ARTICLES

Drug promotional practices in Mumbai: a qualitative study

NOBHOJIT ROY[1, 2, 3], NEHA MADHIWALLA[1,2 3], SANJAY A PAI [1, 2, 4]

[1] Forum for Medical Ethics, Mumbai, [2]*Indian Journal of Medical Ethics* **[3] Centre for Studies in Ethics and Rights, Mumbai, [4] Department of pathology and laboratory medicine, Manipal Hospital, Bangalore INDIA Address for correspondence: Nobhojit Roy, "Candelar", 4th Floor, 26 St John Baptist Road, Bandra (W), Mumbai 400050 INDIA e-mail: nobsroy@yahoo.com**

Abstract

We conducted a qualitative study to determine the range of promotional practices influencing drug usage in Mumbai. Open-ended interviews were conducted with 15 senior executives in drug companies, 25 chemists and 25 doctors; focus group discussions were held with 36 medical representatives.

The study provided a picture of what might be described as an unholy alliance: manufacturers, chemists and doctors conspire to make profits at the expense of consumers and the public's health, even as they negotiate with each other on their respective shares of these profits.

Misleading information, incentives and unethical trade practices were identified as methods to increase the prescription and sale of drugs. Medical representatives provide incomplete medical information to influence prescribing practices; they also offer incentives including conference sponsorship. Doctors may also demand incentives, as when doctors' associations threaten to boycott companies that do not comply with their demands for sponsorship. Manufacturers, chemists and medical representatives use various unethical trade practices. Of particular interest was the finding that chemists are major players in this system, providing drug information directly to patients. The study also reinforced our impression that medical representatives are the least powerful of the four groups.

Introduction

The aim of the study was to determine the range of drug promotional practices in Mumbai, India. The World Health Organisation defines drug promotion as all informational and persuasive activities by manufacturers and distributors, the effect of which is to influence the prescription, supply, purchase or use of medicinal drugs (1).

It is known that inaccurate and selective information is effective for drug promotion (2). It is also known that the quality of the drug information given to Indian doctors is poorer than that given to our western counterparts (3). In India, there is, at present, no legal requirement of continuing medical education or periodic recertification. Medical representatives are often the doctor's only source of information on the latest developments in therapeutics (4).

While such studies have established the importance and quality of promotional information made available to doctors in India, little has been written on promotional practices as a whole.

There are an estimated 20,000 pharmaceutical companies in India, competing for a share of the Rs 1,300 crore market in annual sales, in a poorly regulated environment (5). The picture is complicated by an uneducated customer base (6), a highly privatised health system (7) and the prevalence of "cross practice" – the prescription of medicines in one system of medicine by doctors trained and certified in another system of medicine – though it is illegal in most states in India, including Maharashtra. Finally, many people bypass doctors altogether and obtain scheduled drugs directly from chemists without a prescription (8).

Methodology, sampling and review

Our study used what might be described as a "generic qualitative" methodology. Information on drug promotion is difficult to obtain as it concerns what might be argued are trade secrets, as well as possibly unethical and even illegal practices. We used the "snowball" sampling method and interviewed key informants who could direct us to other individuals willing to share information that we could rely on. Medical representatives were contacted through their trade union.

The following groups were chosen to provide perspectives on drug promotion practices: drug manufacturers who set policies regarding marketing practices; chemists who can promote incentive-based schemes; medical representatives who facilitate the sale of drugs, and doctors who prescribe drugs.

Open-ended interviews were conducted with 15 senior executives in drug companies, 25 chemists and 25 doctors in Mumbai. 36 medical representatives (MRs) were interviewed in five focus group discussions.

Senior executives in 4 multinational and 11 Indian drug companies were interviewed. Of the 25 chemists, five represented wholesalers. Of the 20 retailers, 5 were attached to large hospitals -- two to public hospitals and three to private hospitals. The remaining 15 were stand-alone shops, five each situated in rich, middle-class and slum communities. Twenty of the 25 doctors were from the private sector; 13 were general practitioners, and 12 were specialists; five of them served in rich neighbourhoods, 10 in middle-class neighbourhoods and

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10 in slums. Nine of the MRs were from Indian companies, 27 from multinational companies. Fifteen of the MRs had worked for less than one year on the job; eleven had between one and nine years of experience and 10 of them had 10 or more years of experience.

The interviews and focus group discussions were conducted between February and August 2003 by two of the authors (NR and NM) accompanied by one or more junior researchers. During the meetings, researchers would take notes and cross-check and them with each other, thereafter.

Open-ended questionnaires were used to guide the interviews and focus group discussions. Drug manufacturers and MRs were asked how they promoted their drugs, with doctors and with chemists. Chemists were asked about incentives were offered by companies and other trade practices. Doctors were asked how they received information on drugs and other promotional practices, what they thought about gifts and whether gifts could influence their own prescribing or that of other doctors in their area.

The interviews were coded and the content was analysed to identify emerging themes. The findings were confirmed through triangulation or repetition in other interviews.

The project was reviewed by a technical advisory group (TAG) and an ethics review committee. One of the TAG's key recommendations was not to include consumers, since they had no influence over pharmaceutical promotion. The ethics review committee suggested that tape-recorders not be used for the study, and that researchers take notes instead.

Findings

The four groups of participants interviewed were very willing to discuss the subject of promotional practices; interviewees were more willing to talk about the behaviour of their competitors, or the other actors, rather than their own.

Based on the information received, researchers grouped the promotional practices described into three types: providing information and brand reminders; giving doctors incentives to prescribe, and conducting trade practices to increase drug sales.

Information and brand reminders

Doctors stated that they received information on new drugs primarily through visits by MRs who use flip charts for this purpose. *"These flipcharts show the benefits of their drugs over the drugs of other companies. They also provide results of studies carried out by them on the drug's efficacy." (general practitioner in slum)*

According to the doctors, MRs rarely mentioned drug interactions and adverse reactions but they were otherwise generally satisfied with the information provided and accepted the MR's role. *"Everything is told in a precise way… medical representatives are well versed with their products and quite capable of answering the doctor's questions." (senior general practitioner in middle-class neighbourhood)*

The doctors did state that MRs took up time that could be spent attending to patients and MRs were aware of this. *"Doctors always perceive MRs' visits as an intrusion. Every minute taken up by the MR is time which could have been spent seeing patients and making money in the clinic. Often, MRs queue up early in the morning for doctors who allow only the first three MRs to see them." (from focus group discussion with medical representatives)*

The MRs said they received cursory training in drug information; the flip chart was their main presentation aid. *"Glaxo introduced the concept of flip charts in 1972 and the company doubled its sales in one year." (focus group discussion with medical representatives)* MRs stated that whereas earlier doctors would receive a "detail card" (containing comprehensive information on the drug's benefits and potential adverse effects), they are now shown a flip chart which is not given to the doctor even if asked for. *"The books and flip charts are confidential and every two-three months they are recalled by the company and destroyed." (from focus group discussion with medical representatives)*

MRs noted that often there were inconsistencies between what they had been told to tell the doctor, what was written in the flip charts and what was in the detailed literature. Also, doctors noted that they received literature only if they repeatedly requested it.

MRs were required to give small gifts to doctors, to keep their brand in the doctor's memory. These "brand reminders" varied from desktop items to minor medical equipment, including prescription pads and rubber stamps (with the names of drugs manufactured by the company). It was also reported that some companies employed marketing professionals to build a personal rapport with the doctor by remembering occasions such as birthdays. Further, pharmaceutical companies stated that they did not differentiate between qualified and unqualified physicians in their promotional practices.

Interviewees from the different groups remarked about the pervasive pressure to increase sales. Many MRs remarked that they were under pressure to meet sales targets failing which they could be transferred to a remote area or even lose their jobs. As different companies fought over their share of the market, their own concern was often about losing their jobs.

Incentives

The researchers categorised 'incentives' as those items which were gifted to doctors/chemists, which were of substantial value in themselves and would be likely to serve as inducements.

Both doctors and medical representatives said that brand reminders were increasingly being replaced by gifts of greater value than stationery. These range from jewellery to electronic items and even automobiles.

Some doctors justified the acceptance of gifts because they felt that it only compensated them for the time they spent listening to the MRs. *"MRs never try to bribe to sell their drug. (Gifts) are just a gesture to say thanks for the time the doctor*

gives. Let's say a doctor sees three patients in 15 minutes, the MR is costing him those three patients in his 15-minute talk. So the MR tries to compensate with gifts since obviously he can't compensate in cash." (senior surgeon, Mumbai)

A majority of doctors said they felt that this was wrong. A few would have liked to see limits placed on the value of the gifts; they felt that some gifts were expensive enough to serve as inducements. *"(Accepting gifts) is unethical because many doctors fall prey to these gimmicks and eventually it's the patient who bears the cost." (senior paediatrician, Mumbai)* Others felt that air conditioners, washing machines, microwaves, cameras, televisions, expensive crystals were acceptable gifts.

Very few doctors admitted to having accepted gifts; those who did stated that accepting the gift would not influence their decision about which brand to prescribe. Ironically, almost all of them knew of another professional who had accepted gifts and believed that their prescribing had been influenced by this incentive.

Doctors felt that pharmaceutical companies offered incentives only to consultants and specialists who were considered "good" prescribers, or those whose prescriptions were substantial, as verified by the neighbourhood chemists. They were more likely to get returns of their investment in such doctors. The general practitioners interviewed stated that they did not receive the expensive gifts received by the specialists. However, MRs stated that general practitioners in smaller towns were given more incentives than specialists were. Two MRs said that public teaching hospital doctors were more aggressively pursued, apparently because they were in a position to influence several new entrants into the field. This was corroborated by doctors associated with public hospitals. *"…doctors in these teaching hospitals are in touch with the latest all over the world and keep taking lectures at CMEs, meets, etc. Foreign conferences including registration fees, air tickets and stay for doctors and their spouses are regularly paid for by the pharma companies. Foreign conferences are paid for senior doctors and heads of department, and local conferences are paid for entire departments including the residents if they demand it." (senior paediatrician, Mumbai)*

Most doctors felt that newer and smaller companies were more likely to offer incentives to compete with older, more established companies.

Manufacturers stated that "me too" drugs, or variations of existing drugs, required aggressive promotion while innovative drugs were promoted on the basis of their scientific importance. They stated that doctors were more likely to demand incentives for prescribing the former.

Some MRs said incentives had become less cost-effective over the years as each company tried to offer more expensive gifts than the others. Incentives did not work to build a doctors' loyalty to a particular brand as all companies offered incentives. So they were now increasingly based on the prescriptions generated. Two doctors practising in slum areas showed printed handouts from a drug manufacturer giving targets and incentives to meet them. They were offered a cell phone handset for prescribing 1,000 tablets, an air cooler for prescribing 5,000 tablets and a motorcycle after 10,000 tablets were prescribed.

Another promotional practice was to finance educational programmes and conferences. Individual doctors' travel, stay and conference fees were also paid for by drug companies. Most doctors had no objection to such support and said they could not otherwise afford these meetings that they described as informative. A small minority felt that the lack of transparency in the funding of medical programmes by drug companies was unacceptable. Nearly half the doctors and all the MRs felt that over the past decade conferences had moved out academic college auditoria to five-star hotels which served lavish cocktail dinners, all with an accompanying increase in budgets.

Drug companies stated that funding medical conferences had become less cost-effective; they suggested that doctors as a group had begun to pressurise pharmaceutical companies into financing their associations' programmes and would even boycott drug companies that did not give in to their demands. *"Things have got to such a stage now with doctors actually demanding sponsorship from companies. This year (an Indian drug company) had zero participation in (a specialist association's) conference. The company is now feeling the heat in the form of infrequent prescriptions." (senior executive of an Indian drug company)*

Trade practices

Some promotional practices described in the interviews were trade practices used by drug companies with both chemists and doctors. This included discounts, promotional offers, incentives for stocking only the company's products and rewards for meeting targets.

Medical representatives indicated that the list of products stocked in a chemist's shop depended on the negotiation between the chemists' association and the drug company, and how well the drugs were promoted with doctors. Retail chemists said that the multiplicity of brands made it difficult for them to stock all drugs and they risked being left with unsold stock. They therefore stocked the drugs of those companies which were promoted well both with the chemists as well as the doctors. Hence, it made sense for MRs to be consistent in promotion with doctors as well as chemists.

Many chemists stated that "other" chemists dispensed medicines without prescriptions. Some chemists stated that they sometimes substituted brands when filling prescriptions. They justified both practices saying that poor patients could not afford to see a doctor, or to buy expensive brands.

It was also reported by drug companies that chemists associations charged Rs 500 for a "no objection certificate" to market new products. The company also paid a charge of Rs 5,000 to Rs 10,000 to the association of wholesale chemists to stock a new product. Drug companies also gave other

incentives to chemists to stock their own products.

In addition, interviewees referred to the following:

Screening camps were used to influence public knowledge about a disease and also expand the market for the drug for that disease. Another practice to get a captive market for a company's drugs was reported: financing small hospitals in return for the sole rights to set up the hospital pharmacy.

Medical representatives reported that companies would conduct "post-marketing surveillance" programmes. Doctors were given free samples to distribute to their patients and would receive gifts when they reported back. This information would be collated and used as promotional information.

Another way to give performance-based incentives was to track doctors' prescribing practices through the local chemist, and reward good prescribers. The chemist charged MRs Rs 300 per prescription audit.

Defamation campaigns were run to destroy the sales of a cheaper product produced by another company or even to kill the parent company's product in favour of a more expensive version. One way of doing this was to exaggerate the cheaper drug's side effects.

Among the illegal practices reported were: reuse of discarded packaging for packing spurious drugs, and using hospitals' letterheads to buy large quantities of drugs at marked-down institutional rates and then reselling them.

Discussion

We identified a number of blatantly unethical and illegal drug promotion practices – the provision of misleading or incomplete drug information through medical representatives; gifts that serve as inducements, and trade practices that manipulate consumer access to appropriate drugs. These promotional practices depend upon a nexus between drug companies, chemists and doctors, with medical representatives playing a role. The public health consequences are grave. Though our samples were purposive rather than representative the findings should provoke further more systematic and detailed research.

The doctors interviewed learned about drugs from presentations given by medical representatives using flip charts. They were often not given critical details such as a drug's adverse reactions. Companies ensured that the information given to doctors was limited and biased towards their drugs, and that such promotional material was not left with the doctor. However, doctors were generally satisfied with this information though some felt the time spent with MRs took away from their time with patients.

The doctor-drug company relationship is cultivated through tokens such as brand reminders, as well as through gifts which are more obviously incentives to prescribe. Medical representatives gave gifts to doctors to persuade them to prescribe their company's drugs, and many doctors seem to accept these incentives. Gifts seem to have become more expensive over the years, and more clearly incentives than tokens.

Medical representatives give incentives to those who they believe will prescribe in large amounts, or influence others to do so. Incentives may be targeted to those who are in a position to prescribe in high numbers, such as specialists in the city or general practitioners in rural areas. They may also be targeted at those who might influence others to prescribe, as public teaching hospital doctors are, or at medical students, prescribers of the future. Newer companies are likely to offer more incentives and "me-too" drugs required more aggressive promotion with incentives than truly innovative drugs. Doctors' performance is also monitored in collusion with chemists, and they are given performance-based incentives.

Incentives are also offered to unqualified practitioners for prescription of allopathic drugs, although Indian law states that physicians from Indian systems of medicine cannot prescribe western medicines (9).

Most doctors had no objection to receiving "brand reminders" though these are meant to influence the doctor's prescribing practice. A number of doctors felt that expensive gifts were acceptable. Interestingly, no physician believed that his judgment was influenced by incentives; however, all reported that other colleagues had succumbed to the pressure of incentives, a phenomenon termed the "illusion of unique invulnerability" (10, 11).

While companies stated that the incentive strategy was becoming less cost-effective this continued to be an important activity. They also expressed concern about the expense involved in funding conferences – which they said they were often forced to do, or sometimes face boycotts by professional associations. We note that as companies have become more important in financing professional activities, the practice of giving incentives is reinforced which affects the autonomy of the medical profession and hampers the credibility of the associations.

Post-marketing surveillance done by companies was used to claim success of a drug. Companies use doctors to distribute free samples in order to increase the drug's use, and use the feedback that they get from doctors in order to create promotional material. This promotional practice also allowed manufacturers to bypass ethical boards, the Food and Drugs Administration and expensive clinical trials.

A wide range of questionable, or unethical, or frankly illegal trade practices was described. Companies sponsor screening camps to increase public awareness of a disease and then promote their drugs as the treatment. They create captive markets through centres that use only their brand of drugs. They track doctors' prescribing practices with the help of chemists in order to influence these practices through incentives. They run defamation campaigns against their competitors in order to increase their market share; they even run such campaigns against their own drugs if they have a

more expensive substitute.

The sale of scheduled drugs was influenced by aggressive marketing strategies including incentives to chemists. Medical representatives encouraged doctors to prescribe their products and pharmacies to stock them and also acted as intermediaries assisting pharmacies to get rid of unsold and slow moving stocks, a finding confirming other studies (8). Chemists demand incentives to stock products, dispense drugs directly without a prescription, and some even trade in stolen drugs. Chemists are able to bypass doctors altogether and promote drugs directly to consumers. They may do so in order to benefit from discounts based on volume sales. This confirms other reports (12). Although discounts are an accepted trade practice, reducing the drug to a consumer item is a potential public health hazard as a result of inappropriate use.

We had started the study with the impression that the medical representative is the "weakest link in the chain" or axis of drug promotion. This impression was reinforced in the course of interviews. Medical representatives play a critical role in carrying out the company's programme, building up relationships with individual doctors, and also negotiating with chemists. However, they reap limited benefits from the promotional activity. They are employees of drug companies and also work on a commission. They are unable to dictate terms. They are often concerned about losing their jobs.

Limitations

The small and purposive, Mumbai-based sample does not allow one to generalise from the study findings. Since consumers were not interviewed, their independent decision-making on drug purchases could not be captured through this study. Also, as information from medical representatives was sought in focus group discussions rather than individual interviews, their comments may have been more guarded than otherwise.

Conclusion

The study findings indicate the institutionalisation of unethical and illegal drug promotional practices – at the cost of the consumer -- by drug companies, chemists and doctors, with a role played by medical representatives.

We suggest that effective action against such practices must involve better regulation of the industry, as well as involvement of all the stakeholders -- doctors, chemists, manufacturers and consumers. However, the various associations have not shown any inclination towards self regulation. In fact, many of them are themselves mired in controversy (13). There is limited organised consumer action against spurious drugs and unethical promotional practices in the pharmaceutical industry.

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