one could denounce excessive 'rates of exploitation' (Giddens, 1971) as immoral, still I would argue that the 'spiritual' surplus value consumers are getting in exchange for many branded goods is probably making up for any calculatory rip offs. In a liberal society I think every consumer should be allowed to invest his personal resources freely.

However, biased presentations of drugs are potentially harmful to patient health and present a financial burden to society. They are potentially harmful if physicians are promotionally spun about a drug's indication spectrum, side effects or interaction with other drugs. A typical example is the endorsement of off-label drug use as typically employed by the industry to increase the target market (Angell, 2004; Steinman, 2006, 2007; Lauterbach, 2009). As a result of such doings patients might take a drug at an

inappropriate occasion or point in time thus needlessly risking their health. If drugs are priced far beyond their evident use-value – and physicians are swayed into believing that there is a positive correlation between price and efficacy – promotional discourse becomes a financial burden of the collective body of the insured. From an opportunity cost perspective this is aggravating because it slows down therapeutic productivity. This should neither be asked of patients in need nor of individuals as payers of taxes or insurance fees.

How does marketised discourse impact the roles and attitudes of drug reps and physicians?

Drug reps in my study rated marketised discourse as trivial and deceiving in kind. Many saw it as an insult to their physicians and equally as an offence to their own role conception as scientific advisors. Further to that point, respondents explained that in the past (c. 15 years ago) their role was defined as being a consultant to the physician, providing him with scientific and technical information about the product and its indication. Yet today the focus of their work is meant to be selling which in turn fundamentally impacts the discursive approach to the physician. Before, drug reps were servicing the doctor largely according to his needs. In that they had relative freedom in terms of targeting and call frequency. One respondent characterised his role as being a 'small entrepreneur' within the company. In the past the notion of selling or prescribing drugs was not directly addressed during the detailing talk. It was simply implied that in return for a good service the physician would 'do something' for the drug rep in terms of prescribing or endorsing his product. Yet doctors' engagement was always tentative and thus remained largely intangible during the encounter. Today, drug reps have said to be precisely instructed whom to visit at what time. Importantly, they are trained and directed to transport mainly marketing related catchphrases in a highly repetitive manner to the physician. Most of the talk is prefabricated and its implementation is frequently monitored 'ex post' via market research. As such they now see their role largely as instruments of the marketing department rather than individual consultants addressing the needs of their customers.

At the same time, all respondents revealed that they do not follow their management's instructions with regards to promotional discourse. Motivated by a collective interest to adequately inform the physician, many drug reps try to reduce promotional talk to the benefit of scientific advice. This is done by circumventing or sabotaging promotional talk whenever possible. Typically, detailers replace promotional discourse partly and selectively with their own newly constructed talk. Although not displacing marketised discourse in total, drug reps claim to at least significantly transform the discursive provisions they receive from management. Although it provides a feeling of relief it nevertheless puts drug reps in a conflict of interest whereby they try to adhere to a traditional or idealised role while their management is following a fundamentally different objective. Disparity in objectives and norms is aiding to process of detachment from the organisation. Circumventing the actual company strategy is characteristic of defiant behaviour in response to a cognitive state of detachment or 'anomie' (Durkheim, 1964; Merton, 1949). Respondents are no longer supportive of the organisational objectives yet they not openly contest them. In the respondents' case avoidance of promotional content delivery happens rather covertly. This further relates to the work of Merton (1949) who developed a typology of how individuals may react to discrepancies between their own and e.g. organisational objectives. I like to briefly outline his theory because I find it highly applicable to my research findings.

According to Merton, people will either respond with conformity (which means that they simply accept the goals as well as the institutional means to achieve them), innovation, ritualism, apathy or rebellion. Innovation refers to the acceptance of cultural goals while refusing the legitimate means to achieve them. In other words, the individual finds that to attain given goals it is necessary to employ socially unapproved behaviour (e.g. criminal behaviour). Ritualism describes a phenomenon whereby people refuse cultural or organisational goals yet they nevertheless adhere to them. In such scenario people almost obsessively employ institutional means to attain the goals (e.g. feigned adaptation to bureaucracy). Apathy denotes a state where both cultural goals and legitimate measures are refused and where people react with apathy and self-seclusion (e.g. outsider role). Rebellion on the other hand describes a type of behaviour where people actively strive for a re-structuring of the existing order, although goals and means have not necessarily been defined in great detail. Transferring Merton's theory to my research findings I would argue that drug reps do not display truly

rebellious behaviour as defined by Merton. While e.g. sabotaging promotional discourse surely is a radical measure to employ, it is still only an indirect attack on those in power. Instead, I would locate drug reps' behaviour somewhat in between rebellion and feigned adaptation ('ritualism'). It is a highly destructive act of opposition against the establish system yet it is practised without risking the comforts of that system (e.g. financial rewards, social security etc.).

In any case, attitudes displayed and roles taken by drug reps stand in contrast to the functional assignments given to detailers by management. Thus marketised discourse has a cognitive impact as well as an operational one. On the cognitive level, drug reps are showing signs of isolation which implies the absence of a feeling of identification with the work organisation and its goals (e.g. Blauner, 1964). This disconnect may lead to a great sense of frustration which in turn causes divergent role behaviour to emerge. At this stage then, the operational integrity of the organisation is disturbed because drug reps do not implement the marketing strategy as conceived. Certainly, this will have a negative impact on marketing productivity as costly brand management efforts and promotional marketing plans virtually grasp into nothing. Yet, because defiant behaviour is performed covertly it remains undetected – at least for a certain period of time.

At the physician end, the rise of marketised discourse has further alienated the profession from the industry. Many doctors in my study expressed that promotional talk is not providing a relevant contribution to their work as medics. Instead, physicians have developed a growing distrust with respect to the correctness and integrity of the talk presented to them by drug reps. On first sight this outcome seems like a surprise, considering the fact that drug reps have reported to reduce promotional discourse to the benefit of scientific content delivery. Differences between self-perception and external perception can have an endless number of causes, yet I like to mention those which I consider the most likely in my research case. First of all, drug reps and doctors in the interviewee sample did not come from the same work sphere, which means that doctors voiced back experiences about a different set of people. This could be valued as a shortcoming of my sample and research design. However, my aim was not to investigate discourse within a clearly delineated local system. Instead, I assumed that promotional talk is widely spread across all practices & clinics for which I took a

macro-system or 'grandiose' (Alvesson & Karreman, 2000) approach to my analysis. Given that, direct interaction of sample members would have been neither necessary nor beneficial to my research method.

Furthermore, drug reps as well as physicians may have exaggerated their accounts about promotional discourse. Drug reps – in an act of e.g. moral storytelling – may have verbally inflated their degree of resistance to marketised discourse as devised by management. Physicians – in a mode of cultural scripting – may have artificially amplified their pre-existent reservations towards the industry. Their accounts may therefore dramatise promotional discourse performed during the encounter. Last not least, perceptions will have been influenced by motivations to engage in discourse in the first place. I have addressed this point previously with respect to subjects' divergent perceptions on the prevalence of marketised discourse. To my reading, the 'motivational pre-set' argument also holds true in this context. Physicians who are moved by receiving sound and impartial scientific information may react overcritical if their (high) expectations are not met by drug reps. I found this to be happening especially among hospital doctors in my study who's sometimes harsh responses to drug rep talk were probably due to their idealised view on the purpose and content of detailing.

Doctors' experiences with marketised discourse let them increasingly retreat from interactions with drug reps. The industry's overt and direct attempts to exploit the physician via promotional talk is recognised and in most parts rejected. Sporadically doctors in my study admitted to fall for promotional discourse, typically in cases of data overload and severe time constraints. Yet, in the majority of cases they claimed to fend off these practices immediately. In other words, physicians reject to be pushed into the role of an arbiter to drug marketing. In their responses they said to inhibit promotional talk on the spot by e.g. reprimanding the drug rep or, alternatively, they simply avoid the discursive contact by physically retreating from it.

Altogether my findings point to a situation in which drug detailing is utterly traversed by marketised discourse. Results are suggesting that due to marketised discourse collaboration among the protagonists is in decline and thus total system viability is at risk. Originally conceived to enhance commercial performance, marketised discourse is

leading to cognitive detachment and operational unproductiveness. From an outside perspective none of the protagonists attains their goal which they are associating with drug detailing. Costly marketing strategies devised by management significantly lose their momentum during implementation. Drug reps, despite trying to transform promotional discourse into a relevant service to physicians, nevertheless fail to obtain their customers' appreciation. Physicians, in search for impartial scientific and technical updates, increasingly turn away in frustration about a discourse that is little helpful yet greatly annoying.

Do these findings point to a drug marketing system in decay or are they merely a matter of technical adjustment? To my reading, these insights point to a systemic problem caused my marketization of pharmaceutical knowledge in general and marketised discourse in particular. This will have serious repercussions both at the theoretical and at the operational end. I will present and discuss some of these implications – notably with focus on discourse – in the section to follow. Some aspects surely will have impact on science as well as on practice yet for the purpose of clarity I have tried to allocate them to one or the other camp. I begin with presenting implications to theory and science.

8.2. Implications for theory

One key contribution to theory is the insight that managers and drug reps do not form an ideological monolith with regards to drug detailing. Instead, they display quite distinct motivations for engaging. Managers ultimately wish to advance sales and profits while drug reps primarily strive to serve physicians. In consequence, drug reps do not implement a promotional discourse as devised by management. So far, critical studies on sales and marketing practices in the drug industry (e.g. Strang et al. 1996; Lexchin, 1997; Greene, 2004; Oldani, 2004) solely took to a bi-lateral approach, whereby industry or a drug company as a whole was confronting physicians. Typically, physicians' reception of industry measures was assessed without paying attention to the interim stage of internal translation and transformation. Current contributions are merely referring to the industry – physician interaction and make no attempt to deconstruct the detailing phenomenon (as meaning-making) any further. Researchers in the field have simply viewed the industry as an ideological block, thereby wittingly or unwittingly implying detailers' unconditional agency. Normative disparity between marketing management and drug reps is not being addressed at all. Greene (2004) for example regarded the drug rep simply as an extension of the marketing apparatus. As by my research findings, this assumption is no longer sustainable because drug reps have shown to follow a separate agenda. Thus future research studies on drug marketing – critical and non-critical in nature – can benefit from these outcomes by e.g. placing additional focus on role conceptions and attitudes of drug reps. Viewing managers and drug reps as separate meaning-making entities will result in a more diverse assessment of drug marketing measures against doctors. Besides, it may spark other researchers to examine the in-between role of drug reps, focussing on aspects like commitment, identity or re-professionalization.

To discourse studies, I have contributed a qualitative description of what manifests marketised discourse in context of drug detailing. While marketised discourse has been investigated in other areas like e.g. higher education (Fairclough, 1993) its particularities have not been investigated with respect to drug detailing. Drug detailing is interesting to discourse studies because it tries to discursively link two very distinct worlds and interests. In a truly constructionist fashion I have presented three (groups of) different perspectives on how marketised discourse is figured. A genuinely novel

insight was to learn about how discursive pre-patterning is transformed by drug reps. My findings have supported the theory of Alvesson & Karreman (2000) whereby even powerful discourses can be rejected. Despite artful construction and training, marketised discourse has been recognised and largely refused by both physicians and drug reps in my sample. However, marketised discourse nevertheless keeps breaking ground in modern drug detailing. Drug reps reported to reject and subsequently transform marketised discourse yet doctors in my study still complained about the promotional character of the talk they are receiving. Obviously, feelings of opposition to marketised discourse are not strong enough to fully escape from its binding powers in practice. This connects to the work of Zizek (1989) and DuGay & Salaman (1992) who proposed that discourses should always be understood as a dimension of material practices. In other words, people cannot fully discard unwanted discursive practices because they are bound to them by factual procedures (e.g. sales targets) or conditions (e.g. lack of alternative employment options). In the area of drug detailing, my observations can be a point of departure for further research about being trapped in discourse despite rejecting it.

By portraying drug reps' role conceptions and attitudes, my research has pointed to a cognitive disunity of detailers. Irrespective of the potential consequences these inner conflicts may have – for example that drug reps may feel alienated from work – my study first and foremost highlights the fact that drug reps are moving in between two systems. We have learned from the representatives of each system (i.e. managers and physicians) that their motivations and attitudes towards detailing are quite distinct. I like to add to this empirical insight that also from a systems theory perspective the two spheres are seen as functionally differentiated autonomous social systems each one having its own code of communication (e.g. Luhmann, 2005). Thus it is difficult for drug reps – as we have seen – to communicate in both systems successfully. Those who try may fail in either direction. From an ideological or identity point of view, it is challenging to be simultaneously exposed to the divergent discourses emerging from the two systems. One discourse is promoting sales and profit generation the other is advancing the notion of patient wellbeing and/or physician protection. Further to that note, my research has drawn attention to the fact that drug reps spend much of their working lives in the medical community (***We love our physicians. They are our family. We spend the majority of our lives with them…***, D1, Drug rep, p. 154).

Although my work has not investigated the ultimate consequences of this exposure, it is still suggesting that constant exposure aids to drug reps' alienation from their organisations. This has clearly a practical implication and hence will be discussed in that context later on. Still, my study outcome can benefit scientific research on discourse and alienation (sociology domain) and discourse and commitment (psychology domain). Both alienation and commitment theories strongly deal with an individual's relation to an existing normative system. Being a sociology-minded researcher I like to focus on the alienation aspect. According to existing theory (e.g. Blauner, 1964; Shepard, 1971; Mottaz, 1981) an individual's alienation from work is sparked by his continuous inconformity with the organisation's norms and values. Alienation is expressed in feelings of powerlessness, meaninglessness and isolation (Blauner, 1964). My research is presenting a situation whereby the individual (drug rep) has to deal with two fundamentally different value systems within his work sphere. I do not know of any other occupation where this is the case. Business-to-business sales representatives typically remain within the 'capital' system. Even if they should trade with another system (e.g. the Army) they still find a business representative as their counterpart (e.g. purchasing manager of the Army). Drug reps' unique exposure to two very different systems and discourses adds a new dimension from an alienation point of view. Thus research in this area could benefit from investigating the particular situation of drug detailing.

8.3. Implications for practice

I anticipate my research outcomes to impact the work of managers, drug reps and physicians. Furthermore, I hope to contribute to an overall discussion about how pharmaceutical knowledge and expertise is made available to society. I start with presenting the various practical implications grouped by key protagonists concerned. Certainly, most of my suggestions will somehow have an influence on all players in my research set. Yet, because I view this final part of my thesis as a recommendation for action I like to identify those groups of people who I think should take the lead in implementing my proposals. As such I want to abstain from producing an intangible piece of advice that many may concur with yet no one feels responsible or inspired to

act upon. After all, producing tangible and serviceable proposals that address a concrete business issue is distinctive of a DBA thesis.

8.3.1. Practical implications for management

My research outcomes have demonstrated that the current approach to detailing is neither convincing nor effective. Trying to address the divergent interests by means of pseudo scientific promotional talk seems to widen the cognitive gap between industry and physicians, as much as between managers and drug reps. We have ascertained that from a management perspective marketised discourse is not devised to enlighten physicians but to sway them. This policy is enforced by the fact that competition in the pharmaceutical industry is strong, financial expectations are high yet product pipelines are increasingly empty. Before this background it is idealistic to assume that news from academia will spark an ideological change among drug managers. In other words, managers will continue to follow their self-interested objectives of sales and profit generation. Yet based on my research findings I propose that they display their goals more honestly, openly and thus productively for all players involved. Managers of research based drug companies (those who offer patented original drugs) should re-organise the interaction with doctors by dividing drug detailing into two separate strands: a scientific and a commercial strand. Simply put, the scientific arm is to inform the physician about pharmacological and medical specifics with regards to the drug and its indication. Members of the scientific team should be specialists, educated and trained to competently service physicians. Still, I do not foresee their presentations to be unbiased. Yet I expect that in a dedicated expert discussion format critical shortcomings (e.g. regarding side effects, clinical study design) are more difficult to whitewash. Importantly, scientific detailing of a drug would then not be clouded by promotional catch phrases aimed at inducing action. A dedicated expert team like this would surely become of greater relevance to physicians. This could lift doctors' attention to detailers talk as well as their willingness to receive drug reps in the first place. Drug makers could thus benefit from doctors' increased responsiveness.

The 'commercial' drug rep, on the other hand, should approach the physician with the mandate to win his support for prescribing or recommending his products. This

mandate should be openly displayed versus the physician. As per my study results, physicians are fully aware that drug companies want to lure them into prescribing, therefore an open address of one's commercial interest could be trust-building after all. A prerequisite for this open conduct – both from a motivational and from a legal aspect – would be that argumentation focuses on demonstrating that the drug is feasible from an economic point of view. The product would hence be 'sold' on grounds of e.g. lower total therapy cost, smaller risk of relapse, shorter residence time or higher reimbursement share. In addition, the commercial team would increasingly visit health insurance companies to secure a preferred supplier status. Dividing the detailing task into a scientific and a commercial strand is resource intensive in a service landscape comprising of single practices. However, as office-based physicians progressively grow into larger organisational settings like ambulatory care centres, practice networks and medical care chains, drug companies could develop a key account management to communicate more efficiently. In turn, larger medical units will likely entail a division of labour at the physician end. This, for example, implies the instalment of a dedicated position responsible for scientific information and training as much as the hiring of a commercial manager.

All this is not to stop managers from constructing discourse to the benefit of company interests. However, I anticipate that a divided and dedicated communication structure will improve the overall quality and relevance of the talk because the recipients will be able scrutinise discourse more profoundly. But why should a manager be interested to mitigate his promotional strategy to the benefit of the better argument? To my reading it is a matter of recognising and addressing structural changes in due course. My findings indicate that leverage from promotional discourse is shrinking. Drug reps' solidarity with their companies is dissolving and physicians are increasingly avoiding detailing encounters. Crucially, structural changes in medical care are leading to higher concentration and functional specialisation. While the individual physician may lose autonomy and power, the newly emerging medical units and networks are likely to gain in influence. Thus managers are advised to re-think their promotional sending approach in order to avoid unproductive and de-motivating conduct of business as much as to prepare for the fundamental restructuring of the medical market in Germany.

8.3.2. Practical implications for physicians

According to my findings physicians feel inadequately informed by drug reps. Furthermore, doctors complained about the overt promotional and at times deceiving character of detailing talks. As my results show, physicians increasingly respond to these practices by avoiding the detailing encounter altogether. This is a consequent yet little productive attitude to follow. Instead, physicians could understand my study insights to recognise that the industry's position is not uniform and thus open for challenge. Provided that physicians have a genuine interest – as they have stated during the interviews – in receiving scientific information, they should demand for more unbiased information by the industry across a broad front. In this respect I foresee three main approaches.

First, my results should provide additional argumentation for improved quality controls with respect to clinical study design. In 2004, the institute for quality and efficiency in healthcare (IQWiG) was established to examine – among other things – the usefulness of drugs launched in Germany. The institute was modelled on the UK's National Institute of Clinical Excellence (NICE). While the IQWiG is a helpful institution it can only act very selectively with regards to scrutinising the relevance of clinical studies circulating in the market. In my opinion, physicians' associations (e.g. organised by specialist society) should establish their own checkpoints responsible for the evaluation of clinical study outcomes. Let me explain why this is a critical point of influence: in the process of registration, clinical studies are substantiating a drug's efficacy, safety and tolerability (industry term that describes a patient's tolerance to a drug). In the process of marketing and detailing, clinical study results carry promotional messages. This seems reassuring on first sight yet it still leaves enough of room for interpretive manoeuvring. Study protocols are typically designed to ensure a favourable outcome by all means. Most notably this occurs with so called 'post marketing' studies which are executed to promote a drug's efficacy or tolerability after its launch. Critical observers (e.g. Angell, 2004) note that companies like to optimise outcomes by e.g. playing with a drug's dosing, presentation format or length of application. While the studies are technically correct they are often reflecting an unrealistic scenario. A typical example would be comparing tolerability scores against a competitor that has a higher dosage. Based on these constructions promotional messaging is built. However, if

physicians were able to put these studies to a professional observer located within their own system, three things would happen: (1) irrelevant or unrepresentative studies would be eliminated from the market. (2) In the long run, drug companies would likely respond by raising the quality of their marketing studies. In turn, this would aid to the robustness of the detailing talk which is (3) prone to build physicians' trust in the industry (see also Lagace, et al., 1992).

A second approach to control marketised discourse practices is for professional associations to provide their own drug detailing to their members. This approach is known as 'academic detailing' (e.g. Avorn & Soumerai, 1983; Soumerai & Avorn, 1990; Kondro, 2007) and has been established in countries like USA and Canada but is still hardly present in Germany to date. In academic detailing a trained healthcare professional is visiting doctors or otherwise disseminates evidence-based information about particular drugs or drug classes. Detailing contents are based on impartial, independent reviews of drugs' efficacy. The long-term goal is to advance optimal and cost-effective prescribing from within the medical community. Given my research findings, I recommend to initiate a similar project within the German system. Academic detailing will thereby not replace commercial drug detailing. Due to high costs associated with running a large scale detailing network and due to exclusivity of technical information held by makers of drugs, commercial drug detailing will continue to play a major part. Yet academic detailing could be established as a corrective source of information to doctors. Operated in parallel to commercial detailing it will challenge and eventually reduce promotional discourse practices. However, for this to happen academic detailing requires a critical size which can only be achieved if physicians are prepared to finance the project by means of significant contributions. This would be the ultimate test to the validity of physicians' claims that they are primarily motivated by receiving impartial information.

While the first two approaches presented can be significant in leverage, I still anticipate that their implementation may be delayed by a low degree of organisation, disagreement across specialities and last not least pharma lobbying. I therefore like to present a third approach which to my view is highly practical, low cost and can be implemented fast.

In response to inadequate detailing characterised by marketised discourse, physicians should leverage their criticism by means of internet technology. Analogue to online assessments of physicians by their patients (e.g. www.docinsider.de), doctors (e.g. the association of physicians or single societies) can operate an evaluation website of individual drug rep service. Professionally devised to ensure factual, relevant and non-offending appraisal of service, this instrument can be elucidative in that it allows (subjective) comparison of service, disclose of malpractice and thus altogether increase transparency. All this could be done in accordance with German data protection laws by simply defining the drug rep by company and region. Detailing regions are more or less uniformly defined across Germany to ensure that private research companies like IMS (Institute for Medical Statistics) can monitor script-writing and pharmacy sales on the drug rep level. By mentioning company name and detailing region, other physicians in the region will know. Access to the website could be restricted to doctors and industry representatives. Provided that it is used on a large scale the instrument will have enough informational reliability to be accepted as a point of reference. This can result in physicians e.g. critically questioning drug reps or their managers as to the reasons behind a negative rating. As such it is expected to impact industry behaviour, as pharmaceutical firms are sensitive to wide-scope negative reporting by their quasi customers. If physicians are willing voice their critique about discursive doctor spinning in that way, it is likely to improve the quality of detailing contents and their discursive presentation.

8.3.3. Practical implications for drug reps

Of the three groups of actors, drug reps are in the weakest position. To my reading, drug reps experience affective frailty, caused by inner conflict with regards to their organisational belonging as displayed by my research findings. Their in between role is not fostering a strong self-confidence to resist openly and hence, they do it covertly. Furthermore, their non-managing function within the company makes them highly dependent on management policy and goodwill. Before this background, recommendations for (self-induced) changes in drug rep behaviour are comparably limited in terms of their ability for structural change. To further illustrate my point: Drug reps' access to physicians' attitudes (e.g. to the study insight that physician still

rate drug rep talk as highly promotional) will probably result in even greater transformation of marketised discourse schemes. Yet this will still happen covertly, which is only raising the operational contrast between management's instruction and drug reps' implementation. Essentially, structural changes to the system will have to come from management reacting to outside events like physician pressure or – to a lesser degree – research information.

Assuming for a moment that structural changes are not happening (i.e. ceteris paribus), I foresee implications for drug reps' behaviour to be largely motivational in kind. Reflecting on my study results, certain drug reps may decide to discontinue a career in drug detailing based on the existing ideological contradictions as well as on the new insights regarding the low appreciation by physicians. Candidates interested in a career in drug detailing may critically evaluate their personal values and motivations against the system described by my study findings. Some may see reason to follow a different career path. Several of those remaining in the system might take my research outcomes to develop a more relaxed attitude towards the controversial situation they are experiencing (see e.g. Turner & Bruner, 1986). Knowing that one's perception and attitude is shared by others can produce a feeling of relief and re-assurance in coping with the circumstances.

8.3.4. Practical implications for public discourse

Last not least I like to speculate if my research on marketised discourse in drug detailing may influence society's perception of drug marketing. My research is providing a look behind the scenes of a highly secretive yet influential industry. Insights gained about strategic discourse construction illustrate how careless the industry is using its pharmacologic and pharmaceutical information advantage versus physicians and ultimately versus patients. Reported defiant behaviour by drug reps is highly interesting from a sociological research point of view, yet its actual corrective impact in practice is – according to my findings – at least doubtful. Physicians' accounts about detection of and resistance to marketised discourse must be critically judged before the background of information overflow, time constraints and also personal interests and obligations. As of now, both, deviant drug reps and observant

physicians are not reliable filters or correctors of promotional drug discourses. My qualitative sketch of discourse in drug detailing leaves a worrisome picture about today's drug detailing. My research findings may help to stimulate a critical debate about discursive dissemination of drug information in the public. Increasingly, the pharmaceutical industry (as well as the medical profession) is subjected to critical reports by the public media. Yet media reports typically shed light on outright criminal behaviour like bribery (e.g. German news magazine 'Stern' reported in 2005 about the Ratiopharm case in which the drug company was accused of bribing physicians to prescribe its products). So far, the German public has not been informed about the rather sublime influence-taking via marketised discourse. I would thus wish to raise this crucial aspect of drug marketing to the public awareness level.

8.4. Limitations of the research

My research shows certain limitations which I like to address in the following paragraphs. The first limitation concerns the research sample. While generalizability and representativeness is not of concern to the qualitative researcher, he nevertheless aims for a certain degree of transferability by e.g. ensuring variety in his sample. My research sample surely displays diversity of respondents in certain aspects, still drug reps and managers came from only three different companies. Given the scope of my research questions I would have wished for a greater number of institutional backgrounds. This sample condition – caused by the immense difficulty of getting access to drug companies – clearly restricts the transferability of my findings.

The second limitation comes with the method of qualitative interviewing. Although the interviews lasted 45 minutes on average the contacts with the respondents have been relatively brief compared to e.g. a long term observation. I experienced moments of great communicative intensity, however, I am aware that the exchange had just a snapshot character after all. Furthermore, I have semi-structured the interviews to address my 'a priori' believes and to ensure a fair degree of comparability. This kind of structural designation on my part will probably have limited my investigative flexibility and openness e.g. with regards to uncovering unexpected topics. Still, the strongest limitation with regards to interviewing is that I ultimately had to rely on what

has been said. While I have scrutinized the interview data for signs of e.g. moral storytelling, cultural scripting or political manoeuvring, there remained a great deal of leeway in terms of ascertaining respondents' meaning-making. Finally, I have not subjected my data analysis and interpretation to any kind of secondary analysis by e.g. fellow researchers or the respondents themselves. Due to this omission the credibility of my research findings is likely to be limited to some extent.

8.5. Scope for future research

I see my work as a point of departure for future research, both inductive and deductive in kind. Quite generally, a quantitative investigator might want to test to which extent my findings are generalizable and if they are representative of any specific population. This could entail e.g. a structured interview study about discourse transformation to cardiologists in former Eastern Germany.

Researchers in critical pharmaceutical studies may be inspired to further explore the role of drug reps in drug marketing. Qualitative studies may shed light on whether drug reps are (seen as) agents, mediators or saboteurs of marketing. Ideally, this could be done by long term observations of drug detailing events which would enable the researcher to be closer to the social setting he is studying. Those interested in work alienation may take my study to further investigate the dynamics and consequences of normative disunity between management and sales reps in the context of the pharmaceutical industry. Investigators in the field of organizational discourse may continue to examine how resistance to discourse is curtailed by material practices in the social setting of drug detailing. Altogether, I believe that due to its considerable investigative span my work is providing a great variety of routes for further research in the field of sociology. Naturally, the above mentioned options are only a brief selection of ideas for further research.

8.6. Final remarks

Altogether, my research has given me a new (and critical) perspective on the conduct of the pharmaceutical industry. Investigating especially the views of drug reps and physicians has provided me with a better grasp of the shortcomings and consequences associated with an established system of commercial promotion. Moreover, I feel that conducting the research has enhanced my ability to identify and critically evaluate acts of discursive control and manipulation. From this I will benefit in my role as a critical consultant, aiming for a more transparent and evidence-based service in drug detailing.

The research has also sparked a quite practical idea to increase the quality of drug detailing in the future. The concept of having physicians evaluate drug rep performance via the internet has been further refined in the meantime. I have already registered a suitable name (www.drugrepmonitor.com) and I will present a comprehensive business plan to potential supporters in due course. While this instrument might not necessarily be a great commercial success I am convinced that it can lift the relevance and standard of drug information provided to physicians.

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10. Appendices

Appendix 1:   Interview guide - Drug reps (*back-translated from German*)

Introductory remarks

Hello, my name is Jost-Tilo Gehrke, I am a doctoral research student at Durham University in England researching in the area of drug rep – physician interaction. Thank you for taking the time to share some of your views and experiences regarding this topic with me.

Your accounts given during or after the interview will remain strictly confidential. I will tape record this interview. This is for practical use only. Recording the interview prevents me from taking notes while you speak which enables me to pay full attention to everything that you say. At any time during the interview you can ask me to stop the recording. Do you agree to this procedure?

I will start asking you some questions about you and your work environment:

Work environment

1. For how many years have you been working as a drug rep?

2. What made you choose this career?

3. Could you please describe your current work situation?

4. What have been the key changes in your work environment over the past 10 – 20 years?

5. How has the detailing of physicians changed in that time?

6. How do you rate these changes?

7. Who or what do you think is responsible for these changes?

Detailing the physician

8. Could you please describe a typical detailing visit? What – if any – are the key differences compared to the past?

9. What is your role during the detailing encounter? Has your role changed over time?

10. What would be your preferred role during the detailing encounter?

11. What – in your view – is the role of the physician during the detailing encounter? Has the role changed over time?

12. How would you describe a typical physician that you are visiting?

13. What do you think about the medical profession in general?

Detailing discourse

14. How would you describe the discourse (i.e. the speech, talk, address) you are employing when detailing physicians? What are – if any – the key changes compared to the past?

15. What are typical features of this discourse?

16. How do you rate this discourse? What do you like / dislike?

Responses to detailing discourse

17. How do you think your detailing discourse is received by physicians?

18. What do you think are the key reasons for this reception?

19. What are your reactions to this?

20. How would you describe an ideal interaction with physicians?

21. Do you like to add anything (opinion, observation etc.) to the matter of drug detailing or else?

Thank you very much for your time & support!

Appendix 2: **Interview guide - Physicians (*back-translated from German*)**

Introductory remarks

Hello, my name is Jost-Tilo Gehrke, I am a doctoral research student at Durham University in England researching in the area of physician – drug rep interaction. Thank you for taking the time to share some of your views and experiences regarding this topic with me.

Your accounts given during or after the interview will remain strictly confidential. I will tape record this interview. This is for practical use only. Recording the interview prevents me from taking notes while you speak which enables me to pay full attention to everything that you say. At any time during the interview you can ask me to stop the recording. Do you agree to this procedure?

I will start asking you some questions about you and your work environment:

Work environment

1. For how many years have you been practising as a physician?

2. What made you choose this career?

3. Could you please describe your current work situation?

4. What have been the key changes in your work environment over the past 10 – 20 years?

5. How has the detailing by drug reps changed in that time?

6. How do you rate these changes?

7. Who or what do you think is responsible for these changes?

Detailing by drug reps

8. Could you please describe a typical detailing visit? What – if any – are the key differences compared to the past?

9. How much time do you typical spend with a drug rep? On what does it depend how much time you dedicate to a drug rep?

10. What is your role during the detailing encounter? Has your role changed over time?

11. What would be your preferred role during the detailing encounter?

12. What – in your view – is the role of the drug rep during the detailing encounter? Has the role changed over time?

13. How would you describe a typical drug rep visiting you?

14. What do you think about the drug rep profession (occupation) in general?

Detailing discourse

15. How would you describe the discourse (i.e. the speech, talk, address) that drug reps are employing when visiting you? What are – if any – the key changes compared to the past? Who or what has caused these changes in your view?

16. What are typical features of today's detailing discourse you are receiving?

17. How do you rate this discourse? What do you like / dislike?

Responses to detailing discourse

18. How do you react to this discourse?

19. How would you describe an ideal interaction with drug reps?

20. Do you like to add anything (opinion, observation etc.) to the matter of drug detailing or else?

Thank you very much for your time & support!

Appendix 3:   **Interview guide - Managers (*back-translated from German*)**

Introductory remarks

Hello, my name is Jost-Tilo Gehrke, I am a doctoral research student at Durham University in England researching in the area of drug rep – physician interaction. Thank you for taking the time to share some of your views and experiences regarding this topic with me.

Your accounts given during or after the interview will remain strictly confidential. I will tape record this interview. This is for practical use only. Recording the interview prevents me from taking notes while you speak which enables me to pay full attention to everything that you say. At any time during the interview you can ask me to stop the recording. Do you agree to this procedure?

I will start asking you some questions about you and your work environment:

Work environment

1. For how many years have you been working in the pharmaceutical industry?

2. What made you choose this career? Could you briefly describe the key stages of it?

3. Could you please describe your current work situation?

4. What have been the key changes in your work environment over the past 10 – 20 years?

5. How has the detailing of physicians changed in that time?

6. How do you rate these changes?

7. Who or what do you think is responsible for these changes?

Detailing the physician

8. In your view, what is the role of the drug rep during the detailing encounter? Has his/her role changed over time? What was (your) drug reps' reaction to these changes?

9. What – in your opinion – is the role of the physician during the detailing encounter? Has the role changed over time?

10. How would you describe your role with respect to the function of drug detailing?

Detailing discourse

11. How would you describe the discourse (i.e. the speech, talk, address) drug reps in your company are employing when detailing physicians? What are – if any – the key changes compared to the past?

12. What are typical features of this discourse?

13. How do you rate this discourse? What would you say is the purpose of it?

Responses to detailing discourse

14. How do you think the detailing discourse is received by physicians?

15. What do you think are the key reasons for this reception?

16. How do you think your drug reps are rating the discursive practices they are employing?

17. What are your reactions to this?

18. How would you describe an ideal interaction between drug reps and physicians?

19. Do you like to add anything (opinion, observation etc.) to the matter of drug detailing or else?

Thank you very much for your time & support!