Contribution, Challenge, or Threat?
Dutch Psychiatrists’ Attitudes and Opinions toward Pharmaceutical Promotion

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Chapter one

INTRODUCTION

The pharmaceutical companies not only produce medicines, but also ideas about medicines in the form of quasi-scientific knowledge. (S. van der Geest)

Pharmaceutical marketing is a powerful strategic and operational tool for the pharmaceutical industry to promote their products or brands. Pharmaceutical promotion is one of the key aspects of drug marketing\(^1\), which represents a vast array of processes through which both the medicines and the ideas about medicines are exchanged among manufacturers, prescribers (physicians) and consumers (patients). It encompasses extremely diverse strategies for advertising, sale promotion, and publicity and is not limited to the printed and media broadcasted advertisements, sponsored meetings, and public communication (Hogle 2002). WHO defines drug promotion as “all informational and persuasive activities by manufacturers, the effect of which is to induce the prescription, supply, purchase, and/or use of medicinal drugs”. Pharmaceutical promotion represents a hybrid scientific-commercial nature. Combining science and commerce, pharmaceutical companies implement several marketing strategies to target health professionals. The ambiguous composition of science and commerce in drug advertisements makes pharmaceutical promotion quite a controversial issue. This controversy stems from the industry’s claim that promotion ‘informs’ the audiences in a broad sense, facilitates patients’ communication with professionals, and helps drug consumption patterns to be more appropriate and, say, rational. Opponents, on the other hand, consider the inherent commercial reality in drug advertisements as being the ultimate aim of the pharmaceutical industry due to the corporate-base need for profitability.

Several disciplines have looked at the meeting point of pharmaceutical marketing and the medical profession. Indeed, there is a ‘web’ of interrelationships at this point among

\(^1\) Successful marketing has seven elements known as seven Ps: Product management, Pricing, Promotion, Placement (distribution), People, Process, and Physical evidence. (Source: Wikipedia)
patients, health professionals (physicians, dentists, and nurses), insurance companies, pharmacists, ethicists, macro-level health policy makers, economists, etc. (figure 1). Pharmaceutical advertising has thus been targeted by a thick body of literature in different disciplines.

![Diagram of Pharmaceutical Promotion](image)

Figure 1. The interactive web of relations among the different aspects of pharmaceutical marketing

This study will be an attempt to characterize anthropologically Dutch psychiatrists’ beliefs and attitudes toward pharmaceutical promotion and its influences on their prescribing patterns.

1.1 Literature review

Generally speaking, social science literature takes a radical position on the issue of pharmaceutical marketing while economic literature remains more conservative. Medical journals lay in between with a tendency to criticize what they see as occasional excesses. Quantitative studies based on survey results are significantly more available than qualitative ones.
Introduction

1.1.1 Big Pharma

Big Pharma refers to the body of top 30 or so multinational often United States and Europe based pharmaceutical companies with the highest revenue. Big Pharma is globally influential in both medical and political-economic spheres (Medawar 2004). Profitability for Big Pharma is beyond the matter of survival as an industry. It has been enormously successful in reaching this goal. The pharmaceutical industry has been the most profitable industry in the United States in the last 10 years. While the profitability of the top successful 500 firms from 1994 to 2001 was about 3% to 5%, Pharma ranged between 14% and 19% (Conrad 2004; Medawar 2004). On average, the Big Pharma spends 20% or more of their revenues on marketing. This places prescription medicines among the most heavily promoted commodities (de Laat 2002).

Intensive-marketing initiative: Big Pharma had long been dependent on drug innovation as the main way of survival because it secured the ‘patent’, the right to monopolize the production of a particular drug for a roughly ten-year period at whatever price they determine. In the late twentieth century, the drug innovation pipelines were increasingly becoming dry and the rate of innovation slowed down. At the same time, the cost of research and development (R&D) rose dramatically. At the end of the century, the pharmaceutical industry estimated the price of each innovation around US$ 800 million and later estimated even more than one billion. Although part of R&D budget was paid by the US government, the crisis of innovation threatened the industry (Hilliard 2006; Medawar 2004). “…there are very few industries in which a market can be lost as quickly as in pharmaceuticals” (de Laat 2002: 31).

In response to this crisis, Big Pharma has had two main reactions; both are profoundly influential on the medical profession: Expanding marketplace (facilitated by globalization processes) and intensifying marketing efforts.

Trade liberalization helps Big Pharma expand the market globally. In so doing, they need standard global references in order to scientize marketing and homogenize the demand. For instance, Big Pharma has well exploited the American Diagnostic and Statistical Manual of psychiatric disorders (DSM) as an ‘international’ reference. According to some
critics, DSM-IV was not invented as a “psychiatric nosology but rather a catalogue for marketing psychopharmaceuticals...and as an example of American cultural imperialism” (Lakoff 2005: 61). Globalization offered the Big Pharma stricter patent and brand. It also enhanced Pharma’s sociopolitical power and reputation by lobbying influential bodies such as politicians, medical celebrities, public opinion, and international health organizations (Medawar 2004).

The second strategy was strengthening marketing. Since the turn of the twenty-first century, Big Pharma has intensified marketing efforts dramatically. The money has been shifted from the R&D to the marketing department and marketing strategies have become extremely diverse and been set up as the first priority. In fact, attention has been concentrated on the steadier business of marketing rather than the unpredictable and expensive task of creating new drugs. In the third millennium, as Cooper reports, the ‘winner’ is no longer the one with best products but with best marketers. The sale of the 50 most heavily advertised drugs was approximately equal to the rest 10,000 ones in 2000 (Cooper 2002). In the same year, Big Pharma spent twice as much for marketing as for R&D (Medawar 2004; Hilliard 2006). One of the products of intensive marketing is the blockbusters, accounting for half of the total Big Pharma’s sale. They are not first-rate innovations. Most are ‘me too’ drugs or lifestyle drugs. In the next part, I discuss the influences of this intense, skilled and diverse marketing on physicians and their prescription behaviors.

1.1.2 Influence of pharmaceutical marketing on physicians

For the medical professionals, pharmaceutical marketing is an influential set of dynamics, capable of ‘modulating’ physicians’ prescription behavior (Lakoff 2005, de Laat 2002, and Henriksen 2004). The drug promotion database (DPD) was coordinated by the WHO Department of Essential Drugs & Medicines Policy and Health Action International (HAI) Europe. According to this database, drug marketing is the third most important determinant in prescribing medicines (DPD reviews).

2 For simplicity, I use the term physicians but it can be implied to all professional providers of healthcare with direct relation to patients and with the eligibility of prescription including dentists, midwives, etc.
I was unable to find an article that ‘denies’ the influence of drug marketing on doctors. The papers I reviewed have all reported certain degrees of influence on the doctors’ prescription patterns even through the small-scale interactions: “I find the statement ‘any gift must leave the doctor’s independence manifestly unimpaired’ to be nonsense” (Hodges 1995: 558). Such influence is also said to be a universal issue (Hodges 1995; Lexchin 1993).

1.1.2.1 The quality and direction of influence
Pharmaceutical advertisements have long been targeted to physicians and several papers address it. There is a wide range of interactions between physicians and the pharmaceutical industry, all capable of influencing physicians (Table 1) (Reist 2004; Hilliard 2006; Hodge 1995; Lexchin 1993; Tan 1999). Pharmaceutical promotion ‘interacts’ professionals at three levels: their selves, their professional identity, and their prescribing behavior. Conflict of interest lies at the core of these interactions and is potentially able to change physicians’ incentives.

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<th>Table 1. Examples of influential interactions between physicians and the pharmaceutical industry</th>
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<td>• Establishing personal relationship and creation of loyalty (with the mediation of company representatives)</td>
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<td>• Sponsorship of educational meetings, scientific events, conferences, etc.</td>
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<td>• Sponsorship of authorship of clinical guidelines</td>
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<td>• Post-marketing research (participating doctors are typically paid)</td>
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<td>• Sponsorship of travel to meetings, including accommodation</td>
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<td>• Hospitality at meetings such as free lunches</td>
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<td>• Sponsorship of professional bodies and medical celebrities</td>
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<td>• Sponsorship of clinical research specially drug trials</td>
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<td>• Sponsorship of publications and textbooks</td>
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<td>• Financial ties to the Big Pharma e.g. stockholding</td>
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<tr>
<td>• Product-related (brand name) stationery and gifts</td>
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<td>• Offering free drug samples</td>
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Although literature describes what is influenced, i.e. doctors’ prescription behaviors, there is little clarification of what exactly the term ‘influence’ means. Lexchin (1993) addresses this question by reviewing 227 papers from the US, Canada, Australia, the UK, and New
Zealand to determine the effect of physician-industry interaction. He reviews only medical literature and suggests reviewing sociological or economic literature as well. The main aim of his literature review is to set forth a further research agenda. The directions of influence are ‘uncertain’, he argues. It is not merely the greater rate of prescription of an advertised medicine but also probable ‘inappropriateness’ of prescribing behavior. In fact, pharmaceutical promotion is able to alter doctor’s attitude towards favoring (or adopting) commercial views rather than rendering optimal treatment for the patients. Lexchin also shows that ‘influence’ depends on the type of interaction, the field of practice (including primary or specialized practice), and whether physicians are early or the late prescribers of the new drugs.

Physicians are often well aware of the commercial bias in pharmaceutical promotion. In a survey in Canada, about 90% of responding physicians noticed the likelihood of bias. Simultaneously, they frequently participate in sponsored events where there might be certain influence (ibid).

Among some 73 psychiatry interns, residents and clerks that Hodges (1995) surveys, one third deny that company representatives have an impact on their prescriptions while half of them strongly agree. Even within the denial group, the majority accept some ‘naïveté’ especially for physicians-in-training (Hodges 1995). The same trend is reported by Reist where he considers the field of psychology to be more ‘vulnerable’ to drug advertisements than psychiatry (2004). Hilliard, Hodges, and Reist, who studied pediatricians, psychiatrists and psychologists respectively, have all mentioned the necessity of formal training programs and establishing adequate guidelines to limit the negative influence of pharmaceutical advertisements since doctors are not ‘prepared’. In the next part, I discuss the mechanisms of the so-called influence.

1.1.2.2 Channels of influence

Big Pharma has developed extremely diverse and innovative strategies to influence its targets. Marketing strategies are mainly the subject of marketing and economic journals. However, I narrow it down to some noteworthy channels in the context of prescription behavior.
Distillation of expertise: With intensive monitoring of doctors, the Big Pharma recycles the opinions that are closer to them regarding the values of their products (Medawar 2004). 

Celebrities screening [contagion]: Special focus is (and has always been) on the medical celebrities with influential prescribing behaviors. In this way, they augment their marketing by exploiting their sociopolitical leading positions.

Pharmacodynamic expansion: Widening the extent of indications of drug use by repositioning medicines for new conditions or moving from treatment to prevention such as using antidepressants for treating anxiety (Medawar 2004). In other instance, moving from treatment to prevention like the case of Tamoxifen. Hogle (2002) examines how pharmaceutical advertisements extend the use of Tamoxifen from treatment in breast cancer and prevention for previously cancerous patients to prevention for ‘all’ women.

The tournament of ‘the latest’: This process was intensified by ‘me too’ drugs (Tan 1999; Medawar 2004). Similar to computer hardware market, in which each product is old-fashioned in a very short time after releasing the newer version, the new drugs bombard the market and are intensively illustrated (promoted) as the better. The doctors would thus be greatly ‘dependent’ on Big Pharma to keep their information about the new drugs up-to-date and to be a ‘good’ prescriber as well. Indeed, Big Pharma creates and maintains dependency for physicians to ‘the latest’ information, best served for promoting new drugs (de Laat 2002).

Appealing to doctors’ unconscious: Ferner (1994) believes that pharmaceutical marketing influences the doctors’ unconscious, though they are reluctant to acknowledge it. More importantly, she argues that this reluctance makes them more ‘vulnerable’. She defines the influence as adopting ‘irrational’ prescription behavior since advertisements are not based on logical arguments. Based on the same process, Tan (1999) discusses ‘brand habituation’, which is an endeavor by the Big Pharma representatives to subconsciously induce doctors to prescribe a particular drug. In other instances, massive brand marketing may induce physicians to equate brand names with drug efficiency or reduce their price consciousness (de Laat 2002).
RCT enterprise: A randomized clinical (or controlled) trial (RCT) is a standard epidemiological tool used to evaluate therapeutic interventions and approve the efficacy of a particular drug (Coggon 1997). Most doctors believe in this method as proof of drug efficacy. Therefore, it is not a hard task for the marketers to persuade doctors of efficacy by providing just the result of an RTC. Indeed, RCT, in itself, can be potentially a marketing tool as Pieter’s study of Interferon reveals (1998). His case study warns those physicians who over-rely on RCT without questioning its methodological details. RTC can be a double-edged sword. Hogle (2002), Medawar (2004), Coggon (1997) and Greenhalgh (1997) all describe how this seemingly reliable method for evaluating drugs can be easily biased towards a desirable outcome. There are numerous ways of pushing the trials design in a desired way without troubling the regulators (Medawar 2004). RCT is susceptible to bias by manipulating demographic data, sample size, and more importantly the ‘surrogate endpoints’.

Post-marketing research: Post marketing drug trials – also known as phase IV trials – investigate drug performance, efficacy, safety, and side effects in actual clinical setting. de Laat (2002) describes how the Big Pharma may exploit post-marketing research as a marketing tool.

Greenhalgh (1997) warns physicians of the possibility of such biases and advises them how to ‘get evidence out of a drug representative’. Her advice is noteworthy:

- Ignore anecdotal evidences such as the fact that a celebrity prescribes the medicine.
- Request independent [not sponsored by the industry] publications and peer reviewed articles.
- Ask for evidence in safety, tolerability, efficacy and price
- Evaluate the ‘evidence’ stringently and ask for the methodology and especially for the criteria of defining endpoints. “The pharmaceutical industry is a slick player at the surrogate endpoint game” (90).
- Do not consider ‘newness’ as the excuse to change your prescription.
1.1.2.3 Challenging physicians’ role

With reinforcement of drug marketing, a ‘modern’ form of physician-patient relationship emerged and challenged the conventional politics of the medical profession. This relationship, in its modern form, is more economically driven. Overall, there is agreement in the literature that pharmaceutical advertisements do influence physician-patient relationship. This influence results in major ‘changes’ in their encounter toward consumer-centeredness (Conrad 2004). Other scholars describe this change as ‘overwhelming’ (Hogle 2002), ‘powerful’ (Medawar 2005), ‘radical’ (Fox 2006) and ‘irreversible’ (Donohue 2006).

Fox (2005) also describes the process of patient ‘empowerment’ as a cause of evolutionary change in physician-patient relationship from ‘active/passive’ model to ‘guidance/co-operation’ to ‘mutual negotiation’ or partnership. The role of the patients, their movements, and the dynamics of physician-patient relationship are crucial elements of debates concerning direct-to-consumer advertisements (DTCA), though, it is beyond the scope of this review.

Fox (2006) in his analyses of ‘governance’ in the information age shows that globalization and information technology lead to sophistication of governance and authority within the medical profession, creating a new balance of power (also Conrad 2004). Hogle has also the same analysis in a case study of breast cancer (2002). She shows how advertisements challenge the locus of authority and shift the jurisdiction of decision-making and responsibility from physicians toward patients.

Patients are better educated, better informed through mass media and the Internet, better organized in patients’ associations, more often receive advertising messages and are generally less impressed by a physician's status. As a result, patient attitudes have changed from "OK doctor, if you say so" to a more assertive "But I've seen on television that ..." or "I really would prefer to have medication X." De Laat 2004: 38
Introduction

1.1.3 Pharmaceutical promotion in the Netherlands

Besides the global character of Big Pharma, there are some national differences. Healthcare systems, regulations and legislations, and insurance policies differ from country to country. For instance, unlike the US, direct-to-consumer advertising of prescription medicines is prohibited in the Netherlands (See figure 2). Generic promotion is another difference. It is as much recognized as brand marketing in the Netherlands and physicians are well aware of generic prescription options (de Laat 2002).

Generally speaking, there are few relevant studies done in the Netherlands and very little publications are available in English. In the Netherlands, based on the studies in 1999 and 2001, major marketing activities were direct mail/advertisement, post-marketing research, conferences and promotional events, and marketing by company representatives or drug retailers (Van Egmond-Vettenburg 2001, de Laat 2002) (Figure 2).

Figure 2. Different types of drug marketing in the Netherlands in 1999

*Information aimed at public in the Internet is allowed but advertising for prescription-only medicines which is aimed at the general public is forbidden (Source: CGR).

Most of the prescription medicines are covered by the public and private health insurance. De Laat mentions that, up to a certain level, the costs of prescription pharmaceuticals are typically covered by public health insurance in the Netherlands. Therefore, increase in prescription may lead to an extra financial burden for the (Dutch) government. In his

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3 CGR. The national associations of doctors, pharmacists, pharmaceutical trade and industry http://www.cgr.nl/index.cfm?pageid=4637 (Accessed 20.10.07)
analysis of drug market in the Netherlands, psychiatric drugs (antidepressants, anti-anxieties, and sleeping pills) were the third most heavily sold drug categories after anti-hypertensive and contraceptives with near $400 million sale in 1999 (de Laat 2002).

Pharmaceutical promotion has received particular attention in the past few years, especially in the media. There are also many critical voices nowadays in global, European, or national level such as HAI Europe or Healthy Skepticism. Being fueled by the Dutch media, this issue has become a sensitive issue for the public as well as the professionals and the overall view of the public is critical in the Netherlands (de Laat 2002).

1.1.4 Healthcare and mental health system in the Netherlands

Drug consumption: Prescribing medicines is the most prevalent therapeutic option for Dutch doctors. Although the cost of drug consumption is relatively low in the Netherlands compared with other European countries, it has been noticeably increasing in recent years. Individual drug consumption is also increasing (Van Rooij 2002).

Mental healthcare: The scope of the Dutch mental health system is wide. It is characterized with institutionalized care, proper access to professional resources and adequate health insurance coverage (Van Rooij 2002). Mental healthcare is provided on a referral basis at three levels: General practitioners, psychologists/psychotherapists, and psychiatrists. Psychiatric disorders are widespread in the Netherlands. In an extensive population-based study in 1998, Bijl shows that 41% of about 11000 respondents have faced a psychiatric disorder at least once in their lives. The lifetime prevalence for mood and anxiety disorders was 19% each. This study is, to a great extent, suggestive of relatively high prevalence of psychiatric disorders in the Dutch population. The dominant policy in Dutch mental health system emphasizes cost-effectiveness, specialization, and systematic shifting from in-patient care toward outpatient care (Van Rooij 2002). The main concern in mental healthcare is the extent to which pharmacotherapy offers the chance of successful treatment (ibid.).

Financing and health insurance: The Dutch health care is based on a mixed public and private funding. In the past, an individual was covered by public health insurance when his
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income is below a certain threshold. Above the threshold, he could choose insurance coverage from the private insurers. All Dutch residents were subjects of compulsory coverage by a national health insurance to meet the catastrophic costs (Van Rooij 2002). Since 2001, the Dutch healthcare system has drastically changed towards complete integration of public and private health insurance. Helderman (2005) reports a recent ‘market-oriented healthcare reform’ in the Netherlands as a result of an evolutionary change in national health system towards ‘managed competition’. The dominant policy in the new healthcare system is cost containment and increase in private financing opportunities (Van Rooij 2002).

To sum it up, the literature suggests that pharmaceutical marketing has definitely influenced physicians, their prescription patterns, their social role, and the dynamics of their classic encounters with the patients. In an era when the modern medical profession has clearly become part of ‘corporatized medical market’ (Conrad 2004: 171), pharmaceutical marketing has been able to ‘reframe’ professionals’ as well as public opinion. Through the pharmaceutical promotion:

Big Pharma [has] come to enjoy powerful and increasing influence over the policies of nations, the conduct of medical science, the perspectives of the press and media, the judgment of doctors, and the understandings and welfare of consumers. Medawar 2004: 101

1.2 Statement of the problem and research questions

Pharmaceutical marketing is the hallmark of the ‘new medical-industrial complex’ as Relman proposes (in Conrad 2004). The promotional materials of pharmaceutical industry are commercially fueled and lunched toward the medical profession. What will happen when it reaches the destination? What will happen when it incorporates the marketplace rules-of-play into the world of medicines and medical profession? And how would the medical professionals react to this interaction? A lot has been written about the pharmaceutical promotion but these questions are yet to be answered.
Literature reveals that this interaction is universal and applicable to all medical fields and almost all healthcare contexts including the Netherlands. It is also clear that this interaction highlights a salient conflict of interest between the industry and the medical profession. Physicians ‘pull’ scientific information but the pharmaceutical companies ‘push’ promotion (Fox 2005). This unclear border between scientific information and commercial promotion creates room for the medical professionals to be influenced either positively or negatively (Hilliard 2006). Hence, the influence is a socially constructed concept.

Scarcity of similar studies: Although the literature has convincingly highlighted and described this interaction, few articles have tried to describe ‘the results’ or possible consequences of the very influence of marketing. After an extensive medical literature review, Lexchin concluded that the result of this influence is ‘uncertain’ (1993). Later literature however, sheds some light on the issue. For instance, Reist (2004), Conrad (2004), Ferner (1994) and Mansfield (2006) address the concept of ‘vulnerability’ to drug marketing as a result of physicians’ reluctance – or even denial – to acknowledge being influenced by the Big Pharma. However, these studies do not discuss how physicians perceive the influence and deal with it. The abstract concepts of influence and vulnerability merit further elaboration by anthropological/sociological studies.

Qualitative/anthropological gap: According to the Drug Promotion Database (DPD), available research is mostly quantitative and survey-based which provide an estimation of how many people agree with or disagree with the appropriateness and effect of various forms of promotion. Moreover, there is a striking lack of more complex studies to understand medical professionals’ attitudes, behaviors, and the perceived effects of drug promotion with their practice. Physicians should talk in their own words about their attitudes toward promotion and how it affects them (DPD Reviews). DPD emphasizes the necessity of qualitative studies concerning this issue and recommends:

ethnographic research, in which the researcher spends time with doctors and tries to understand how promotion fits into their working lives…We need to move beyond simple surveys of attitudes to more sophisticated understandings of how people react to promotion, and how they understand their own reactions. DPD reviews
Introduction

**Rare studies in the Dutch context:** To the best of my knowledge, studies about the influence of pharmaceutical marketing have been predominantly carried out in the United States and to a lesser extent in the UK and Canada. Studies that show the influence of drug marketing on the medical professionals in other countries are even scarcer. De Laat (2002), who describes the effects of the Big Pharma marketing on prescription patterns in the Netherlands, clearly mentions that (up to his paper in 2002) there is no study on the effects of pharmaceutical marketing on prescription behavior in the Netherlands. However, his study is an economic analysis. I was unable to find any sociological study on this issue in the Netherlands.

**Main objective:** This study aims at exploring the Dutch psychiatrists’ attitudes and opinions towards drug promotion. It is an attempt to better understand the actual reflection of promotion and influence on psychiatrists’ prescribing behaviors. Therefore, the main research question is ‘**How do Dutch psychiatrists perceive pharmaceutical promotion and what are their attitudes about the influence of promotion on their individual and collective prescribing patterns?**’

**Further research questions:** Studying physicians’ attitudes and their prescribing behaviors will also enable us to climb the ladder and gain a wider perspective on whether the pharmaceutical promotion is a tool for empowerment or vulnerability, freedom of choice or dependence, and rationality or irrationality in medical practice. Further questions are as follows.

- How do Dutch psychiatrists perceive their colleagues’ prescribing patterns?
- What changes do Dutch psychiatrists perceive in their own and their colleagues’ prescribing behaviors over time?
- How do they think they are supposed to react?
- How do they perceive the (im)balance of information and promotion in independent or industry-sponsored literature?
- How do they perceive the new and the old medication in regard to drug promotion?
- How do Dutch psychiatrists think about the influence of promotional endeavors on medical professionalism?
- How can professional authority be challenged by the effects of drug advertisements?
1.3 Summary of chapter one

The literature convincingly shows that the pharmaceutical promotion influence medical and health professionals and is potentially able to affect their prescription and the provision of optimal treatment, and in larger scale, the overall healthcare quality and outcome. Despite the fact that the influence is a socially constructed concept, the scarcity of qualitative studies on the physicians’ attitudes toward pharmaceutical promotion justifies this research. It is an attempt to contextualize influence of pharmaceutical promotion and to clarify Dutch psychiatrists’ attitudes toward the influence.
Chapter two

RESEARCH METHOD

...I am afraid studying physicians’ prescription behaviors is as tricky as asking them about their sexual behaviors. (An expert advisor)

This study is an attempt to explore the Dutch psychiatrists’ attitudes toward pharmaceutical promotion. Using a qualitative approach, I will explain how they perceive, believe, react, and articulate their interaction with the pharmaceutical industry and the influence of drug promotion on their prescription. The emerging issues will then be discussed within a broader theoretical framework.

2.1 Psychiatry; an abstract field

Two main reasons convinced me that psychiatry could be the field of choice for this study. Dealing with human behaviors, there are two major gray zones in psychiatry. First, unlike many other fields of medicine, in psychiatry there is no objective way to validate disorders and sharply distinguish normality and abnormality (Moncrieff 2005). Disorders of mood and mind are not as concrete as somatic ones. Therefore, there is a blurred boundary between what is subjectively entitled as normal and as abnormal. Secondly, while medication is a definite treatment modality, there are certain non-pharmacologic alternatives for treating psychiatric illnesses through psychodynamic therapy. Treatment decision, therefore, relies greatly upon the perceived biological and/or psychotherapeutic ‘school of thought’ in disease etiology. In those gray areas, there are ample opportunities for the pharmaceutical industry to influence psychiatrists and this creates space for more complex interaction between the industry and psychiatrists. Therefore, the field of psychiatry is a fertile ground for sociological studies aimed at understanding the interaction with the pharmaceutical industry.
2.2 A meta-fieldwork: Problems in entering the field and finding respondents

Stepping into the field was very challenging to me. Indeed, I exerted as much effort for finding respondents as I did for the whole fieldwork (interview, data collection, and analysis). Indeed, in order to find respondents, I experienced another fieldwork (within the main fieldwork). Given the importance of this pre-field experience, what happened in finding respondents is in itself ‘data’ and thereby worth being described. It may be beneficial for those readers who intend to design similar studies and carry out research on medical profession in the Dutch context or elsewhere.

Before starting fieldwork, I assumed that I would be able to contact psychiatrists, privileging my medical identity and find enough respondents. I assumed contacting psychiatrists would not be that difficult but this was not the whole scenario. It was only one side of the coin. Not only are they busier than I had thought but also, more importantly, they are always requested to participate in several research projects especially in academic centers. So, their minds had already been filled with several research requests from different parties. Subsequently, one can realize that they have to simply reject most of the invitations for participating in research projects. “Unfortunately, I have to disappoint you. Lack of time and involvement in too many projects at this moment are simple reasons that makes me say ‘no’ to all requests like yours” said the head of department of psychiatry in one academic center. I was not familiar with the context (Dutch psychiatric system) and the more I went through, the more I realized the difficulty of making appointments with psychiatrists.

In order to get a better idea of how to enter the field, I consulted the staff, my fellow classmates, and Dutch doctors. Not surprisingly and in accordance to what my supervisor guessed, I was frequently told how difficult finding respondent among psychiatrists is. “Psychiatrists are always busy; you know that we are in relative shortage of psychiatrists in the Netherlands; they are often much busier than other specialists”, Said an experienced advisor.
Nevertheless, observing hierarchy, I decided to start entering the field with the help of gatekeepers i.e. the head of psychiatric or research departments in different institutions. I simply sent an email and invited them to participate. I introduced myself as a Master student with a medical background. I mentioned the study briefly and ask them if I can contact other psychiatrists in their departments and invite them to participate. Days passed and I received no reaction from the three academic centers and one definitely negative reaction from the forth. I had to find another strategy. I had to introduce my research more strikingly to deserve being paid extra attention by psychiatrists and the heads of departments.

My supervisor and one of my fellow classmates suggested me to rewrite the invitation more comprehensively. This time, I rephrased the invitation letter introducing the project and myself more impressively. I rephrased my identity as a “general practitioner currently enrolled advanced extra training program in medical anthropology”. The title ‘dear Dr. X’ was substituted with ‘dear colleague’. I described the project precisely and briefly in less than one page because I knew that the longer invitation letters might not be read. I also contacted a psychiatry resident and asked his point of view toward this second version of invitation letter. He suggested me to clearly mention whether this study is sponsored by the industry; whose interest the result of the study is; and where the result is going to be published.

In the second round of finding respondents, I realized another practical issue, i.e. the role of secretariats in facilitating entering the filed. I went in person to them, described the project and myself, and asked them for help. Unless they forwarded my invitation to the psychiatrists, there would have been little chance for my email to be circulated through the psychiatrists and be given the chance to read. “We are receiving hundreds of emails and as much letters each day” said a secretariat. This time, I received some positive reactions though. For the negative reactions, busy schedule was yet the main excuse. Furthermore, many psychiatrists were in the USA at that moment since American Psychiatric Association (APA) was having its annual conference, which was an attendance-must for some Dutch psychiatrists.
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A very important issue here is that people normally do not read the letters carefully, probably because there are many similar requests on their desks. Although I had already included all necessary information in a packed piece of text in my invitation and described the project carefully, I received several emails in which I was asked again about the same information such as the duration of interview, whether it is going to be conducted in Dutch, and whether it is sponsored by the industry. The most emphasis and concern was nevertheless on the duration of interview that did make sense given the psychiatrists’ dense schedules.

I was disappointed to receive insufficient positive reactions and was about to change the focus of the study, switching from psychiatry to another. As the last resort, I also asked my supervisor and other AMMA staff to put me through their networks, which worked well. Ultimately, I could secure finding enough (perhaps more than enough) respondents.

This meta-fieldwork had a certain message; Practical obstacles are unpredictable and should not be underestimated. The efficient use of the ‘combination’ of strategies will enable the researcher to bypass the practical hindrances to enter the field. Particular attention should be devoted to the facilitating role of the secretaries as well as networking and snowballing techniques in conducting similar research.

2.3 Studying a sensitive issue

The second challenge of this study was the sensitivity of the topic. At social level, it is a topic with growing sensitivity partly due to the interest of the (Dutch) media in recent years. “The danger is that the media has put psychiatrists in the role of followers of the industry that they prescribe pills for everyone because the industry wants them to do. Psychiatrists, then, have become more aware and reactive to this debate”, one of the psychiatrists told.

I had planned to ask psychiatrists’ opinion concerning their own and their colleagues’ behaviors. I was concerned about the tendency to associate ‘exploration’ with ‘judgment’ while asking about behavioral patterns. Although I clearly described that the aim of the
Methodology

study is just explanation and by no means judgment, interpretations of the study took
different directions. I ensured them beforehand that the study is by no means judgmental
and all identifying data will be used anonymously. I also emphasized that the psychiatrists’
accounts would reflect only their personal opinions and would be, by no means, the
representative of the institutions, in which they are working. Nevertheless, the perceived
scrutiny as the aim of my study heated up the subject and invoked further challenges. A
gatekeeper expressed a reasonable concern on possible ‘consequences’ of participation in
this study. No one from that institute participated in my study.

...your request is still in debate in our organization. There is a certain tension
between the personal responsibility of doctors and the policy of the center.
Psychiatrists, who saw your request, refer to the strict policy of the institution as
their guiding standard. They are legally bound with this standard, and in the Dutch
juridical system, the institution has a liability for the professional quality of
doctors. Our colleagues addressed the head of the pharmacological department to
get an advice about what to do with your request… (Anonymous)

Some skepticism was also emerged by the gatekeepers on the reason why a non-Dutch
physician became interested in ‘inspecting’ psychiatrists’ prescription in their organization.
They told me, “how on earth can I be sure that you are not sponsored by the industry or the
media?” or “how should I know that you are not an artsenbezoeker (pharmaceutical
company representative) introducing yourself as researcher?”, etc.

Further negotiation, however, corrected most of these assumptions but reminded me of the
very description of an experienced physician-anthropologist on the sensitivity of the issue
while I asked him for advise: “I know many psychiatrists as my friends and I can introduce
you to them, but I am afraid studying physicians' prescription behaviors is as tricky as
asking them about their sexual behaviors”.

2.4 Study sample and location

In research proposal, I had planned to interview some 10 psychiatrists each in two
sessions. Given the psychiatrists’ busy schedule, I realized that making two appointments
was not feasible. Instead, I decided to interview more psychiatrists and focus on certain topics in each interview. Finally, I interviewed 27 psychiatrists with quite broad range of experience and heterogeneous work setting. Psychiatry residents [*assistenten in opleiding*] (being trained to be specialists) were also included. Only one respondent was excluded since he was a graduate medical student and had just started practicing cross-cultural psychiatry. Ultimately, I obtained a sample of 26 respondents based on ‘purposive sampling’ method. For the sake of anonymity, psychiatrists are given numbers in the order of interviews, and hereafter, will be addressed by numbers. When reading the next chapters, one may retrieve the respondents’ characteristics to get a better idea of whose quotes are they? One respondent was basically an experienced general practitioner, who has worked for about 20 years in the filed of psychiatry (psychiatrist 21). I summarized the respondents’ specifications in table 2.
Table 2. Specifications of the respondents

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Position</th>
<th>Main field of expertise</th>
<th>Duration of Experience* (year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>R</td>
<td>C</td>
<td>1</td>
</tr>
<tr>
<td>P2</td>
<td>P</td>
<td>G</td>
<td>30</td>
</tr>
<tr>
<td>P3</td>
<td>R</td>
<td>G</td>
<td>3</td>
</tr>
<tr>
<td>P4</td>
<td>A</td>
<td>C</td>
<td>20</td>
</tr>
<tr>
<td>P5</td>
<td>A</td>
<td>C</td>
<td>7</td>
</tr>
<tr>
<td>P6</td>
<td>P</td>
<td>G</td>
<td>18</td>
</tr>
<tr>
<td>P7</td>
<td>P</td>
<td>G</td>
<td>32</td>
</tr>
<tr>
<td>P8</td>
<td>P</td>
<td>C</td>
<td>23</td>
</tr>
<tr>
<td>P9</td>
<td>S</td>
<td>Ps</td>
<td>21</td>
</tr>
<tr>
<td>P10</td>
<td>P</td>
<td>F/CC</td>
<td>19</td>
</tr>
<tr>
<td>P11</td>
<td>P</td>
<td>CC</td>
<td>21</td>
</tr>
<tr>
<td>P12</td>
<td>P</td>
<td>G</td>
<td>19</td>
</tr>
<tr>
<td>P13</td>
<td>R</td>
<td>C</td>
<td>6</td>
</tr>
<tr>
<td>P14</td>
<td>S</td>
<td>M/CC</td>
<td>26</td>
</tr>
<tr>
<td>P15</td>
<td>R</td>
<td>G</td>
<td>3</td>
</tr>
<tr>
<td>P16</td>
<td>A</td>
<td>Ps</td>
<td>20○</td>
</tr>
<tr>
<td>P17</td>
<td>A</td>
<td>G/E</td>
<td>27</td>
</tr>
<tr>
<td>P18</td>
<td>P</td>
<td>G/E</td>
<td>27</td>
</tr>
<tr>
<td>P19</td>
<td>P</td>
<td>Ps</td>
<td>24</td>
</tr>
<tr>
<td>P20</td>
<td>P</td>
<td>C/CC</td>
<td>29</td>
</tr>
<tr>
<td>P21</td>
<td>P</td>
<td>CC</td>
<td>22</td>
</tr>
<tr>
<td>P22</td>
<td>A</td>
<td>M/C</td>
<td>8</td>
</tr>
<tr>
<td>P23</td>
<td>A</td>
<td>G</td>
<td>21</td>
</tr>
<tr>
<td>P24</td>
<td>A</td>
<td>C</td>
<td>8</td>
</tr>
<tr>
<td>P25</td>
<td>S</td>
<td>Ps</td>
<td>16</td>
</tr>
<tr>
<td>P26</td>
<td>S</td>
<td>G/CC</td>
<td>35</td>
</tr>
</tbody>
</table>
Methodology

Since interview topics were designed considering the dimension of time, the duration of clinical experience was of particular importance. Including residency-training period, the duration of respondents’ medical experience in practicing psychiatry ranged diversely between 1 and 35 years with the average of 18.7 years. Given the objective and the short time period of the study, no exclusion criteria was set for the working position, age, sex, and other demographic variations.

Interviews were conducted in Amsterdam, Utrecht, Leiden, Alkmaar, Diemen, Amersfoort, Noordwijkerhout, and Oegstgeest in the order of frequency. Twenty-one respondents were interviewed in their private offices, four psychiatrists at their homes, and one in a public place. I summarized the respondents’ general and specific characteristics in the following tables.

Table 3. General characteristics of the respondents

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>20</td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
</tr>
<tr>
<td>Duration of experience (year)</td>
<td>1-35 (mean: 18.7)</td>
</tr>
<tr>
<td>Practicing psychiatrist (non-academic)</td>
<td>12</td>
</tr>
<tr>
<td>Resident in training</td>
<td>4</td>
</tr>
<tr>
<td>Senior professor</td>
<td>4</td>
</tr>
<tr>
<td>Academic clinician</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 4. Distribution of respondents based on their main area of expertise

<table>
<thead>
<tr>
<th>Main area of expertise</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>General psychiatry</td>
<td>10</td>
</tr>
<tr>
<td>Child and adolescence psychiatry</td>
<td>8</td>
</tr>
<tr>
<td>Adult mood disorders</td>
<td>4</td>
</tr>
<tr>
<td>Adult psychotic disorders</td>
<td>4</td>
</tr>
</tbody>
</table>
Methodology

Table 5. Distribution of respondents based on their work settings

<table>
<thead>
<tr>
<th>Work setting</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>General psychiatric clinic/hospital</td>
<td>12</td>
</tr>
<tr>
<td>Academic clinic/hospital</td>
<td>11</td>
</tr>
<tr>
<td>Emergency and acute care</td>
<td>4</td>
</tr>
<tr>
<td>Cross-cultural and refugees</td>
<td>4</td>
</tr>
<tr>
<td>Community mental health center</td>
<td>3</td>
</tr>
<tr>
<td>Forensic psychiatric center</td>
<td>1</td>
</tr>
</tbody>
</table>

Overlapping is possible

2.5 Data collection

Data collection took place in seven weeks from May 21 to July 9, 2007. In-depth semi-structured interview was the main tool for data gathering. An interview topic list was designed to cover the main issues during interview. In so doing, I designed a preliminary checklist based on the literature and the statement of the problem. The checklist was then revised and evolved toward an interview topic list. In order to ensure whether this topic list will direct me to the main research questions, I carried out a pretest right before starting fieldwork. I interviewed one general practitioner as a first line consultant for psychiatric illnesses. This pretest helped me to make the topic list more accurate, familiarize myself with the context, manage the time of the interviews, estimate the amount of data that can be produced, and other practical necessary skills. The pretest data was not included in the mainstream data analysis for she was not psychiatrist.

The other methods such as participation or observation (in visiting patient) were not possible and not often a productive tool. Focus group discussion could not have provided desired privacy and comfort to discuss this sensitive issue. Although I had requested an appointment of about 30 minutes in the invitation letter, the duration of interviews were luckily more. It lasted from 30 to 75 minutes with the average of 52 (excluding greetings and informal discussions). After the first some 20 minutes of the interviews, I asked respondents about the time in order to evaluate their reaction on whether I can exceed the appointed time of 30 minutes. Despite their prior strong emphasis on making short
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appointments for less than half an hour, they were not that much strict on keeping time during interviews (with the exception of only one respondent). I was frequently told that given the importance of the matter and their willingness to discuss it, I could continue interviewing them and exceed the scheduled time. Building rapport in one session of relatively short interview was difficult, though necessary. In doing so, I tried to present myself non-judgmental, motivated, and explicit. My medical background was quite helpful too.

Based on the type and the amount of data in the first five interviews, I made some minor adjustments in the topic list to better suit my theoretical perspective. The topic list addressed the main outlines of the issue, though it was not followed too strictly given the wide range of ideas. In the first half of the fieldwork, some common themes emerged during the interviews. In the second half of the fieldwork, I carefully listened for the themes in the psychiatrists’ answers and probed when it appeared. In the last five interviews, the preliminary analysis was also presented to the respondents and they are asked for their comments on that as well.

Interviews were conducted while stressing my interest in the respondents’ own perspectives and opinions. Interviews were initiated with a general question about prescribing patterns. They were encouraged to look at their own and their colleagues’ prescription behaviors respectively. Verbal diaries and vignettes were used to facilitate the flow of data and to avoid asking straightforward questions. In order for the interviews to be more efficient, I ended up with asking respondents any suggestion or remark regarding the quality of interview, the relevance of the research questions, and practical adjustments in interviews. After each interview the respondents was sent an appreciation letter, welcoming any further feedback or critic. Some remarks were really helpful to fine-tuning the rest interviews.
2.6 Theoretical approach and data analysis

Coming back to the research objective, it could be efficiently addressed using cognitive-interpretive theoretical approach. However, given the proximity of the topic in its very nature to the macro level sociopolitical interactions and critics, analysis would not be sufficient unless the interpretive viewpoint merges political-economic perspective. Therefore, ‘critical medical anthropology’ is the main theoretical model for analyzing data (Hardon 2001).

In dealing with data, I positioned myself in the middle of Plummer’s continuum (Green 2004), somewhere in between pure analysis and pure narration. I tried to unpack, organize, and interpret psychiatrists’ accounts in order to contextualize the problem and reflect its complexities within the theoretical framework. I used a pragmatic mixture of approaches from content analysis to framework analysis (Green 2004).

All interviews were digitally recorded and transcribed verbatim while being checked for internal inconsistency (coherence in accounts). If found, that particular question was excluded. The computer program ATLAS/ti, was used to process the primary data. Transcripts were coded and categorized. The revised interview topic list was set as the main framework for intense open coding to identify the categories and subcategories. With thematic content analysis approach, the data was sought for some common themes. Three main themes were revealed and similarly used to outline the next three chapters of this thesis:

- Ideas about prescription behavior (in relation to pharmaceutical promotion)
- Perceived pharmaceutical promotional strategies
- Perceived effectiveness and side effects of promoted medicines

Subsequently, axial coding was performed to look for relationships between the emerged categories (Green 2004). Using selective coding, analysis in the later phase was aimed at developing more abstract and theoretically informed concepts from the codes and their associations. In so doing, constant comparison (within and between cases) and ‘theoretical
Methodology

sampling’ were considered (ibid.). This means moving back and forward between theory and data to capture the theoretical assumptions embedded in the respondents’ accounts.

Since ‘how’ is said was as important as ‘what’ is said, I tried to preserve the integrity of respondents’ narratives during analysis and reflect their own accounts, though with minor abridgements to fit them into textual (grammatical) and contextual situations.

**Credibility:** Similar to other qualitative descriptive studies, credibility relates to the ‘repeatability’ of the interpretations rather than generalization of attitudes (Green 2004). Providing ‘typical’ accounts with generalizable findings is not the aim of this study. Nor can it be achievable in small-scale studies alike. Rather, the idea is to demonstrate a conceptual and contextual generalizability and provide thick description of prescribing behavior. Next to that is the applicability of the research idea, method, and findings to other settings, and to other populations, which, per se, addresses the reliability of the study. One can pursue generalizability in knowing how far these findings help us understand what ‘is going on’ in situations where commercial interests meet medical profession (ibid.). Credibility also refers to the aims of the qualitative analysis, which are “to both reflect the complexity of the phenomena and to present the underlying structures that ‘make sense’ of that complexity” (Green 2004: 175 emphasis in original).

2.7 Ethical consideration

Upon starting each interview or even in advance, I clarified the reason why I chose this topic, followed by a short autobiography. I started interviews presenting myself as an Iranian general practitioner, who is interested in studying multidisciplinary research on medical professionalism. I constantly tried to build up and maintain a sense of comfort during all interviews. I declared no conflict of interest to conduct this research. I asked them to feel free to stop the interview at any time they want. I acknowledged the language barrier since both the respondents and I should use foreign language to communicate. I told them that there might be some misinterpretations due to the language barrier and apologized for that in advance. I also emphasized that discussions would merely reflect their personal perspectives and would not represent the policy of their working university
or organization. I re-stressed the aim of this study, which is explanation and by no means judgment. I assured anonymity and confidentiality of ‘all’ identifying data. I did ask for their permission to record interviews. Nobody expressed any concern or disagreement on recording interviews. Nor did any respondent ask to stop discussion on a particular issue throughout the study.

2.8 Limitations of the study and coping strategies

2.8.1 Language problem: Opinions and attitudes had to be expressed through English language, which was neither respondents’ native language nor mine. Not frequently though, there were some instances in which language barrier hindered the flow of interview. Therefore, my respondents or I needed spending some times to rephrase ourselves. Although language problem is acknowledged, there is a delicate issue that conducting interview in English for non-native speakers might be more preferable than the hypothetical situation, in which I knew Dutch language and had to translate transcripts into English. It could have seemed less original.

2.8.2 Social desirability bias (SDB): The second limitation of this study is the main bias in response to questions. Theoretically speaking, respondents may be tempted to give the socially desirable response rather than describe what they actually think and behave (Nancarrow 2000). When investigating a behavior, there might be a tendency to respond in a socially desirable way in order to present oneself favorable to the interviewer and/or to preserve self-esteem function. The former is known as ‘impression management’ and the latter as ‘self-deception’ or ‘ego defense’ (ibid.). In this study, the issue of what influences prescribing behavior was one that the respondent him or herself might be unwilling or unable to answer thoroughly and precisely. Therefore, to deal with this bias required psychologically and sociologically sensitive interviews rather than straightforward questions. Direct questioning was highly probable to be misinterpreted as judgment and thus, would have interfered productive interviews.

In order to restrict SDB, I tried to implement techniques that Nancarrow (2000) suggests. For instance, I asked the psychiatrists’ opinions about their colleagues and explicitly
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showed my curiosity in “what is going on in the psychiatric community rather than what is wrong with your prescriptions patterns”. In fact, I managed the interviews toward indirect questioning, assuring confidentiality and anonymity, and being non-judgmental. Instead of asking what the instances of irrationality in prescription might be, I asked where they think their positions are compared with the ideal situation in prescription. In other words, I clarified that when I used the pronoun ‘you’ in my interviews, I meant a plural ‘you’, which refers to Dutch psychiatrists. In spite of implementing all mentioned techniques, SDB inevitably existed to a certain extent.

2.8.3 Sampling limitation: Utmost attention was paid for the study sample to be as diverse as possible in terms of work settings and opinions. However, respondents were among those psychiatrists, who were willing to participate and had reacted positively to my invitation. To this end, I had not freedom of choice to ‘choose’ among psychiatrists. I could not be sure whether I covered as wide range of ideas as I ideally wished. Nevertheless, as we will see in the next chapters, the range of ideas was reasonably diverse given the scope of this project. On the other side of the coin, one can assume that psychiatrists who had reacted positively must be enthusiastic to share novel and salient ideas to me. There should be enough motivation for them to voice out and this could fill the gap.

2.8.4 Time limitation: The topic is so broad and diverse that the more I went through it, the more I realized that there is yet a lot to know. My interest, ambition, and curiosity notwithstanding, did not allow me to confine my project to the time schedule assigned for this Master thesis and I have to submit it a bit later. However, I saw it the other way round and thought to myself that the time for doing such a project is really limited. Having more time would definitely result in providing thicker description of prescription and drug promotion.

2.9 Summary of chapter two

This study is a qualitative approach to the sensitive issue of prescribing behaviors in psychiatry in relation to pharmaceutical promotion in the Dutch context. Based on
Methodology

purposive sampling method, I interviewed 26 psychiatrists, residents included, with diverse work settings and duration of experience. I conducted in-depth semi-structured interviews using an interview topic list, being adjusted throughout the fieldwork to better triggering the main objective of the study. All identifying data were kept anonymously and confidentially. The theoretical perspective was a merge of cognitive-interpretive and political-economic approach resulting in critical medical anthropology. After open, axial, and selective coding of transcripts respectively, moving back and forward between theory and data enabled me to capture the main themes embedded in the respondents’ accounts and discuss them within a broader theoretical framework.
RESEARCH FINDINGS

CHAPTER 3: PRESCRIBING BEHAVIOR
CHAPTER 4: CHANNELS OF INFLUENCE
CHAPTER 5: PSYCHOPHARMACEUTICALS
CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS
Chapter three

PERCEIVED INFLUENCE ON PRESCRIBING BEHAVIOR

You are supposed to prescribe the best medication for the patient and not the best-promoted medication. The danger is where I replace the second with the first. I try not to do, but I am sure it happens sometimes. (P15)

3.1 Psychiatrists’ prescribing decision-making

I started interviews with general question about psychiatrists’ own prescription behavior and factors that may shape their decision in prescribing medication. In the complex realm of prescribing behaviors, psychiatrists undertake complex cognitive processes to make treatment choice among available options. Prescription behavior has important analytical features based on physicians’ attitudes, emotions, motivation, perceptions, communication, subconscious, and unconscious. There are numerous factors in psychiatrists' points of view that influence their prescribing behaviors. I summarized these factors in four levels and sorted them more or less in the order of citation in table 6.

The perceived aspects of decision making in prescription behavior can be classified into two main groups. Some are ‘constitutional’ (primary) such as knowledge and educations. Some others are ‘interactive’ and capable of influencing, improving, or weakening the effects of primary factors. As mentioned in chapter one, pharmaceutical industry has a powerful influence, and can interact with decision making and prescription behavior at different levels. Indeed, in almost all four levels listed in the table 6, there is room for the pharmaceutical industry to influence psychiatrists. Later, we will see whether and how these interactions are perceived.

**Individual variation:** There is individual variation in the psychiatrists’ perception of their prescription behaviors. It is very difficult to generalize patterns of making choices. However, it somehow reflects the position of psychiatrists in their professional career, the
Prescription behavior

duration of experience, the main field of practice and personal beliefs, which is a combination of experience, evidence, and influence.

### Table 6. Perceived features of prescribing behavior in the order of citation

#### Personal level
1. Drug recognition (familiarity with certain medicines)
2. Literature and scientific evidence
3. Previous experience, specially, the very first impression (about effects and side effects)
4. Influence of the pharmaceutical industry
5. A preset pool of medication in the mind
6. Try and error
7. Enthusiasm and curiosity to certain medicines such as new products or off-label use
8. Habituation (what the pen writes) (automatic prescribing)

#### Community-related level
1. Recommendation from colleagues, professors, fellows, working institutions, etc.
2. Education in congresses and symposia
3. General attitudes of the institutions toward pharmacotherapy or a particular medication
4. Influence of the pharmaceutical industry
5. Advice from psychiatric associations
6. Opinion leaders
7. Education at medical school or during residency training
8. Problems with non-pharmacological treatment options such as psychotherapy

#### Patient-related level
1. Previous patients’ experiences
2. Specific practical setting such as the last resort inpatient center
3. Individual patents’ profile (such as co-morbidity)
4. Patients’ culture and expectations
5. Patients’ compliance and concordance
6. Being already on certain medication
7. Symptom-relief approach (specially in acute and sever cases)

#### Pharmacological level
1. National/institutional guidelines and protocols on drug indications and choices
2. Certain benefits such as placebo effect, long acing form of medication, positive use of the side effects (e.g. sedative effect for agitate patients), etc.
3. Drug potency (idea of light or heavy medicine)

Individual differences in prescription behavior reflect variety in ‘prioritizing’ the mentioned factors. For the younger respondents such as residents, evidence is the most important and for more experienced psychiatrists, their own experience is given the top priority. For P13, evidence is clearly the first factor: “I think one step ahead of experience-based practice is evidence-based”. A more experienced respondent believes that “only when you gain more and more experience with medications, you would be able to stay out
of the pitfall and make a better choice” (P18). According to P5, prescription behavior has evolotional pattern during professional career:

First, we ‘learn’ to prescribe particular medications more commonly. As resident, you learn more from older colleagues and professors in your department. When you grow further in your profession and get your own experience, then you rely more on your own experience from your own patients and from others’ stories, you have heard in congresses. So, you follow the literature in a different way from what you had done when you were resident. You explore other aspects of medicines like side effects, off-label indications, best age groups, fine tuning of the dosage, etc…not every medicine is investigated for everything in double blind studies. So, you will develop other criteria for your decision. (P5)

Psychiatrists who work in cross-cultural setting tend to consider the patients’ expectations ahead. P20 explains. After making sure of the certainty of diagnosis and before initiating treatment, P20 says, “I have a lot of cultural questions to ask such as attitudes of the family. We must find a common appraisal. I try to find the treatment which all of us can believe; patient, the parents, and me. I take the advantage of being an outsider, ‘Bloody Foreigner’ in the patients’ eyes [name of a book about the history of migration in the UK]. This helps me to ask some questions, which [for some colleagues] seems to be inappropriate but are very crucial and efficient. So, we should all agree that prescribing medication is better option”. Having said so, the patients’ expectations cannot always be considered in prescription. Psychiatrists sometimes find the patients’ culture and expectations problematic. There are diverse cultural backgrounds in the Netherlands. P7 describes how patients’ expectation to be prescribed pills can influence their prescribing medicines:

Patients from other countries [who live in the Netherlands] come to the office with the expectation that they go out of my room with medication. It is hard to go against it and you are not taken seriously when you don’t prescribe medication. “I come here to get some pills; Doctor, don’t you know the business?” If I say to the

4 Underlined words in the quotes indicate strong emphasis either verbally or through facial expression.
patients that I have a pill for your treatment, I am acknowledged and recognized and they think that I did my job well. However, later you will find out that most of the patients might not be satisfied with the pills anymore…so, there is a temptation to take medicine. (P7)

The very first impression of how the medication works is particularly crucial. “We tend to conclude that if this medication worked well for this patient, it is a good medication and we would be eager to prescribe it for other patients (P19).

Field of specialization also seems to affect prescription behavior. For instance, child psychiatrists tend to be more cautious and conservative toward medication. They all believe that medication is not the first step in treating children with psychiatric illnesses. P1 has the idea that “excluding some exceptions, we use medication just to ‘facilitate’ treatment we have already set up for the patient and not as the main way of therapy”. In Child and Adolescents Psychiatry (CAP), prescribing medication is a hotter and more complicated topic than in adult psychiatry. P13 explains how prescribing medication relates to the social role of parents and their belief system:

A really rational approach to medication by the parents does not happen commonly. There are two types of [parents of] patients. Some are really in favor of medication and some strictly do not want medication for their children. Some parents are distraught and have tried several treatment modalities; considering themselves as not competent enough to change their children’s behavior. These parents are really interested in medication and ask you in the very early stage of the treatment for medication. They think that the only thing that is gonna be helpful is the pill. The other group don’t [want] to see the child’s problem or they are basically against the medication for themselves and their children…We, then, have to persuade some parents that their children does not really need medication and vice versa… [So] to me, the first step is to know what parents think and want; what they have already tried; what they heard from others and the media, and then try to fit therapeutic options into their beliefs. (P13)
Placebo effect seems to play a big role in providing medication. In chapter five, we will see how psychiatrists see this gray area and ‘doubt’ the actual effect of most of the psychiatric medications in treating patients. In this situation, placebo effect in itself would often be a reason to prescribe medication. “It is a major part of our therapy” (P10). As such in CAP, where “there is a big placebo effect. All medications even Ritalin, which has proved pharmacological effects, has also placebo effect. It is not my personal experience; it is in the literature…Especially for SSRIs it is difficult to realize the real effects out of its placebo effect. So, where there is no effect, why prescribe medication. You may say, well, I prescribe medication just based on the placebo effect but it isn’t harmless” (P4).

P17 believes that the choices have been set up in the mind beforehand and psychiatrists have already thought about their choices prior to patients visit. Making choice can also be a random process as P7 says that it is simply try and error. “By just a random process, you start with a medication in the beginning of your career and then follow the medication and its effects. If it works, you will try it next time”. This process may shape personal preferences for physicians: “I prefer to prescribe the medication that I ‘like’ based on my experience, patients’ feedback and also try and error” (P21). Interestingly, once psychiatrists establish their set of personal preferences, it would have a positive feedback on their prescription. “The more you prescribe a certain drug, the more likely to choose it another time” (P3).

In the earlier stages of practice, curiosity to establish experience plays an important role specially to gain experience with new medications and with those that psychiatrists are not well familiar with. However, there may be a sense of being influenced by the pharmaceutical industry at this point. “…I am very eager to try one of the drugs that company X designed…the effects would not be necessarily what they say. So, I’m curious to try new drugs in patients. I like to gain experiences and to have a broad arsenal to choose from. I’m definitely willing to do so” (P3). Other resident has the same idea: “although most of my experience is built by my supervisor, sometimes I want to prescribe a medication I’m not quite familiar with or I have not that much information or experience with. In this gray area, you might be influenced more easily. For instance, less is known on the effects of SSRIs compared with Ritalin [in CAP]” (P13).
Prescription behavior

Habituation is also perceived to affect decision-making. It is the process by which the doctors move from diagnosis directly to prescribing medication. It is possible sometimes that ‘the pen’ writes prescription and not the physician.

Even if the harm of the influence is not for the patient when you choose one medication among the similar ones, it still might harm yourself in the way that you practice medicine routinely and make it a common practice. You should be aware not to do that. (P23)

3.2 Pharmacotherapy versus psychodynamic psychotherapy

The scope of psychiatry is very wide. In other fields of medicine, treatment is possible by hand, knife, and/or medicines. In psychiatry there is another exclusive treatment method, namely, talking. There are different orientations in practicing psychiatry and making treatment choice. Non-pharmacological treatment options usually play a great role in treatment plan. Some psychiatrists prefer to have psychotherapy-oriented, community-oriented, or family-oriented approach. P5, who is not originally Dutch, describes psychotherapy to have a longer history as the main therapeutic mean in psychiatric profession in the Netherlands:

…we should answer this question within the medical culture of Dutch psychiatry. In Holland, psychiatry has long had psychoanalytical culture and the biological psychiatry is new. It is new in the whole world but in Holland, it is newer. Maybe during the last 15 years it’s getting more important. Before biological psychiatry, talking was the main means to treat patients. The culture of psychotherapeutic psychiatry is still strong in this country and most of my colleagues, including myself, still have a heart lying with psychotherapeutic psychiatry. We prefer ‘talking’. In this way, you can imply your own way of therapy and control the treatment much better. When you give medicine, you cannot control the therapeutic output and you just have to wait, if it works or not…In Holland, the biological psychiatry is not as strong as in America but it is getting stronger nowadays. (P5)
After the introduction of biological and evidence-based psychiatry, it seems that psychiatrists have been more impressed by biochemical psychopathology, which claims that disorders happen due to disturbances in neurotransmitters in the brain, so it can be corrected with the medicine. Psychotherapy and pharmacotherapy have epistemological differences. Rephrasing Lakoff (2005), biologically oriented psychiatrists give medicine, so that the patients do not talk but psychoanalytic therapists give therapy to help patient talk. Psychopharmacology is becoming more and more pervasive in the late twentieth and twenty-first centuries and ‘pharmaceutical reasoning’, with its statistical rationality, has really outpaced psychodynamic rationality (ibid.). “We are more interested in neurotransmitters and usually go for pharmacotherapy” (P10).

Psychotherapy is believed to be less preferred by both the patients and psychiatrists. Some respondents also see a gap in comparative evidence-based research for the efficacy of these two modalities (P9, P7, and P3). Furthermore, there is a limitation in reimbursing the psychotherapy costs by the insurance companies if it exceeds a certain (usually up to 16) sessions, which is considered insufficient for treating some patients. Having said so, psychotherapy has its own place in treatment. P26, a psychotherapy expert describes:

To me, medication is necessary only when there were very strong symptoms. For most of my patients [PTSD], I do psychotherapy. I develop an effective evidence-based protocol for psychotherapy. Only in co-morbidities and severe symptoms patients may need medication. Psychotherapy helps people to understand the problem and the very fact that how important their emotional discharge are. In the late phase, it helps them to learn and restructure their mind and the way of thinking. One of my students showed clear biological response to psychotherapy at the level of neurotransmitters and neuroimaging.

I know that many psychiatrists are really badly trained in psychodynamic therapy and psychological knowledge. There are two main reasons why psychiatrists prefer pharmacotherapy. The first is that they may feel disappointed when dealing with patients with strong symptoms because it rarely resolves symptoms…They routinely prescribe medication to prevent the feeling of ‘hopelessness’ in treating symptoms. That is not what I like. I know that, for example, with exposure therapy [a kind of psychotherapy], the symptoms vanish quickly…psychotherapy and
Prescription behavior

pharmacotherapy are two treatment options with different tools. They can help each other and it is up to us to find out how, which one, and in what order they should be used in different disorders for individual patients. (P26)

Feasibility is the second problem for doing psychotherapy. It seems that pharmacotherapy is easier and takes less time and effort than psychotherapy. Moreover, according to respondents, there is the shortage of psychotherapist in the Netherlands, which makes long waiting lists for that. Some respondents compare psychotherapy and pharmacotherapy:

We are [practicing] pretty medication-based and not so much psychotherapy based. It’s really much easier to prescribe drug. There are lots of people who are taking SSRIs. That’s the matter of convenience. If you take pills instead of going into different phases of therapy, it can be much easier. I’m sure that this choice is influential. This is also the problem for general practitioners…the long waiting lists for mental healthcare institutions and also noisy administration require quite a long time to organize psychotherapy. So, they prescribe drug…I don’t think it is a bad thing. It’s [only] not the most preferable thing in many cases. (P3)

Medication seems to have more short time and tangible effects that psychotherapy. P7 interestingly explains: “I must say that I have to prescribe medicine in most cases. It’s easy and quick and brings immediate satisfaction…however, I do know that some patients really need talking out of the medication”. The question here is why pharmacotherapy is able to offer an ‘immediate satisfaction’ and psychotherapy is not. As far as alleviating symptoms in short term are concerned, one may find an answer for this question.

Nevertheless, there is almost always room for non-pharmacological therapy in psychiatry especially in CAP and cross-cultural setting, in which the medication is not perceived as the first choice. P26 believes that psychotherapy can still be a favorite choice because “you can treat most patients with psychotherapy in 16 sessions while they have to take medications for a very long time in their lives”. Psychotherapy is also a fundamental part of treatment in CAP.
Although, it is much easier to prescribe medication, I think prescribing SSRIs is a sign of lack of attention of psychiatrists and family doctors to the psychotherapy, which is always the first step. (P 22)

3.3 Profit versus benefit; conflict of interest

The pharmaceutical industry has its own cycle of life, in which profitability is a matter of survival. Being rooted in global capitalist economy, the pharmaceutical industry has an insatiable appetite to make more and more profit for the sake of ever more-demanding shareholders. The pharmaceutical industry and the medical profession have a constitutional similarity and a difference. As far as the pursuit of benefit is concerned, the medical profession plays the same role but for the sake of the patients not the companies’ shareholders. This conflict of interest is pointed out by almost all psychiatrists explicitly or implicitly. P14, among others, describes the phenomenon.

The well-being of the patient is the utmost favor, but pharmaceutical industry has to make profit in order to survive. To us, this is the patients’ benefits that must be set prior to the companies’ benefits. (P7)

… It is the matter of earning as much power and money as possible but we have another interest, the best interest of the patient. I am supposed to prescribe medication for my patients not for the company. (P24)

For and against: Psychiatrists react differently and somewhat contrastingly to this conflict of interest. Some such as P7 take a skeptic position and consider promotional activities as an immoral invasion of the industry toward the medical profession; “…It is useless, it’s sales, it’s commercial. It is not what I hope to find” (P7). P2 has a typical pessimistic opinion. Conflict of interest is perceived as problematic for this group of psychiatrists. Those who have pessimistic opinion prefer to ‘protect’ themselves by staying away from all kind of promotional efforts and materials. This abstinence is perceived as a professional and moral value.

[There should be] non-profit pharmaceutical industry…It’s against my morale that you earn a lot of money out of the sickness of people. For me this is the most impossible business. That’s of course, in clear conflict with our capitalist system in
which you invest money to make profit. I can imagine that they must be profitable. But that’s not correct in my eyes. (P2)

…do you know how bad the pharmaceutical industry is…the only thing they want is a lot of money. Of course, I accept that they have to [be profitable]. (P6)

On the other side of the spectrum, some psychiatrists take a ‘liberal’ position. They believe that pharmaceutical companies have to be profitable and they do not trigger medical profession to spoil it. P10 and P17, who call themselves liberal in this sense, believe that psychiatrists must put their spectacles wider and see the complexity of the issue. “When you understand the depth of the situation, you can handle it more easily and make your choice better”, P17 says. Widening of perspectives implies some circumstances in which being influence is not wrong.

You are influenced by them and you cannot deny it. The problem is if it is good or bad...Sometimes, when the medication is effective, its promotion is at the interest of the pharmaceutical industry, the psychiatrists, and the patients. So there is the same interest. For example, it is good to be influenced and to prescribe for depression something that covers sexual dysfunction as well. In this case, the pharmaceutical industry, the patient, and the doctor have the same interest and there is no problem with being influenced. So, the industry has just highlighted something that has already been there. I have tried it and it works. In this case, the industry, physicians, and patients pursue the same interest. Since the initiative was from the industry, it seems complicated. Some other times the interests go apart in two different directions and they promote something that for example the dose is not appropriate. Here there is conflict of interest and being influenced is not good. If you are aware, you can evaluate when the interests are similar and when are conflicting. However, it is sometimes difficult. (P17)

Although incompatibility of the interests is acknowledged, the later group does not interpret pharmaceutical promotions as a threat to the medical ethos and norms. They do not believe in distancing from the industry but notwithstanding consider awareness necessary to recognize competing interest and to deal with the industry.
Prescription behavior

We really need them [the industry] and love them. However, we must always be aware that they may influence us because they want to sell their products and that’s why the industry [exists] for. So you only need in the back of your mind to remind that they want to sell their products by convincing you that they are the best. (P3)

… The industry has to make money and we are dependent on them for developing new drugs anyway. They are not bad people. (P 21)

Therefore, the main difference between the two groups is not in whether the influence of the pharmaceutical industry is perceived. Neither group denies the influence but they politicize the issue differently. Subsequently, other related issues such as the way they perceive colleagues’ behaviors or the new medication are also given different agencies. I will come back to it later.

3.4 Perceived influence in reaction to pharmaceutical promotion

Inevitable influence: Although there is a wide range of attitudes towards prescribing behavior, there is a consensus that pharmaceutical promotion influences prescribing patterns. Influence, in a sense is inevitable for it is constructed through playing the social roles. Similar to all other interactions between individuals and social institutions in the society, the ‘medical-industrial encounter’ also mandates mutually influencing and being influenced to a certain extent.

Being influenced is inevitable. Everybody is influenced by everything. It is not bad thing per se. It is the way we are performing our roles in the society and in our profession as well. It’s not possible not to be influenced. What you should do is to be ‘aware’ of that and to weigh these influences properly. In this sense, you can use the industry’s influence in a good manner, as a support for your clinical experience and improve your practice. (P25)

Almost all respondents acknowledge the influence of pharmaceutical industry on prescribing behaviors. While according to the literature, there is certain ‘denial’ in acknowledging being influenced, none of my respondent denies the potential negative consequences of this interaction. Even a few psychiatrists do exclude any possibility of
Prescription behavior

‘positive’ influence from the industry. Therefore, the second consensus is the perception of probable negative influence on their prescription patterns. Almost all psychiatrists are also of the opinion that there should be a particular insight in order to deal with the negative influence of the pharmaceutical industry. In most instances, they used the word ‘awareness’ or ‘criticality’ to describe this insight. They believed that awareness is the main (and sometimes the only) tool to ‘protect’ themselves from the potential negative consequences. Awareness in their perspective means having critical insight to percept what is going on in the seemingly inevitable interaction with the pharmaceutical industry. It is parallel to what I am pursuing in this research as well.

When you are critical, you will find out how much you are influenced by the industry. It is quite necessary to develop scientific attitudes towards our [own] prescribing. Developing scientific attitudes means that you critically look at all factors that influence your judgment…You have to be aware of that. (P7)

**Professional taboo:** Being influenced is often perceived as a professional taboo. Conversely, practicing free of influence is perceived as a social value in psychiatric community. It reflects professionalism⁵ and rational prescription. In an extreme sense, “I don’t want to be influenced. I want to keep my hands clean” (P7). This idea is pervasive in some reactions to my question on how they perceive being influenced. “The idea that I’m not influenced is an illusion we like to claim but we have no control over the influence. It is related to the fact that I should not be influenced” (P26).

I asked them whether they see anything wrong if they have the choice to choose between two medications (both can benefit the patient) and prescribe the one that is more promoted. Some show zero tolerance to the influence and believe that “there should be no reason at all to be influenced. Your example [my question] is wrong” (P2). In P8’s words, “it’s not nice at all to be manipulated” (P8). Others do not associate it with necessarily wrong practice. “I don’t think it is morally wrong. You can have a preference for certain brands for some reasons as long as it doesn’t harm your patients. I don’t think that you should let yourself ‘never’ be influenced by the industry” (P3).

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⁵ The Royal College of Physicians of London defines medical professionalism as “a set of values, behaviors, and relationships that underpins the public trust in doctors” (Irvine 2006: 49).
**Professionalism and emotionalism:** Even if being influenced in this sense is not wrong for an individual patient, most psychiatrists think that at collective level it will be able to shape their opinion and let ‘irrational motives’ play the role in their decision making. P20 expresses concern:

> If I accept some small gifts [from the pharmaceutical industry], it may not change my ‘prescription’ but it would be difficult to explain to my patients and myself that it didn’t change my opinion (P20).

Given the inevitability of influence, when one’s own prescription behavior is given intentional attention, brought to the consciousness, and actively scrutinized in reference to the professional and social values and codes, psychiatrists may perceive the negative feeling of being influenced by the pharmaceutical industry.

> If you think that you are influenced and it is not acceptable, it will give you a negative feeling toward yourself [and your professional identity] as a doctor (P22).

Those who regard themselves as liberal, consider an emotionally driven strictness in their colleagues’ reaction to the perception of influence.

> Most of the psychiatrists have fixed opinions. They are rigidly against the pharmaceutical industry. These fixed opinions come from emotions and from the conflicts in interests that make psychiatrists feel being manipulated and then they become angry and say, I don’t want to talk to the industry anymore because I don’t want them to decide for me. We are often so against or so in favor of medication that forget to evaluate ourselves. You should see the pharmaceutical industry as a market in a wider economic scope and as part of the capitalist system, we have decided to choose for our society. We have to recognize where they [medications] come from…On the other hand, you can see that in the countries with no capitalist system, [the problem is that] there is not any new medication and all are the remake of the western products. The question here is how far it is bad if you are influenced. The whole thing is that it is sometimes good and sometimes bad. That is not to say that it is always bad or always good. (P17)
The constant switching between professionalism and emotionalism is evident in too many accounts. Given the alleged fact that the pharmaceutical industry is powerful enough to influence psychiatrists’ choices negatively, emotionalism may be seen as a protecting tool or as an agency toward the endangered professionalism and toward securing sound (rational) prescribing patterns. Therefore, there is a constant back and forth movement toward denying and accepting being influenced. Arguments like these are quite common: “I’m sure that I’m not influenced but I’m not hundred percent sure. I’m a person like others that can be influenced by the industry” (P8). “I think I’m influenced but I ‘struggle’ to be free” (P9).

**Self-psychoanalysis:** Having a dramatized opinion and emotionally positioning oneself against the pharmaceutical industry seem to create a vicious cycle unable to ‘prevent’ psychiatrists from potential threat of inappropriateness in prescription. In other word, denying being influence may result in more vulnerability. According to P17, psychiatrists should implement a psychoanalytic approach toward their own prescribing behavior. He clarifies with an example that “when the chance of committing a murder is higher? If I tend to murder you, and I recognize that I could murder you or when I deny that I could murder you? It is the same. If you deny it, you would be more vulnerable and more likely to be corrupted by the industry” (P17). Another example is said by P13: “Are we really interested in looking at our own prescription behavior critically to see the possible influence of the industry? I always like to think they do not influence me but [when I reflect to my own prescription behavior,] I do know that advertisement really works. It’s a dangerous idea to think it doesn’t work for me. It’s like stepping into the casino and thinking that I am never gonna be addicted to gambling or using heroin and say that I wouldn’t be addicted” (P13).

**Threatened authority:** The mentioned negative feeling is not confined to merely challenging the professional norms. Another important reason why psychiatrists gain a negative feeling is a perception of threat to their professional authority. P3 clearly describes:

I think in the medical profession, doctors always want to, at least, feel [with strong emphasis] that they are autonimized in their decision-making, treatment, and
prescription. When you get guided by the pharmaceutical industry, you may feel that you are less autonomized than [what] you actually wished to be. That might cause the problem. You may think that you must be free of all influences from the outside and just be there for the [best interest of] the patients and give as best care as possible to them. It is quite a reason why you don’t want to be [influenced] because of the thinking that you are less autonomized. (P3)

### 3.5 Perceived rational prescription of medicines

**The crucial first step:** In psychiatry, it seems that there is a long way between the onset of symptoms and definite diagnosis. A crucial question in exploring prescription behavior is whether there should be a pause between (final) diagnosis and treatment. Once psychiatrists come up with a certain diagnosis for a patient, three different steps in their prescription behavior can be recognized. The first step is whether there is any indication to prescribe medication. In this phase, psychiatrists should ask themselves: “Does my patient really need medication for her depression?” Only after finding a convincing answer to this very first crucial question should psychiatrists go to the second step and ask which drug category suits the patient best given their profile. According to P5, many psychiatrists bypass the first step and equate treatment with medication. This may direct psychiatrists away from rational prescription when ignoring active thinking about the real indication of medication:

There is a group of psychiatrists who don’t like to prescribe medicine at first stage and do other kinds of therapies. Only when you come to the conclusion that medication is really handy, then, you [must] go to the other questions; which drug category and then which one? If writing medicine becomes ‘automatic’, then, we don’t think about writing or not writing drugs and just jump to the second step; which drug? In this way, the first step is already ignored and this is the danger. The influence of the industry in the first step is very big, very big, I would say. (P5)

Even in the third step, when everything is evident that the patient really benefits from taking medication, there also should be a certain hesitation and ask which one among the
certain drug category suits the patient more. Try and error may obviously be helpful in this phase and not in the previous phase.

In psychiatry, we don’t have really specific medication. In the national guideline (*Farmacotherapeutisch Kompas*), there are 10-20 different suggestions for depression. One of these would be ideal but I cannot determine. Perhaps I decide based on the side effects. I have to find it out by try and error. So, there are not exact and concrete factors that determine which one to choose. (P7)

The perceived effects of medications have also an important influence on prescribing choices. In chapter five, we will see how ideas and beliefs around the effects of medications are constructed.

**Knowledge-based prescription:** In psychiatry, treatment processes deal with human ‘behavior’ and are not as concrete as in other fields of medicine. As mentioned before, psychiatry often faces difficulty to draw or identify a distinctive border between what is entitled as normal behavior and what is abnormal. Interestingly, the similar problem can be evident in studying psychiatrists’ prescription behaviors and distinguishing rational from irrational prescriptions. Rational prescribing of medicines is thus difficult to define. Given the overall difficulty of treating psychiatric illnesses, both a resident and a senior professor agree that psychiatric medicines are often prescribed based on despair and not scientific indication.

A lot of psychiatric problems have really difficult to treat unless you have accurate diagnosis and be aware of all interactions that can account for. So, I hope that we are prescribing more rational; more research-based ideas about why we prescribe medication and for what kind of problem. I hope that the way we are prescribing has become more out of knowledge and not of despair. (P3)

Psychiatrists may become disappointed in the possibility of treatment especially in dealing with patients with strong symptoms. So, they routinely prescribe medication to prevent their feeling of helplessness and impossibility of treatment. That is not what I like. (P26)
**Prescription behavior**

**Awareness**: Where there is inevitable influence with potential negative consequences, awareness of the existence of this influence would prevent undermining professionalism and irrational practice. Accordingly, rational prescribing patterns would depend on whether and how they perceive ‘awareness’. The inevitability of the influence toward possible irrational prescription enhances the impotence of awareness more and more.

I think it is good to be aware of [the fact that] pharmaceutical companies are there for just one reason, promoting their products, and still being able to listen to them and then objectively weigh for yourself what you want to do with that information and how it is going to influence your prescribing behavior. It feels fine for me to prescribe medication but in the back of my mind, I always think if I should have really prescribed that drug. So, I must be aware to see how it influences me…when I recognize myself prescribing a drug more than that I could actually ‘defend’ on the basis of guidelines, literature, etc., then, I should be more critical towards myself and ask myself why I am doing this [prescribing this drug]. I think it is part of the professional life during my whole career to ask myself. It’s really necessary to be critical about that…and be aware of how this works; not to get ride of the pharmaceutical companies but to know actually how you deal with that, how to handle it…It should be an ongoing process and part of [our] training. It’s necessary and I think the [negative] influence on me after about 3 years of experience would be lower than two years ago when I had only one year experience. So, I assume that at the end of my career, I shall be able to be free of influence but that’s probably nonsense. (P3)

Introspection is necessary though, not sufficient. Specialized knowledge is also essential to be and remain aware. Much attention has been paid to publicly discuss the promotion but specific education for psychiatrists is reported scarce. Only two psychiatrists remember a brief education or lecture during their residency training in this regard.

The best way to make sure that a clinician is not influenced in a bad way is to provide them with a good education. If you are able to understand what is going on in the researches, publications, industry, and promotions, then you can make rational decisions. If you understand statistics well enough, you can judge by yourself what is true and what is not. If you have lack of knowledge of the
processes of promotion and possible biases in drug research, then it would be difficult to be critical. It is necessary to know how we should judge our own prescriptions. (P21)

Therefore, psychiatrists often consider awareness as the mainstay of rational prescription. By rational prescribing behavior, psychiatrists consider a critical appraisal of their own and the Big Pharma’s behavior. “All we would like is to improve the lives of the patients. That’s the emotion to which the pharmaceutical industry tries to attach. The only weapon against it is to be critical” (P9). In other words, P14 suggests “what I try and everybody should do is to ignore all irrational things when the pharmaceutical industry visit you and seduce you by providing gifts or by inviting to the congresses…you are also influence by ‘rational’ things when contacting pharmaceutical industry. What you should do is to distinguish between rubbish and rational thing. The more knowledge and awareness, the less the chance of being influenced by irrational things” (P14).

P23 describes that psychiatrists should know the ‘why-ness’ of prescribing and not let their selves and their professionalism be the captives of the chore of routine medical practice.

You have to be alert why you prescribe that medication. You should always doubt whether your behavior is rational or not. Irrational prescription happens when you believe that a certain drug is better for a certain disease [and not for an individual patient]. Rational is when it is evident for you that drug A is good for some patient and drug B is also good for some other patients and both have disadvantages. To this point, there are not good or bad medicines on the market. (P23)

Cost-awareness: Price awareness is another step toward rational prescription. Some psychiatrists are price sensitive and consider the economic burden of their being influence in prescribing brands and relatively expensive medications. Expensive prescription, when a cheaper option is also available, is not perceived ‘irrational’, though it can contribute to an increase in the total healthcare expenditure. Since marketing significantly reduces price sensitivity (de Laat 2002), it probably contribute to the psychiatrists’ negative feelings towards their prescription.
Prescription behavior

You may have the same feeling when you consciously or unconsciously feel that you are contributing to the increase of the costs of healthcare [through prescribing promoted expensive medications]. (P3)

… It is wrong when the only reason to choose expensive one is that you visit some nice persons from the company, who have talked to you and convince you about that [particular] medication. In this way, we are contributing to pay from the national healthcare budget to the [industry’s] stockholders. (P9)

I have written this part on the first Monday of September. Coincidentally, while I was thinking how to elaborate on the issue of awareness, it was right at 12.00 o’clock and I heard wailing of the warning siren across the neighborhood. It was obviously a caution, a notification, or a reminder to be at least mentally prepared at any time to deal with possible hazards; to behave rationally in risky situation. It is a reminder of something that seems to be obvious, yet necessary to be reminded. There may be an analogy for prescribing behavior, where an internal warning siren in the psychiatrists’ minds may be quite helpful or necessary. Of course, it is not as dramatic as such.

3.6 Ideas about colleagues’ prescription behaviors

So far, what has been said reflects the individuals’ own prescribing patterns. Asking about colleagues’ prescribing behavior in reaction to the influence of the pharmaceutical industry may reveal how they perceive the interaction in collective level, which means Dutch psychiatric community (if could be generalized as such). In addition, exploring ideas about colleagues is an indirect approach to cope with the SBD as described in chapter two.

Relative denial: Ideas about colleagues again revolve around the issue of awareness and criticality. “It is not possible to be a Dutch doctor and not be aware of this issue” (P21). On the other hand, there may be the tendency to project instances of irrational prescription onto other colleagues, assuming that ones’ self is much less influenced than their colleagues. I would call it a ‘relative denial’ (as opposed to the absolute denial of not acknowledging being influenced, which was not believed by any of my respondents). Relative denial also justifies indirect approach to the issue. Steinman (2001) argues that
Prescription behavior

Doctors may be confident that they are not much influenced by the pharmaceutical industry or not at all but many of them are not so confident about their colleagues’ behaviors.

Relative denial is also evident in the difference in placing the red line of negative influence. P10 receives from a company the free subscription of British Journal of Psychiatry with ‘some extra-advertisements inside’ it. His accounts are suggestive of relative denial.

I’m not even aware that they send me the journal. It doesn’t have to do with the medication they want to sell. Indeed, I’m influenced. In a sense, I am being bought by them and I cannot [absolutely] deny it…but there is a difference in being bought by a drug company with accepting British Journal of Psychiatry or by a trip to the south of Spain (P10).

The uncritical are more: Respondents consider their colleagues alongside the continuum of criticality.

I think psychiatrists are [distributed] across a continuum based on their idea about the pharmaceutical industry. Some are criminal [with a low voice], I should say with very irrational practice. But the most psychiatrists are in between. (P6)

Psychiatrists find it very difficult to estimate how far their colleagues are distributed along the continuum. However, the idea that uncritical colleagues are more than critical is pervasive. At the same time, they believe that awareness in psychiatric community is growing and you can hear more critical voices nowadays. I quote some ideas for better clarification.

There is a group of psychiatrists and I am one of them that are very suspicious. I never go to [the sponsored] trips. I don’t need their money. I can afford going to beautiful places. Then you have a very uncritical group; those who really go to the [sponsored] conferences near a fantastic beach. In between, there is a group that is aware now and then and also profiting. I don’t know how big these groups are. I think that the critical group is smaller. (P7)

…some are very critical but the most are not critical. I received a lot of criticisms from the other colleagues, who believe more in the industry than me, why I
Prescription behavior

prescribe older medication for psychotic disorders. The influence is quite big and many colleagues must learn about it. There is a lot to be done. (P8)

… I know that the majority of younger colleagues are critical. They are more cautious and aware that they should not try every new product immediately. They stick to general guidelines and guidelines from their organization. There is also a hot discussion among colleagues nowadays. You can see there are two different opinions in the letters sent to the journals. Some are very much against the industry and some believe that we must cooperate with them and we are not enemies. (P12)

… Psychiatrists are now more critical than before towards the information from the industry. The era that psychiatrists had been dependent to the industry passed. We now have independent colleagues as well as psychopharmacologists like professor Moleman. Although awareness has enormously increased, still you can see that the conference of the Dutch society of psychiatrists is a big market and many colleagues coming back with big bags of all kinds of promotions and free gifts, but I was surprised and I did not visit the stand of the pharmaceutical industry. (P16)

Old and young colleagues: Both young and old colleagues believe that the younger are more critical. A senior professor and a young resident describe this trend and interestingly, relate it to the changes in training and education overtime. Younger colleagues seem to be better trained to question their own prescription.

Younger psychiatrists are more critical because they have a more updated knowledge in terms of evidence and they haven’t developed their own clinical folklore yet. They have to go by what is provided to them by literature. The residents are in the midst of critical thinking as this is a goal of education. But the issue is that the effect of that [criticality] may flow away after finishing education. (P14)

… Some experienced colleagues might not think in this way because evidence-based medicine in psychiatry has been introduced recently, about 5-10 years. Older colleagues have been trained in the time that evidence-based medicine was not really an issue. They may used to consider clinician-based medicine instead of evidence-based medicine. We [the younger] are a different generation of
Prescription behavior

psychiatrists. Instead, the experienced psychiatrists have more knowledge and experience about psychotherapy than we do. (P13)

… Not all experienced psychiatrists would be necessarily critical because when they were trained it was not that much an issue or maybe because after so much years of working, they may not pay attention to it or they may forget it. (P3)

Academics and non-academic colleagues: Work setting is a particular focus upon which there is certain discrepancy in ideas. Almost all psychiatrists believe that academic colleagues should be more critical but some are not sure whether they are as critical as they are supposed to be. They have not only better access to the latest evidence-based sources literature and research but also have special funds to attend the conferences and thus, keep their knowledge up-to-date. Moreover, in academic centers there is a constant interaction between different generation of scholars and residents, which provides them the opportunity to mutual learning, sharing, and updating knowledge. For non-academic psychiatrists this would be limited to the conferences. Nonacademic psychiatrists however believe that their academic colleagues are less critical than what they are supposed to be. Reciprocally, academicians believe that nonacademic colleagues are not critical enough. This discrepancy between academic and nonacademic psychiatrists is explained on the basis of access to information and educational funds. P14, an academician, believes that “in nonacademic centers, psychiatrists might be more susceptible especially for those who don’t have budget for conferences. For them, accepting invitation from pharmaceutical industry is attractive”. P25 has also the same idea: “in academic center we have founds to go to congresses. I don’t know if that is always the case but in academic centers, people are more critical about that [the negative influence of the industry]. It is difficult for non-academic centers to access the information. So the information they get via pharmaceutical industry plays more important role in their decisions” (P25). They have meeting with residents and discuss the literature instead of just speculation about a particular case or medication, says P26.

Non-academic psychiatrists often do not agree with the following statements. The quotes are clear enough:
Prescription behavior

I suspect some professors that are not as independent as they pretend. For instance, a professor in the academic center of the University of X openly and clearly promotes some medications. I cannot trust on him. He should have been paid a lot by the pharmaceutical industry. (P7)

… Once, there was a lecture about the lesser chance of decay in the brain volume with atypical antipsychotics and a professor doubted and objected this idea. Six months later he gave a lecture sponsored by the pharmaceutical industry about the same issue and clearly mentioned that atypical antipsychotics have less decay in brain volume. He had clearly changed his opinion about that (P8)

… What is bothering me is that those academic psychiatrists, who are considered as opinion leaders (OLs) are mostly strongly connected to the industry and get paid for their convincing lectures. They should be independent and it’s not good that they are bought by the pharmaceutical industry. It is their job to be objective due to their professional status, academic and teaching position, and visiting more patients. I am just a practicing psychiatrist and I get my information from left and right or from the industry or reading in the evenings. In the academic field, it is their job to find out objective and neutral information but most of them are taken by, paid by, and influenced by the industry. (P18)

… Long ago, the universities were free from the influence of the pharmaceutical industry. There used to be a strong wall in this respect but you can no longer see it. You can see some academic people who are working for the industry at the same time and I’m afraid that their connections are more personal and financial. Of course, the other side is that they have money for drug research and the universities do not have as much [so academicians may have to work with the industry to develop drug research]. (P21)

**The guy from Lilly:** An academic professor however, believes that in certain situations there might be no consequence to work with the pharmaceutical industry. In his view, the collaboration between academic psychiatrists and the pharmaceutical industry is not wrong “unless it becomes too much or only for a particular company. In this case, people may see you as ‘the guy from Lilly’ and you downgrade your academic status” (P25). He believes that when the fund is limited in academic centers, there is nothing wrong with being
sponsored to develop the knowledge of medication provided that psychiatrists maintain their professional power (scientific and objective governance) and carefully monitor how the study is designed and conducted in terms of objectivity.

**Child psychiatrists:** In CAP the range of ideas towards colleagues are more homogenous than adult psychiatrists. Since the situation of pharmaceutical promotion is trickier in CAP and there is less evidence for the effectiveness and safety of pharmacotherapy, all child and adolescent psychiatrists are of the same opinion that their colleagues are reasonably critical to eliminate the negative influence of the promotion. They seem to be more cautious in pharmacotherapy for children than for adults.

### 3.7 Perceived changes over time in reaction to pharmaceutical promotion

Positioning the perceived prescribing behaviors into the framework of time may give more comprehensive insight on how psychiatrists see possible changes in their prescribing behaviors under the influence of pharmaceutical promotion. To that end, I asked them about the perceived changes in their own and their colleagues’ prescription nowadays compared with some one or two decades ago. The aim is to capture the possible ‘trends’ in their practice overtime at both the individual (respondent) and the collective (colleagues) level. Young colleagues are not exempted from this question, though experienced respondents have more to say.

**Biological psychiatry and capitalism:** Across the passage of time and especially in the last 5-10 years, pharmacotherapy – the relatively new treatment modality derived from biological psychiatry – seems to have enormously speeded over psychodynamic therapy in treating psychopathologies. The recent soar in the rate of prescribing medicines can be attributed to over production of medicines, their aggressive marketing, and the dramatic pervasiveness of biological psychiatry, in which alteration in brain chemistry ‘is set’ as the primary cause rather than a consequence of mental distresses. This trend is more apparent in CAP, where according to the respondents, pharmacotherapy used not to be as ‘conventional’ as it seems nowadays.
Prescription behavior

In CAP, it’s very evident that they prescribe medication a lot more. When I was in my trainee 20 years ago, there wasn’t any medication for CAP. Now it’s become very common. So, I see a significant change. People focus on pharmacotherapy much more than other options because there is a lot of attention to biological psychiatry recently. 20 years ago the focus was psychotherapy in whole psychiatry especially in CAP. (P4)

According to the respondents, there are much more pharmaceutical choices nowadays than before. However, many are just ‘me-too’ products and may not be eligible to be entitled as really new ‘choices’. Medications, notwithstanding are prescribed much higher nowadays. P20 thinks that this is not necessarily an achievement. “I’m not a communist but I think it is very capitalistic idea that you need too many similar drugs in each category. It is waste of money and could not really improve our practice…Of course, my idea is not for this era; it is old-fashioned”. Whether having numerous choices is real or fake, increase in prescribing medicines is particularly evident in contemporary medicalized world. Antidepressant (SSRIs) prescription is just one example.

When I started in 1975, antidepressant prescription had very low rate and depression itself was not all over the places as it is now. That’s the example of the power of pharmaceutical industry. They attract doctors’ and patients’ attention that whenever you feel depressed you need some medicines. I myself had never prescribed antidepressants as much as these recent years. (P7)

… There is a lot more prescription of medication in CAP compared with 10-15 years ago. Colleagues are no longer conservative to prescribe pills. 10-15 years ago they did not prescribe medication for ADHD and believed that it is better to do psychotherapy and talk to patients… I’m quite sure that antidepressants have also been prescribed a lot more nowadays. First, they were prescribed only for depression, later for anxiety and compulsion disorders. There is a trend to prescribe almost everybody these pills. I’m quite sure. (P8)

**Combined prescription:** Another change is combined prescription. It is perceived to be less common in the Netherlands than the US though, is reported particularly with antidepressants. “If one antidepressant is not ‘enough’, they prescribe two from different
categories, e.g., Venlafaxine plus Mirtazapine. Ten years ago, it was very strange if someone had done that. It still seems strange” (P12). One may doubt whether this seemingly extensive emphasis on pharmacotherapy may lead to more irrational practice. P6 is of this opinion.

Under the influence of the pharmaceutical industry, psychiatrists prescribe in more irrational way. They prescribe two antidepressants at the same time. I’ve witnessed these behaviors. Maybe it is good to prescribe two antidepressants at the same time but not as the first or second choice; as the tenth choice. They are spending huge money in marketing because they have been succeeded. I think the role of the industry in this irrational behavior is now much more than before. (P6)

**A very recent vigilance:** Some psychiatrists believe that there have been some changes in favor of rational prescription nowadays. P2 believes that choices used to be shaped by some powerful authorities while nowadays we have moved from authority-based to guidelines and more objective evidence for making choice. A younger respondent also has the opinion that nowadays, more evidence is available and helps us to better prescription.

I think in the last few years, we have been able to build a large body of knowledge about which medication does work, which one may work and which one really doesn’t work. So I think that [nowadays], you are able to prescribe slightly more accurately and with fewer adverse effects. (P3)

Although they believe that the majority of colleagues are not critical, most psychiatrists believe that just very recently (the last some three-four years), there is a collective determination toward prescribing more rationally.

Fortunately, only in the last few years, we’ve been more conscious about the dangers and the relative effectiveness of medications. Whether it has resulted in prescribing less, I don’t know. But I think psychiatrists have become more careful…also general practitioners are now more aware. (P4)

There is also a reported growing consciousness toward the necessity of fine-tuning of the dosage of psychiatric medications. This is perceived a step toward rational prescription because accurate dosage of medicines means fewer side effects, better patient’s
Prescription behavior

compliance, and probably lesser expenditure for medicines. “I think we have become more careful nowadays in prescription. We don’t prescribe as high-dose as we used to. So I hope we will be prescribing more rationally” (P13).

**Stricter regulations:** Another perceived change in prescription was associated with the stricter national regulations to restrict pharmaceutical marketing. It is reported by almost all psychiatrists. These regulations seem to have eliminating effect on some industry’s extravagancies typically in sponsored meetings. Psychiatrists however believe that other diverse and often subtler strategies to promote medicines receive little attention by the regulatory bodies.

For antipsychotic medicines, there is a huge change toward prescribing atypical and new antipsychotics but there is also a little change backward at the moment. The industry has also changed their way because they have to. The rules are now far stricter in sponsoring travels. This change has a good direction on psychiatrists’ prescription and may prevent corruption. (P25)

... I think the negative influence is decreasing because the pharmaceutical companies are nowadays quite restrained. I mean like up to 5 years ago, pharmaceutical companies could take you out for holiday to the south of France and they could give you material things and benefits. (P3)

In the next chapters, I will discuss the promotional strategies and describe how respondents, including P3 and P25, believe that the extent of influence is beyond these seemingly limited offers of material gifts.

### 3.8 Summary of chapter three

In the complex realm of prescribing behavior, the decision is made at different levels: personal, peer-related, patient-related, and pharmacological. These features are given different priorities, which stands for the noticeable individual variation in psychiatrists’ prescribing behaviors. Between the two main treatment modalities in psychiatry, pharmacotherapy is believed to have received more attention because of the immediate satisfaction of relieving symptoms and feasibility. Being influenced by the pharmaceutical
industry is generally believed to be inevitable. However, awareness and criticality are heavily emphasized as a socio-professional value and a necessary tool to deal with this inevitable interaction. Awareness represents constantly maintaining a proper combination of introspection, knowledge, and vigilance of the ‘why-ness’ of prescribing medicines based on the individual patient’s profile. It also includes constantly and consciously investigating the sociopolitical construction of influences within the broad scope of concordance or conflict of interest. This criticality is thus crucial to rational prescribing. Conflict of interest is given different agencies resulting in either an emotionally-charged hesitation to interact with the pharmaceutical industry in order to protect professionalism and professional authority, or keeping communication with them with a preoccupation of criticality. Colleagues are virtually distributed alongside a continuum from being too naïve to absolutely critical with probable concentration somewhere near the uncritical pole. At collective level, colleagues are believed to be often uncritical with a trend to be more critical very recently. Regulatory bodies are also believed to have been stricter to the industry nowadays to eliminate the negative influence of the promotion, though there is less attention to the subtle and sophisticated forms of influence.
Chapter four

PERCEIVED CHANNELS OF INFLUENCE

What do you think when you hear Ziprexa® hundreds of times? It is Olanzapine plus Lilly. (P11)

Advertisement works: It works; otherwise, there would not be that huge amount of money spent on that. Acknowledging this fact, my respondents are asked to describe the perceived and experienced promotional strategies. There are extremely diverse, creative, nicely designed, and ever-changing strategies in pharmaceutical marketing implied explicitly such as in printed advertisements and drug company representatives (artsenbezoekers), or implicitly. I listed possible interactions of physicians and the industry in the table two. Almost all of the interactions are perceived to have promotional nature. In other words, any approach from the industry is seen to be promotionally laden in one way or another. Respondents believe that these strategies often appeal to their subconscious or unconscious in subtle and sneaking way. It might induce psychiatrists “just as when you see a cup of coffee during a movie, you then feel thirsty or when you see people yawn, you yourself yawn but you are not aware of that” (P1). That is probably one of the reasons why the literature says that some psychiatrists feel they are not influenced.

Narcissism: P10 criticizes his colleagues, who are visiting the ‘big market of free gifts’ (P16) at the stand of the pharmaceutical industry in meetings and congresses. He argues that psychiatrists really need critical insight to realize the inherent strategies behind promotional endeavors. The success of marketing indicates that its designers have efficiently excavated their audiences’ characteristics. They know their audiences thoroughly and probably better than they themselves do.

Once I asked some colleagues at the congress what they are doing there [visiting the stands of drug companies], they say listen, it is not gonna have any influence on my prescription policy. I asked them: So, why do you think they are inviting us and spend money? Are they stupid?...They are even keener than what we are to ourselves and what we think about the way our minds are constructed. We think we
Channels of influence

are independent but they know that we are not independent. We are just narcissistic people. They know us much better than we know ourselves…My colleagues laughed and denied in react to my critic… (P10)

Promotions are intense and endless and get us caught in the ‘bombardment’ of advertisements. First, because the competition between the medications even within one drug category is now increasingly being tougher. Secondly, the prohibition of DTCA in the Netherlands may potentially intensify promotional efforts to the doctors (Lakoff 2005). However, promotions are believed to be less aggressive in the Netherlands compared with the US. Promotions are particularly working in the situations where psychiatrists are not sure about their choices. Indeed, “when psychiatrists are not so sure what to choose, then there is more space for being influence. Concerta and Equasym are good examples. Both are long acting methylphenidate but Concerta is more expensive and Equasym is newer. This is where advertisement works” (P22). Promotions are reported to have been increasingly sophisticated and influential.

We all have to be away from this powerful magnet. However, they [the companies] finally will find their way to your home, to your car, at your desk, and into your mind. (P13)

Unconscious influence: Social psychologists have demonstrated that our everyday assumptions and inferences about the causes of our own behaviors are incomplete. The cognitive processing of our behaviors and their causes is often very familiar or very trivial to us. Therefore, this processing generally occurs unconsciously. In other words, most of our behaviors, especially the habitual ones (resulting from prior learning and chronic practice) are never processed in the conscious level and we are not aware of that unless we grab attention to them intentionally (Ricker 2006).

Pharmaceutical promotion like many other kind of advertising has the capacity to influence at the subconscious level. Psychiatrists may not be aware of the moments and the ways of influence unless they meticulously and critically inspect their prescriptions and negotiate it with others. “There is a big influence but with an unconscious process. It doesn’t come to your conscious unless you start thinking about it actively and talking to other colleagues”
Channels of influence

“We are unaware of the times when our opinion is molded by the pharmaceutical industry. We might think we have scientific view towards a particular medication but our opinions are at least partly formed by the pharmaceutical industry” (P10).

Pharmaceutical marketers are constantly appealing different entries to interact medical professionals. Studying gateways of interaction in the psychiatrists’ pints of view reveals various psychological, (medical) sociological, cultural, and political-economic processes, and thus, is of particular importance. With an anthropological perspective, studying promotional strategies would definitely differ from that of marketing and economic studies for it helps to contextualize the sociopolitical aspects of interaction and influence. Some exemplary channels of influence have received particular attention by psychiatrists. They have also been reported to me enthusiastically probably due to their pervasiveness and/or exoticness. They are discussed below based on the frequency of citation. I discuss them in the frequency of citation.

4.1 The mediated influence: pharmaceutical company representatives

Perhaps the most routine channel of influence is the drug company representatives (hereafter artsenbezoekers). Some required characteristics of being good artsenbezoekers are innovation, pride, partnership, flexibility, integrity, respectfulness, and teamwork abilities.6 The main idea is to establish and maintain an efficient personal relationship, through which a good mutual image and reputation are created and scientific-commercial messages can be exchanged. At “the conjuncture of marketing and biomedical research” artsenbezoekers play a bridging role to deliver the promotional messages (Lakoff 2005). Artsenbezoekers are, no doubt, supposed to have nice personal characteristics. Psychiatrists describe artsenbezoekers as really nice people, neat, polite, well educated, keen, intelligent, attractive, willing to listen to you, and those who know stories about other colleagues. However, there is another fact central to the all psychiatrists’ opinions toward artsenbezoekers. “They get paid by the industry and their only goal is to be nice to you, to influence you, and convince you to prescribe their products” (P9). They also promote ideas

6 http://www.artsenbezoeker.nl/kandidaat/wiezijnwij.htm
about medicines. As P26 puts, “they just sell the illusion that you have power with the medication”. These seemingly unified ideas however, result in contrasting directions. Some do ‘visit’ or ‘accept’ *artsenbezoekers* and some do not but almost all have recent or past experience of visiting them.

**One-sided storytellers:** Psychiatrists have different expectations from their possible relationship with *artsenbezoekers*. Their reaction to them depends on whether their expectations have been met. Opponents perceive visiting *artsenbezoekers* as dangerous or useless. They do not want promotion. They do not visit *artsenbezoekers* or if they do, it is just because “it is impolite to reject them all the time” (P19). “We want advice, which is different from what *artsenbezoekers* offer to us” (P7). “They are too commercial. It is waste of time and is not what we hope to find, namely, scientific debates” (P2). “They seduce you to think in this way that well, their medication is better than this one [that you are prescribing now], which is not scientific” (P19). Even according to P20, “they may ‘fool’ doctors because we have no enough time to read everything about medications. We have a good general knowledge but we are not expert in a particular medication while *artsenbezoekers* are. Their job is to sell them. Visiting *artsenbezoekers* are useful, provided that you know enough about the subject. Otherwise, you might be cheated” (P20). Opponents also do not trust on the information and materials that *artsenbezoekers* provide due to their perceived merely commercial contents. They often do not take their information seriously. What *artsenbezoekers* provide, my respondents mostly agree, is just a filtered, sifted, and colored information, ‘made’ to triumphantly illustrate a positive and perfect image of medicines. They are spokesmen of the industry whose mission is to tell successful stories about medications. Even otherwise is not expected in the eyes of some respondents for it is “like selling a car. You are not going to say that my car is not that stable when you want to sell it” (P10). P23 completes:

The information provided by *artsenbezoekers* is not very valuable. They are not neutral. If you knew all details for a medication, you would then realize how selectively they provide information to you…I don’t say to them that you are not objective; they themselves know; that’s part of the game. (P23)
Stereotypes: There seems to be certain stereotypes in the *artsenbezoekers*’ promotional efforts, which is the second matter not welcome to the psychiatrists. “I cannot trust in *artsenbezoekers*. They always pick some graphs out of the articles [literature] and insist on persuading me but I’m missing the context and the commentaries. They also hand in many printed materials which I never take into account” (P24). As P18 says their promotion is comparable to detergent promotion. “They always wash white and always wash ‘whiter’ than others”. In P10’s words, “the fact is that they always end up with the old story that this well-known doctor in your field is very satisfied with this mediation. Why don’t you try it as well?” Therefore, psychiatrists may find it irritating that *artsenbezoekers* always provide the superficial and repetitive form of information over and over again. “Theses information is really on the surface and doesn’t give me a deep insight on how better the medication works in comparison with other products” (P13).

*Artsenbezoekers* have a difficult job. They work in two different milieus with different mentality and rationality. Wandering between the scientific and commercial pole of their job, gaining a proper balance is hardly achievable.

I often feel being treated as a customer instead of a professional. When I am treated as a customer, there would be a nice dressed up person in my office with a briefcase full of glossy advertisements and small gifts. When I am treated as a professional, then there would be someone in my office, who is able to objectively tell me what literature has said about the effects of a medication. Someone, who is willing to sit next to me and think with me and evaluate together with me in what circumstances the medication does work and in what circumstances honestly does not…I don’t visit *artsenbezoekers* anymore. I did that but they did not get from me what they wanted and I did not get from them what I wanted. (P13)

Insufficient knowledge: Excluding some exceptions, the *artsenbezoekers* are perceived not well informed about the medication. More importantly, “they do not understand what psychiatrists need and lack enough knowledge on [the very field of] psychiatry” (P25). Even if they know more details about the medication than psychiatrists do, they are not able to explain some ‘why’ questions particularly about the efficacy and exact dosage. This make some psychiatrists feel ‘disappointed’ to visit *artsenbezoekers*. P16 comments:
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Artsenbezoekers are like the "Jehovah Witnesses", a strong Christian movement in the Netherlands. They really come to your door to convince you their religion. After some discussions, they soon come to the point that they do not know and they must go to the leader and then come back…so I have given up and do not like to spend too my time with them. (P16)

Nevertheless, not all psychiatrists are opponents. “Although I don’t allow artsenbezoekers to come to me, they are always wandering about in this corridor [of the polyclinic] with all nice presents” (P26). P5 believes that they are not in the position of obliging doctors to prescribe. Therefore, as long as they do not violate the psychiatrists’ autonomy and “refresh their memories of the presence of their products in the market, it wouldn’t be a destructive threat” (P5).

A productive relationship: There are some instances that visiting artsenbezoekers have been seen as not useless, if not very useful. As I have noted before, psychiatrists frame the artsenbezoekers’ profession as establishers of ‘commercially-driven relationship’. While opponents put their emphasis on the ‘commercial’ element, others focus more on the notion of ‘relationship’. Therefore, for some psychiatrists visiting artsenbezoekers is potentially a productive means of communication both as information and a testament to evaluate your awareness about the influence.

I do see artsenbezoekers because I think it is necessary that you learn how to communicate [with the industry], how to rate the influence that they want to have on your own functioning. So, I see one or two of them every 3-4 months. They try to update me on some products that I do already use [prescribe]. For example, for a new antipsychotic drug, an artsenbezoeker just talked to me on the updates. He showed me some PowerPoint about the new research results and we discussed how I’m prescribing the drug, how that works for me, and how I feel about that. He also gave me some reprints of research…He never pushes me…pretty distant, and it feels fine for me…I think it is a good way to know how to handle this [information] without being influenced too much. It is good to be aware that someone is there for just one reason, promoting his own product, and still be able to listen to that and
then objectively, as far as possible, weigh for yourself what you want to do with that information and how it is going to influence your prescribing behavior.

… It feels fine for me but in the back of my mind, I always think if I should have prescribed that drug. But let’s just be aware and see how they are gonna influence us…Whenever I see the *artsenbezoekers*, I would have the feeling that everything they say is promotion, but I know that a lot of things that they say is just information. So even if it is 60% promotion and 40% information, it feels like 80% promotion and 20% information. But because of the whole aura around pharmaceutical industry, the paranoia that you taught, you think that it’s much more promotion than information. (P3)

**Cautious negotiation:** Therefore, when visiting *artsenbezoekers* is a means of communication, psychiatrists would welcome them and give them the opportunity to a deeper and more intimate interaction. Communication in this sense creates room for psychiatrists to discuss the articles, review them, and actively ask *artsenbezoekers* to provide information on the negative side of medications as well. It helps psychiatrists to identify the methodological abstractness of some publications and “make the articles more concrete for daily practice” (P18). Nonetheless, given the inherent potential of being influence, the interaction between psychiatrists and *artsenbezoekers* turns out to be a ‘cautious negotiation’.

I am always a bit skeptic about what *artsenbezoekers* tell me and let them know that as well. I, then, search whether the medication has had a bad side, which they do not tell me. I give them feedback and give them the opportunity to respond. In fact, I try to have dialogue with them to get a better idea why the medication does work or does not. Most of the time they smile and admit that it is logical that I am skeptical. They always tell me that they provide as objective information as possible. As they say in Holland [a proverb], ‘I tend to take it with a little salt’. *Artsenbezoekers* spice up information. Not totally objective though, their information cannot be lie. (P15)

**Best impression:** Once *artsenbezoekers* are allowed to see psychiatrists, they are indeed offered fertile ground for further promotional endeavors. Making and maintaining the best
Channels of influence

impression is generally the main principle of the missions of *artsenbezoekers*. However, psychiatrists often believe that this impression tends to turn the nature of their mutual relationship toward a more personal (perhaps intimate) relationship in some cases.

If you like the person who is telling you about a medication through a personal communication, it may be more likely to believe their sayings as rational and not rubbish, like the other human interactions. It’s not incidental that they have changed their way of promotion nowadays. Years ago, I was visited by the male *artsenbezoekers*. Later on, it was all attractive women, why?...Um, let me listen to her while seeing her [beauty] and smelling her nice smell. Promotions are getting more sophisticated and with nicer designs nowadays. (P14)

Good impression is also rooted in the extent to which *artsenbezoekers* ‘recognize’ psychiatrists’ position in the ladder of professional or social power. P9 believes that they astutely do that. Pretending to recognize the psychiatrists’ professional territories and strictly keeping the borders not violated is the secret of success for an *artsenbezoekers*.

The pharmaceutical industry spends a lot to have good relationship with doctors. They are very keen on the neatness of doctors. The fact is that doctors like to be [considered] important and they do their best to make doctors feel important. You can see that the influence is subtle and smart. (P9)

Establishing rapport facilitates marketing strategies and helps *artsenbezoekers* to influence psychiatrists more efficiently and diversely. According to the respondents, with maintaining a close relationship, *artsenbezoekers* will be able to promote medicines. For instance, they induce friendly attitudes toward their very company. They provide detail information on how to switch the patients’ regimen to their products. They ask psychiatrists to complete promotional questionnaires and often pay them. They indirectly promote the off-label indications, which are prohibited if done directly. They guide psychiatrists how to direct patients to change their insurance policy to be entitled for reimbursing their products, etc.

*Artsenbezoekers* often prefer to have personal meetings with physicians. Some psychiatrists believe that in the one-to-one communication you may not be able to
critically examine the information. Instead of not visiting *artsenbezoekers*, they suggest that psychiatrists can organize group meetings in clinics and put the promotional material in the scrutiny of an array of colleagues rather than dealing with it individually. This protective strategy may reduce the chance of negative influence.

### 4.2 Influence at congresses, the ‘interested knowledge’

Scientific meetings provide a breeding ground for the industry to promote their products. Congresses have long been the focus of promotional efforts. According to the respondents, there seems to be a mutual interest in both the industry and the congress to establish or maintain financial relationship. For psychiatrists, congresses are portals for the global scientific infrastructure and excellent opportunity to keep updated in the ever-changing realm of contemporary medicine. Congresses provide the best opportunity to enter “the circuit of cosmopolitan systems of expertise and to be embedded in an atmosphere of “interested knowledge” – the conjuncture of marketing and biomedical research” (Lakoff 2005: 141 emphasis in original). The congresses have another important function. They are often believed as “nice social events to meet colleagues” (P18) and socially and scientifically interact them. Hence attending congresses usually receives enthusiasm.

For the pharmaceutical industry, congresses are audience-rich environments with a great likelihood of receptivity toward promotional endeavors. They are also a good occasion for the *artsenbezoekers* to get to know doctors and establish or reinforce their relationship. When the industry send you to a congress, P18 says, all of your moments are monopolized by luxurious things; during trip, at the airport, at the hotel, during dinner, etc. and there is hard to escape from that entire dense program.

**The politics of the congresses:** In the open atmosphere of mutual interaction between psychiatrists and pharmaceutical companies at congresses, the power relation is striking. P4 reports a sensitive case in a Dutch psychiatric congress and explains the interplay of professional and commercial power.

Two years ago, some colleagues and I wrote an article regarding the inefficiencies of SSRI treatment in children. That was in the period of international congress of
psychiatry in Holland, which was sponsored by the pharmaceutical industry. The company X asked the Dutch psychiatric association (NVvP) to cite a declaration in the website that there is indication for prescribing SSRIs for children and adolescent, [in order] to counteract what we had argued in our article. Then I was told that the pharmaceutical industry warned the association to withhold their financial support for the congress if they wouldn’t do that…So, our association put that statement on its official website that SSRIs do have indication for children. They said in the website that in the period that SSRIs were prescribed more, the suicide rate came down. That’s not accurate and proved, but they put it in the website. It was misleading and I think they did it because they just wanted money for the congress. These sorts of things make me think that how easily we [our association] are influenced. I think it was brutal that pharmaceutical industry said that you should write this declaration in the website, otherwise you won’t get our money. I think psychiatrists visit the website and say oh, our association says it’s ok. Maybe they don’t read the literature [and just trust in what this association said]. It is an important influence and worried me. (P4)

P9, a member of NVvP, has another idea. He believes that the association is well able to restrict the influence of the industry. In the Dutch national annual congress, the influence of the industry “depends on how much room we give to them. In the committee, some people said that we must be kind to them. Maybe it is not ethical but I believe that we should not be kind to them because they will pay to the congress anyway. They are very interested to be there because all psychiatrists are there. They like to present themselves there, so in my opinion, we are able to and should minimize their position at congress as much as possible” (P9). According to P22, this confinement can be seen at least in making some changes in the place of the stands of the pharmaceutical companies in the congress. “Nowadays in congress if you don’t want to see the stands of the companies, you don’t need to see them because they organize their place apart from the dining room. Before, they were connected to the public hall” (P22). Nevertheless, the idea that sponsorship of the NVvP congress has negative influence on the professional association is more reported.
Influence at the congresses may start with a cup of coffee or a free lunch, which seem to be “quite innocence and [to] have nothing to do with the medication they are promoting but you should know that they are over there to control the minds and the hearts” (P10). The influence at congresses tends to be quite intense and in many case pampering. Psychiatrists believe that the intense flow of promotions is strange and sometimes annoying. P14 describes:

There was a new [named] medication and the pharmaceutical company X spent a lot to promote it. They invited colleagues to Rome to a very expensive hotel. It was supposed to be a congress but it was more a pleasure covered up as a conference; Concerts, city tours, and all other nice things were over there. You could see the logo of the medication they were promoting ‘everywhere’, in the hotel, in the dining room, on the plates, and even on the toilet papers! (P14)

### 4.3 The gifts, calls for reciprocity

At the less complex level, promotions include a range of small gifts such as company-labeled stationery or all sorts of books often with extra-cover or extra-advertisements. Despite its ancient origin in marketing, small gifts seems not to have been old-fashioned yet. This can be ‘an entry’ for the further (constant) process of influence. There are probably different entries for everyone. The general principle is to create loyalty. “Some like pens, some like free lunch, some is tempted by extra-dinner, and some by a trip to Mediterranean region, in one way or the other (P13). “They always want something in return and you feel a sense of commitment to do that” (P25). Therefore, “when you are thinking about A or B, you say oh, the company of B was so nice; she gave me dinner, so why not B” (P13). However simplistic it might sound, it certainly is not free of influence. P6 strongly agrees that the gifts do have ‘minimal influence’. Right after I started interviewing him, he points out the stuff in his office and says, “This is a real ink for my pen. All the books at my desk were bought on my own and not from Lilly or other companies. You do not see any sign or logo of the pharmaceutical industry in my office, do you?” (P6).
4.4 Perceived influence on scientific evidence, the ‘colored information’

‘Evidence’ refers to something that is used to “determine or demonstrate the truth of an assertion”. In scientific research evidence is accumulated through experiments. Evidence-based medicine is defined as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett 1996: 71). Practicing evidence-based medicine requires clinical experience as well as expertise in retrieving, interpreting, and critically evaluating scientific studies. An appropriate medical practice relies upon the proper combination of individual clinical experience (internal evidence) and evidence-based practice (external evidence) (ibid.). Randomized clinical trial (RCT) is the ‘gold standard’ of evaluating the efficacy of treatment modalities including medicines. It is considered the most reliable form of scientific evidence. According to BMJ editorials, the randomized trials, and especially the systematic review of them, are “so much more likely to inform us and so much less likely to mislead us” (Sackett 1996: 71). In this section I clarify psychiatrists’ views on the ‘evidence’ that provided or sponsored by the pharmaceutical industry. The industry plays a great role in designing, funding, and leading scientific research to develop new medications and/or to do post-marketing evaluation of the existing ones. In so doing they organize joint research projects with academic and research institutes. Promotional principles may influence all of the mentioned steps. Through sponsoring drug research, the pharmaceutical industry then does its best to ‘deliver’ a body of seemingly reliable knowledge known as scientific evidence, though not free of promotional influence.

The industry’s domination in drug research: A great majority of psychiatrists express their concern on company sponsorship for psychopharmacological research. They agree with the CATIE study (Clinical Antipsychotic Trials in Intervention Effectiveness) – a nationally funded study on antipsychotics in the USA – that the emphasis of the industry in doing drug research is “on meeting regulatory and marketing requirements and on obtaining expanded marketing claims for the drug. Not on evaluating the effectiveness of the product at the general population level. As a result, industry-sponsored research does

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Channels of influence

not address broad public health needs or the needs of individual practitioners seeking to make good clinical decisions for individual patients” (CATIE website).\(^8\)

Although psychiatrists are not opposed to the industry’s sponsorship, they do express concern about the dominance of this kind of research. However, it seems somehow inevitable because at grassroots level there are always not enough budgets in governmental and academic centers to carry out the costly research on medications independently. Secondly, the pharmaceutical industry has the means and the motivation to develop studies about medications. “…it is part of the capitalist system, we have chosen for our society” to have too many choices to prescribe (P17) “When you want to have free market, you get this. It is about money and then you may have corruption” (P9).

**Slight paranoia:** If the pharmaceutical industry takes a leading role in drug research, psychiatrists believe, there would be serious doubt on the very accuracy of the evidence because their research would be commercially colored from design to result. “You never know whether something that right now is true would still be true next year” (P21). Therefore, psychiatrists hesitate to ‘trust’ on the company-sponsored drug development research. They believe this kind of research is not objective enough to be relied on. Most of them emphasize that it is not unreasonable to be slightly paranoid towards scientific literature. P3 exemplifies:

…There have been quite a lot of examples on how the industry [has] withdrawn information from the public. Like Rofecoxib (Vioxx®), that they did not explicitly mention its potential harms for coronary artery disease. You should be skeptical about the research that sponsored by the industry. Of course, they want to publish nice results. (P3)

… For some literature that is sponsored by the industry, I have the feeling that there might be something hidden between the sentences. I am paranoid about the literature. (P13)

\(^8\) http://www.catie.unc.edu/alzheimers/about.html
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This ‘paranoia’ is inclined to the selectivity of information provided by the industry and not to the provision of wrong information. Their data is robust and they do not tell physicians lie, P17 says, because otherwise they would ruin their reputation and more importantly “would be shot by each other. They always tell the truth but not the whole truth” (P17). Paranoia, to that end, motivates psychiatrists to seek the ‘whole truth’ which again means being critical. P5 believes that psychiatrists are naïve if they would not check whether they are provided with complete and comparative information.

Nonetheless, the inherent commercial interest of the industry is perceived to be powerful enough to influence the research trajectory. Influence in this sense means ‘manipulating evidence’ toward reaching the desired result, which is going to be used in promotions. Thus, the objectivity of their research would be dubious. Respondents’ uncertainty on objectivity of studies encompasses all stages of clinical research namely, research question, entry criteria, study design, dose range, sampling, analysis, reporting, wording, and publication.

Pharmaceutical companies can set up whatever research they like. There is a discussion nowadays that when the industry wants to set up a study, they first look at the results and if they see the possibility of positive result, they will do and publish that. (P4)

**Study design:** It is the design of the RCTs that largely determines whether the results are unbiased and objective (Pocock 1993). He warns clinicians that “deficiencies in design cannot be corrected by sophisticated analysis and interpretation, so that reliable conclusions are impossible” (Pocock 1993: 237). The likelihood of producing misleading results in RCTs seems to be more than what Sackett claimed. Some psychiatrists consider many drug researches not objective for they are open-label (not double blind) or there are no comparative studies available. They often consider RCTs for some new medications to be really misleading. The tricky question is, for instance, how the pharmaceutical companies want to show the extra-benefit of a new antipsychotic like Paliperidone, while they set this medication against a placebo in their trials and not against the latest available antipsychotic in the market (e.g. Risperidone). P6, answers himself “because they don’t want to show extra-benefit”. The aim is to find a ‘substitute’ for Risperidone, which is
going to go off patent. Similarly, some psychiatrists mention another instance, where the new medication is set against the standard antipsychotic but with a very high (wrong) dose. Among several times I was told this story, I choose P2’s. He describes how using the wrong dose of medications in trials can exaggerate the effect of new medication as well as the side effects of the old one, which best suits marketing new medication:

There was a lecture about 30 years of research with antipsychotic medications. Haloperidol had long been the golden standard and new medicaments in clinical trials were set against Haloperidol. After 30 years, the industry used very high dose of Haloperidol, so the side effects were worse, they gave 10-20 milligram Haloperidol daily, which is far too much. The normal [dose] is around 1-5 mg. So, after 30 years [of experience with Haloperidol and see its effectiveness] my colleagues are simply misled by the pharmaceutical industry that it has very bad side effects (P2).

**Sample selection:** Samples too, are not free of influence. Generalizability of the result of drug trials is questionable to some respondents. First because most of researches done by the industry have small study samples specially in CAP and there is frank necessity for more drug research and in larger scales. Secondly, patients with psychiatric disorders are not similar to that of being selected for the trials. In other words, those who react to the announcement of RCTs in the US and participate in trials and often get paid are undoubtedly not similar to Dutch patients and specially in-patients [with possible comorbidity], P10 argues. Consider the following example of antidepressants:

In psychiatry, it is really hard to set up accurate investigation. For instance, if you want to set up a study on the efficacy of antidepressants, not all of the candidates would be alike. Some people would not have sleep disturbances, some people would not have concentration disturbance, some would have just sexual problem, some would only feel unhappy, and some would only feel nothing. So in such heterogeneity, it is very hard to set up a study on [the actual effect of] antidepressants.

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9 According to Pocock (1993), the pharmaceutical industry usually combines the result of some scattered multi-centered small-scale trials into one package of evidence to be presented to the regulatory bodies such as FDA to obtain marketing approval.
Another thing is that your individual patients may react totally different to the average available information about the drug [evidence]...I’ve experienced this case where I’ve just read that a particular medicine would not helpful for patients with bipolar depression. Contrary to what we believed for about 30 years, a recent, excellent article with no industry’s interest shows that the patients would not benefit more from the addition of a particular antidepressant to a mood stabilizer than those who are only on mood stabilizers. But still I see patients who recover from depression by using that antidepressant as an addition to a mood stabilizer…We don’t know the mechanism. (P3)

Methodological mystification: Studies on medication and drug trials are often carried out with a multidisciplinary expertise on pharmacology, medicine, epidemiology, statistics, etc. The majority of psychiatrists express clinicians’ difficulty in understanding the methodology part of the literature on medications. They often feel the necessity to ‘translate’ data of RCTs into the everyday clinical practice. It is sometimes difficult to understand “what an article says and means” (P1). Moreover, to be able to critically evaluate the objectivity of the articles requires cross-disciplinary expertise, having sufficient knowledge on all above disciplines, which is often not the case for many clinicians. According to the respondents, sophisticated results (as it is constantly becoming so) may be less likely to be spent enough time for, understood, and received scrutiny by the clinicians. They tend to refer more to the abstract and conclusion parts of articles, which are in turn, less objective than the result part. The clinical interpretation of statistical findings may create room for promotion and pharmaceutical industry has recognized this delicate situation. Moreover, busy clinicians often read no further than summaries of the articles.

I am a clinical practitioner not a researcher and for me it is rather difficult to evaluate the literature [methodologically] whether they are really objective. The way they design the studies is sophisticated to follow. I can never check the statistics they use. I often read abstracts and conclusions. I have to believe them. I have neither knowledge nor time to check everything. (P21)
Publication bias: In accordance to the selectivity of literature, publication bias can contribute to promotional influence on the evidence. Negative trials may not be published or may not be considered interesting enough to merit publication anywhere so the published evidence is biased in favor of medication. Journals may favor certain finding and mainly positive ones. “I fear that the editorial standards in specialist medical journals (where most trials are published) are less critical” (Pocock 1993: 238 explanation in original).

Some international journals accept only articles that go with the mainstream. I know one case about Ritalin that they didn’t accept negative article because they think, it is not mainstream. The mainstream is that methylphenidate is fantastic. Most of the time the mainstream depends on the researches sponsored by the pharmaceutical industry. It is nonsense to think that they are independent. (P20).

…Finding desirable result in this condition is not difficult. Alas, most psychiatrists may say that oh, it is published in the American journal of this or the Dutch journal of that, so it is good study and I believe it. (P9)

In addition, the methodologically weak studies in favor of companies’ medicines may only find their ways through ‘infamous’ and not peer-reviewed journals. Therefore, the very publication of drug research ‘somewhere’ does not guarantee the objectivity.

4.5 Conjure-up conditioning

A reported covert strategy of the industry is to constantly and repetitively promoting certain medication in order for the medication to ‘pops up’ first in the psychiatrists’ minds. Repetition may take different forms; verbal, textual, or both. This conditioning process may interfere the critical evaluation of that medication.

When you hear the same things from pharmaceutical companies all the time, you might forget to think about it critically. If you hear all the time that this is really great, this is really great, this is really new, you might stop thinking about why you want to prescribe this drug and what is actually known about this. I think this happens commonly that people prescribe something because they’ve just ‘heard’ from the industry that this drug is good. So, I think the information from the
pharmaceutical industry can actually ‘blur’ our ability to make a clear decision. I can imagine that when you are overfed by all information about the benefits, you might forget the actual effects and side effects…Every now and then, you hear that psychiatrists repeat the stuff that seems to stand already from pharmaceutical advertisements. So probably, somewhere it get left behind in your brain and you start thinking about the medication in the way that the pharmaceutical industry wants [you] to do. I witness the effects of marketing. It does work. It has worked with me. (P3)

Furthermore, in their struggle to set their minds and their pens free from the influence, psychiatrists may be overcome by the very repetitive nature of this strategy. When they hear “repeatedly all the times Lilly, Lilly, Lilly in the congress” (P20) or elsewhere, it would occupy their heads and at least partially direct them to prescribe the product of this company.

Differentiation is another basic technique to facilitate remembrance of medicines. They attach a certain message to the products. They attach the name of the medication to the congress or attaching a few words to the medication. For instance, the antidepressant for women, or the antipsychotic for obese patients, etc. P12 reports a perceived strange type of association in promotional strategies with double influence:

I got a mail to request a book from the pharmaceutical industry…Just answer how many times you prescribe Efexor® on this card, write you address and send this card. They will send you a book from Midas Dekkers called “Lichamelijke Oefening” [Physical exercise] for free. In his funny book, he is against exercise. It is a nice example of influence. Maybe next time I prescribe medication from the company, who gave me the book. Another influence is that this guy writes in a cynical way that exercise is not helpful. So when you want to make choice you may recommend depressed patient not to take exercise and just take pills. I really cannot read the mind of the Wyeth Company, ‘Leading the way to a healthier world’, but I think that is the way to influence doctors. (P12)
4.6 Reflective influence (involving the public, patients, and patients’ organizations)

Interaction with the public can be seen as an attempt to ‘bypass’ the prohibition of direct-to-consumer advertisement in the Netherlands. It may range from promotional materials in the doctors’ waiting rooms, to announcement for paying to the artists and celebrities if they ‘get’ their products, to the strong support of the patients’ organizations, etc. One can track the footprint of the industry in the accounts and demands of patients and their organizations. This subliminal influence on the patients will then be redirected towards the psychiatrists and in a sense is a smart strategy to influence doctors. It is pervasive in CAP more than adult psychiatry. All eight CAP respondents reported this trend. Patients and – in CAP – the parents of patients have recently been very well informed, more active, and
more sensitive to their (children’s) treatment. They may often provide new information for their doctors. It often happens that patients come with some pieces of information from the internet, newspapers, etc. and ask psychiatrists to prescribe a particular medication.

There is a new drug for ADHD called Equasym. The first person whom I heard about the existence of Equasym was a mother. The parents are very active especially in the internet and I think the real influence nowadays is on the parents through the internet and the media…I had a patient last week who came with lots of torn-out pages of an American magazine about patched Ritalin. Sometimes people just come in and say ‘I want this’, especially with the American magazines. That one came from Oprah Winfrey magazine. In that case, it was not available in the Dutch market and it was easy to me. But if there would be good reason to use the patch instead of the pill, I think I would do that, but not because it feels fashionable to take a certain medication. (P1)

The similar case is reported by P15. He had some cases, who wanted to take Prozac for example, because they heard it in a Hollywood movie. He believes that it’s not necessary bad thing as far as patients are given some choices “because of probably better compliance or when they believe in it, the placebo effect would be more”.

The prohibition of direct-to-consumer advertisement seems to be unable to confine marketing strategies to only professionals. The involvement of the public can go beyond the choice of therapy and even negotiating diagnosis. Not entitled as direct-to-consumer advertisements though, there are also some interactions between the patients and the industry. P4 tracks the influence from the public to physicians.

When the pharmaceutical industry influence patients, I think it is strong enough to influence us, as well… People come to my office and say that my child does this and that, so I think he has ADHD and he needs this medication…They say it’s a good medicine and want that medicine for their children. If I don’t give medication, they go to other colleagues and ask for it…Of course, I’m not against being well informed and it’s good that parents and patients make their own decision. I see myself and my colleagues as experts who can give the patients advice, but they decide themselves…Also in Holland, there is strong parents-of-patients’
organization and they work strongly together with the pharmaceutical industry. That’s the way that they can promote directly to the patients…there is a book from patients’ organization and the industry together with a few psychiatrists. The book is not bad but it focuses too much on medication and that’s the purpose why the industry makes it. (P4)

The influence of the industry on the public follows the same unconscious processes as it does for physicians. Moreover, according to P5, the public tends to internalize or ‘memorize’ only positive and successful stories about new medications and only side effects of the old medications. Sometimes psychiatrists face difficulty in convincing patients that there is no sufficient evidence available for a particular medicine. “Parents have heard too much about Concerta and maybe next year they want me to prescribe Equasym…Most of the time when I explain what Concerta does and what is inside of it, then some parents say, ok, now I understand that both [Concerta and Methylphenidate] are the same but with different coating” (P22). These public assumptions regarding medications notwithstanding find their ways to the prescriptions. P5 describes how this influence (on patients) can be redirected to the psychiatrists.

People [the public] don’t think about certain things; they believe in that. They hear from each other or from the bombardment of advertisements only the positive aspects of medicines. They are not interested in the mechanisms (pharmacodynamics) or whether this is the best choice…but we [professionals] are supposed to look at the other aspects of the story. Once the brain is washed that medicines are good, then there is a pressure from the public that I should prescribe medicine and not the other way round. For example, when Prozac was introduced in the US, the whole public believed that it is a holy medicine. So you missed the critical thinking for the first step of your decision; whether the medicine is necessary or not…Even if doctors are critical enough, they will have to say to the patients that some disorders don’t need medicine and even they may fight each other; ‘…no, doctor, I do want medicine’. (P5)
4.7 Targeting opinion leaders and professional associations

Opinion leaders (OLs) have long been a central pillar for pharmaceutical marketing. OLs are the physicians with high prescriptive power, because either they have a lot of patients or they are well-known and trustable among the colleagues (Lakoff 2005). They have two contrasting directions. Some are leading the left wing opinions and are quite critical. Others lead the right wing ideas in favor of the industry. The industry pursues OLs in order to develop alliances, to make them as a ‘brand spokesmen’, and to capture the trust of other doctors (Lakoff 2005). P18 and P26 express their concerns about the possibility of financial connection of “OLs, mostly academicians, who are being bought by the industry” (P11).

You see some important OLs from the USA come to the Dutch yearly congress. They get fund from the industry and not from the government. This makes me sad. For instance, last year Dr. Nancy Anderson, the chief editor of the American Journal of Psychiatry, came to the Dutch congress only to present one-hour lecture. Her travel was sponsored fully by the industry. In fact, she had obligation to the industry. When such persons become so dependent to the industry, it makes me sad. (P26)

OLs are identified hierarchically by the industry at three levels: global, national, and institutional. They have extremely important role in convincing other colleagues to prescribe a particular product. P12 describes how the industry identifies OLs.

They sent me an enquiry and asked me whom I consider the most influential colleagues in the filed of depression for myself. They asked me three names for international, national and regional colleagues. The industry said, “We would like to know if we organize congresses who we invite for you to give lecture.” But that is a nice strategy to identify OLs. I remember when I was the OL of this institute two years ago, they offered me trips to the US to convince me. It is their job to invent new and hidden strategies all the time. (P12)

Another technique to better linking to the OLs is to offer them a market oriented phase-IV clinical trial. This is called ‘seeding trial’ and is designed for an already approved
medication intended for promotional purpose rather than to prove drug efficacy (Lakoff 2005). The general principle of being influence here, according to a social psychologist, is called ‘Hawthorne Effect’. It is an endeavor to transform OLs into powerful and loyal advocates for the sake of the company (Marsden 2005). It is offered to P8 and he explains it:

For Strattera®, a new medicine for ADHD, they asked me to participate in an open-label trial for 10 patients and for each patient they said that they would pay €3000. By open-label, I mean not double blind studies that are not objective of course. I told them that I have to discuss it with our pharmacist and I don’t think it is an objective study. They answered me that it is just a seeding trial that doctors get acquainted to it. It is not set to serve higher goals [than marketing]. (P8)

4.8 Monopolizing prescribing choices

This is according to P7 is one of the newest strategies of the industry. This strategy is mainly seen in three following situations:

- Offering free samples and encouraging psychiatrists to switch to the new regimen. After a short time that the patient takes free samples, psychiatrists may ‘continue’ that new regimen for an extended period of time. In particular cases, P10 says that after that period if I don’t see the desired effect, I may try higher dose, so I treat myself as if I am obliged to continue the medication and that’s not correct. (P10)

- Filling hospital stocks with certain medications in collaboration with the pharmacy units of the hospital. For those who are working in in-patient settings, they then have to prescribe only certain brands that are available in the stocks.

- Redirecting the influence on psychiatrists towards the general practitioners (family physicians). General practitioners then have to refill the recent prescriptions.

While psychiatrists express particular sensitivity to possible situations in which the professional autonomy is violated, this strategy raises less reactions probably because it is not perceived as a promotional strategy.

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10 For more discussion please refer to the Annex
4.9 Promoting diagnosis (diagnostic blockbusters)

The extent of marketing strategies is not limited to promoting medications. “It’s not only about pills, they also ‘invent’ diseases and psychiatrists are weak to react. The whole profession is weak. The pharmaceutical industry makes different drugs; then makes the definition for a certain diagnosis. It is beyond promoting pills, they promote the diagnosis as well…it is getting more and more complicated” (P17). Lakoff mentions the same phenomenon and argues that nowadays the pharmaceutical industry “cannot only seek to find the key for the lock but can dictate a great deal of the shape of the lock to which a key must fit…Companies design not only medication, but also the conditions that the medications are supposed to target” (2005: 159). This strategy has been reinforced with the process of medicalization, which was discussed in the introduction part. Not surprisingly, this is illustrated by a parody campaign addressing the fictional Havidol® as the ‘first and only’ medication for treating DSACDAD!

![Figure 5. A parody ad for a fictional drug, Havidol (pronounced like the sentence 'have it all') and DSACDAD](image.png)

4.10 Channels of positive influence, a normative mentality

As I mentioned before, there is also an optimistic perspective toward the influence. The ‘set of dynamics’ between the industry and psychiatrists is not always complained about.
Channels of influence

Some psychiatrists, P13 says, make a positive use of their interaction with pharmaceutical industry and seek opportunities for their patients’ and their institutions’ benefit. “I think some companies are willing to sponsor educational programs for the family members of psychiatric patients. You may think it is just another strategy for promoting their products but you can think another way that they are making a lot of money and they are willing to spend some of them to theses programs. It just all depends on the way you look at it” (P13). Contrary to those who dramatize interactions, other respondents see it in a more normative way. As the head of a psychiatric institute, P16 conceptualizes the influence in the following channel as positive:

The industry can really offer something as ‘contribution’ to our work. The company X has sponsored training and education of my staff, for instance, in cognitive-behavioral treatment, [although it seems to be not parallel to the overall policy of drug promotion]. They only support me [the institution] financially and I don’t have obligation to choose the lecturers dependent to the industry. We do not have enough budgets to organize these workshops ourselves…Of course, they have stories about their medications to tell us; of course, they have some influence. I have probably better feeling towards their drug and maybe, I prescribe their drug more. They just want to convince me but it is part of the deal. They support me and I [on behalf of other colleagues in the institute] listen to their stories. I am curious to know what is really wrong with it; which kinds of promotion are not matter, and which one means being [negatively] influenced. In this way you can find where the boundaries of being influenced are and where is the threshold for each one. I can imagine that everyone has some kind of contact with the industry. (P16)

In accordance to what P16 proposes regarding the boundaries, a few psychiatrists have set up the lines and defined the border of negative and positive influence. For instance, for P22 “it is good to know that a new medicine comes. It is good to hear from industry that for example, Equasym is in the market but that’s enough; just to know that it is there. For the rest, you should search for other source of information” (P22).

Concluding optimistic ideas in this regard, so far as we consider the necessity of the development of new medications, we have to show tolerance, express our sympathy to the
Channels of influence

industry, and admit that there is not only a black picture for the pharmaceutical industry. Again, central to this different positioning is the discrepancy in politicizing the issue of influence.

4.11 Summary of chapter four

Pharmaceutical marketers implement several innovative, extremely diverse, nicely-designed, and ever-changing strategies in promotional interactions. Studying gateways of interaction in the psychiatrists’ points of view reveals various psychological, (medical-) sociological, cultural, and political-economic processes, and thus, is of particular importance. Regardless of having overt or covert nature, promotions often appeal to unconscious self. Visiting *artsenbezoekers* may be the most common form of interaction. Psychiatrists have or have had experience with *artsenbezoekers* and overall believe that they do not convey that much important information to merit spending time. Some stereotypes are perceived in the *artsenbezoekers’* promotion, which is often boring. Communication and updating knowledge are the main reasons why *artsenbezoekers* are visited by some psychiatrists. There is a general sense of skepticism toward the scientific evidence and the drug research sponsored by the pharmaceutical industry. One of the respondents’ main concern is the dominance of the sponsored drug research trials, whose objectivity is largely believed as dubious due to the likelihood of manipulating the construction of evidence in favor of desired results from study design to publication. At congresses, there seems to be a mutual but unparallel interest for psychiatrists and the industry to interact. Other perceived strategies include small gifts, conditioning toward particular medications, redirection of the influence on the public, influence on opinion leaders, elimination of prescription choices, and promoting diagnosis. A few psychiatrists see the channels of influence as a normative way of the interaction that can often be beneficial for their patients or institutions.
Chapter five

IDEAS ABOUT PSYCHOPHARMACEUTICALS

I already knew that Sertraline has less metabolic side effects but it had never been so important to me until the day I read that advertisement... (P21)

5.1 Ideas about efficacy, safety, and side effects

Psychopharmaceuticals are the joint products of the pharmaceutical industry and the modern biological psychiatry. They are supposed to reverse biological psychopathologies and demonstrate the desired result. Whether they achieve the claimed results depends on the mysterious combination of their efficacy and side effects on the individual patients. Drug efficacy and side effects constitute one of the main loci of attraction for the industry to promote their products. In this section I will show how psychiatrists perceive drug efficacy and side effects in relation to pharmaceutical promotion.

‘Better-than-the-competition’ promotion: A desirable medication, as pharmaceutical industry wishes to produce and claims in promotions, is the one that demonstrate optimal result and minimum (objective and subjective) side effects. However, drug efficacy and side effects have more strategic role in marketing. There is also a relative route to depict a best image for a certain medicine, i.e., to show ones’ own product has more efficacy, less side effects, or (less or) no serious side effects. It might be a subjective claim and other (rival) companies, in one way or another, may claim the same. Most of the respondents believe that this latter strategy has speeded up over the formers and marketing is increasingly shifting toward better-than-the-competition promotion, which requires more concentration in efficacy and side effects as a tool for ‘differentiation’.

When you want to promote a new antidepressant, you should focus on a new niche in the market that hasn’t been taken [captured] before. So in the [marketing] campaigns they say to you all the time that our product has an extra benefit on the not-yet-understood somatic complains during depression. But the thing is that when you read literature, most antidepressants do so. (P3)
Uncertain efficacy and practical discrepancy: Almost all respondents are of the opinion that, excluding immediate symptom relief, the real efficacy of psychopharmaceuticals is uncertain in many cases. They are even less efficacious than medications in other fields of medicine. The P24’s pediatric colleagues, who referred patients to her “have a high expectation of what I can do for the patients with medication compared with what they themselves can do” (P24). Subsequently, there is a significant discrepancy between the ‘claimed’ and the ‘experienced’ effects of medicines. Psychiatrists give four reasons for this discrepancy. First, they question the evidence upon which the promotional claims of efficacy are based as discussed in chapter four. Second, it refers partly to the fact that unlike laboratory side effects (such as leucopenia) the behavioral effects and side effects are perplexed, abstract, often subjective, and difficult to quantification and investigation. For the industry, the situation is often more complicated.

They may tell you several stories that your first choice is not as good as you think. This drug works slightly better than the one you are prescribing. But what they say in their promotion and what we have experienced with the new products are always different…they say that how well some drugs work but our experience showed they don’t. Or the other way round, how we oppose some drugs because of all the fuss, whereas, in practice it seems to be reasonably working drugs. (P10)

Thirdly, the discrepancy also depends on the patients’ individual variations. For instance, “some patients may develop sexual dysfunction with a medication for which this side effect is not known or common. At the same time, not all patients with Paroxetine [which is ‘known’ for its sexual dysfunction] face sexual side effect. So, it is very individual” (P19). Finally, patients’ compliance is crucial, though receives little attention in daily practice. P10 criticizes some psychiatrists, who believe in the industry so much that do not question the efficacy of medication when it does not work well.

…but in a sense, we are bound to continue medication and not to change it if the effect is not desirable. We have also little scientific approach to the patients’ compliance. If a certain medication does not work as much as we wish, we might change or add another diagnosis. If, for instance, a patient does not react to a medication, they may end up with [adding] the diagnosis of personality disorder for him or there may blame the patient for not being improved that much. We must think that the
medication does not work for the patient but we are very narcissistic and may say that it is the patient who hasn’t been a proper patient for this therapy. We are willing to help patients, no doubt but it is very delicate and tricky situation and a lot of doctors would deny it. (P10)

**Focusing on side effects:** The soar in blockbuster production has provided psychiatrists with a wide range of choices and more choices within each drug category. Given the pharmacological similarity of the blockbusters in terms of efficacy, marketers would then particularly focus on side effects to differentiate their products. Sponsored research on side effects might outpace investigating the real effects. This may end up with ambiguous efficacy; where there is more evidence available on side effects rather than the real effects. As P4 argues about Paroxetine “despite its known side effects, we are not sure about the effects we want from this medicine” (P4).

There are some antidepressants in the market that have less side effects, very easy to take with the less daily dose. But quite a lot of them are not as good as the others that do have more side effects and do need close monitoring. So you may say, well, antidepressant is antidepressant and just prescribe the one that you have heard more about, probably with fewer side effects but you cannot be sure about its actual effects. (P3)

Marketing-induced overemphasis on side effects seems to have been influential on prescriptions. Paroxetine (Seroxat®), a SSRI antidepressants, is an example that reveals how crucial the role of side effects is in depicting the best image of medicines in marketing scenarios. P17 is not the only respondent, who tells me the story of Paroxetine:

Seroxat® is prescribed a lot by GPs and psychiatrists. The pharmaceutical companies choose the issue of sexual dysfunction as a matter and then promote a product with less sexual side effects instead of Seroxat®. Indeed, they promote a subject that they themselves have chosen…It is not lie, of course. (P17)

**Side effects as periodic hypes:** Promotional campaigns often highlight some side effects (usually nonfatal ones) that have already existed and make these side effects ‘hype’ in favor of a product with claimed less such side effects. This requires ongoing moving to
another set of side effects every now and then. Not that new promotional strategy though, it is very influential in the prescribing ‘status’ of the medication in the psychiatrists’ minds. Side effects specially when well publicized may create a collective negative reaction to certain medications and idealize other product, without those side effects. This can be shifted every now and then to another product. Consider the case of Prozac® (a brand of Fluoxetine), the pioneer of SSRIs and its successor Seroxat®:

Prozac® was introduced with a very aggressive and intense marketing about 20 years ago…it had long been believed that psychiatrists should prescribe medication only for sever symptoms of depression. When Prozac is introduced, this insight is replaced with another one that even for the slightest symptoms you had to prescribe antidepressants and the best antidepressant is Prozac and it makes people happy (P18). The whole public also believed that it is a holy medicine (P5)…Years later, there was high rate of reported suicidal thought in the adolescents, though was not said successful suicide. The companies were afraid of bad publicity and in some states in America, its prescription was banned. Then they saw suicidal attempts in the depressed cases, who didn’t take this pill. Again they did research and found that for those people who don’t take this medication, there was higher rate of successful suicide. The fact is that at the initial phase of treatment with SSRIs there is agitation and activation and the younger people are more likely to present this phase. you have to [monitor patient and] wait for the next phase which is mood improvement…So the whole image was turned around in the APA and Prozac again found good papers…doctors, then turned against medication and against pharmaceutical industry and the media joined them and they did a bad job. It is an important point for you to put in your paper… (P17)

Similar story happens to Seroxat® and makes it ‘notorious’ for its sexual side effects among the antidepressants. Thus for some colleagues, Seroxat® is despised now and “rarely prescribed and is not a favorite medication anymore. Now we are prescribing mainly the new one, and there is no rational argument behind that. It is completely dependent on the marketing strategies” (P26).
Antipsychotics are another examples. The pharmaceutical industry promoted typical antipsychotics for years. Then, at a certain moment, i.e., the time of marketing atypical antipsychotics, they choose the subject of extra-pyramidal symptoms (EPS). According to the respondents, they make it a bulleted syndrome and then promote the new product (Risperidone). In order to promote something with seemingly less EPS, they ‘first’ “convince psychiatrists that EPS is very bad” (P13). So the EPS of the first generation of antipsychotics ‘becomes’ bad when atypical antipsychotics is going to be promoted. Among the very atypical antipsychotics, weight gain is main issue. “It became an issue at all when another product (Quatiapine) came to the market, which seemed not to have the same side effect” (P25). This process seems to have never a stop and “we have been cheated but we still continue” (P10). In the P12’s words:

…now people from Risperidone come to me and promote the fear of weight gain of Olanzapine. The company of Risperidone has sponsored many congresses to promote the dangers of weight gain. You see the EPS also with Risperidone but still prescribe it because you think weight gain is too worse. So, they create new diseases like ‘metabolic syndrome’ and then promote fear of disease. That is why millions of dollars are made…Most recently, Abilify® [a brand of Aripiprazole] is being promoted mainly for its less sedative and metabolic side effects. (P12)

Side effects-oriented prescription: Although some side effects like weight gain seems to be not that much disastrous as claimed for all patients, there may be a tendency to evaluate and prioritize prescribing choices on the basis of promoted side effects instead of “looking at the individual patient’s profile and making an optimal balance between the effects and side effects” (P19). For instance for a certain antidepressant, P1 had put some patients on it and then she has taken ‘all’ of them off it again based on side effects. “Now I’ve started thinking if I should prescribe it, try it again for some patients” (P1); and she is indecisive. Hence, psychiatrists may “weigh side effects with more sensitivity nowadays” (P12) and this influences their prescription. Although, the influence is less likely to cause stopping

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11 Contrary to the perceived fact that EPS has long been recognized as the side effect of typical antipsychotics and could be eliminated with dose tuning in individual patients. Also see the section influence on scientific evidence.
prescribing a medication (just because of possible side effect), it may cause ‘rearranging’ prescribing priorities.

…I thought myself, um, weight gain is really an important side effect for Mirtazapine, for example. Why shouldn’t I prescribe Sertraline? It did influence me in this way. (P21)

In react to this influences, P19 argues that there are usually large differences between the effects and the side effects of a medication in different patients. Side effects can be best dealt with through close monitoring and ‘fine-tuning’ of the dose especially during the first some weeks – when side effects are more reported. Fine-tuning, however, is a challenging and timely task because in psychiatry, there is a small window between the effective dose and the dose with which side effects appear. It certainly needs patience, attention, and experience, P16 recommends.

**Efficacy and side effects over time:** In modern psychiatry there are several stories similar to the above mentioned case of Fluoxetine, where some (long-term) side effects gradually appear after introduction of the product. So, “when you see the long-term effects and side effects, a lot of drugs seem much worse than we thought they were when they were introduced” (P3). Hearing the stories of side effects makes some respondents worry that “maybe the new medications we are prescribing now have long-term side effects that we don’t know at this moment. The problem is we, P25 believe, are dependent on their publications, which are not always objective. Moreover, for registration processes they usually use short-term and small scale studies, which are unable to detect possible long-term side effects.

Strictly speaking, the respondents do not believe that the pharmaceutical industry withholds information about the side effects even for some medications like Dutonin® or Serdolect® that have been banned due to serious side effects soon after introduction to the market. Nevertheless, some side effects and especially long-term ones will yet to be discovered and it is also an ongoing process. As such for the real effects and optimal dosage that obviously takes considerable amount of time to be clarified.
Psychopharmaceuticals

Psychiatrists notwithstanding “cannot wait for years” (P5). They can follow the literature and prescribe just cautiously. What they should consider, P10 emphasizes, is that having little side effects for a (new) medication when being promoted doesn’t mean having really little side effects. He suggests to set the patient(human)-centered agenda ahead of medication(side effects)-centered approach.

5.2 Ideas about new medicines

The newer-is-better mentality: It sounds repetitive when I say that there is a pervasive ambiguity in the efficacy of most of the psychopharmaceuticals and they are generally not working well enough. Therefore, Psychiatrists are very often confronted with the patients who have tried several medications and have not been cured yet. In their struggle to treat (usually) chronic or recurrent illnesses, psychiatrists “are always looking for a better medication” (P2). This is another important locus of attraction for the pharmaceutical industry. They triumphantly come while promising the euphoric solutions, i.e. new medications. In this situation, it is not only the new medication that is promoted but also the very newer-is-better mindset. This seems a better fit to the computer and electronic market rather than psychopharmaceuticals. This mentality involves the public as well as professionals. “They are also willing to believe that new products are better in effects and less in side effects” (P5). P10 has an example:

The patients search internet and read about their disorders and visit drug advertisements. For them, the new medications are much attractive. Once I treated a well-known journalist with Seroxat®, where it was new in the market. She said: ‘This medication worked for me well and you know I am the first one in the circle [of friends and fellow journalists] who takes Seroxat®. It’s sexy’. (P10)

The quest of the better, a constant hope: Despite all this uncertainties, psychiatrists are often “stimulated” to try the new medication with the hope of better response, if not cure. This desire, at least partly, stems from their sense of professionalization because “if they don’t try, they may even feel guilty because it might have been a solution” (P26). This

12 Also see the section ‘the tournament of the latest’ in chapter one.
creates opportunity for pharmaceutical promotion. According to P2, promotion may ‘equate’ the newer with the better, and the better is an ongoing hope for most of psychiatrists as well as their distraught patients.

There are three main uncertainties toward the newer-is-better idea. P15 proposes a grass-root question that should be answered beforehand. He questions whether the newer is really the newer and not just a ‘copy’ of an existing one. He does have no strong reason for the new antidepressants like Duloxetine or Escitalopram to prescribe while he has “so many antidepressants which have been researched better and longer” (P15). As P20 says, “they are mostly fancy innovations”. The second problem refers to the ambiguity in effects and side effects of the new products especially in long-term, as I pointed out in the first section of this chapter. P8 seriously doubt how the newer medication could be better when there is no enough time elapsed for the real efficacy and side effects (often serious) to be investigated and identified. “To try the new medication and see the efficacy and side effects are the process of some 20 years” (P5). So, the new medication may be even ‘less safe’ as P8 puts. The third issue, upon which almost all respondents agree, is that the old medication may also be better than or as good as the new one especially if the dose is carefully adjusted. As an example, psychiatrists point out some studies such as CATIE or STAR*D who have done some comparative studies between old and new medicines. Comparative studies have significantly broadened their clinical insight toward the old medication. “They have a positive effect on how we prescribe old antipsychotics because we have learnt that the old ones may be effective with a less dose and thus with less side effects” (P25).

**Fashion:** Four respondents emphasis this word as the second reason why psychiatrists are too in favor of the new products to the point that they may “forget about Haloperidol”. P5 continues:

> America is a big locomotive for everything new...When doctors in America prescribe a new product, we in Holland, try to do the same but some years later. At first, it becomes a fashion and you have to try the new medicine because it feels fashionable. You can use the word ‘fashion’. The pharmaceutical companies determine the fashion. (P5)
It is also the point, where the colleagues influence each other as P8 describes below:

In our institution, we start with the old medication, Haloperidol with very low dose and in more than half of the cases, it is sufficient and works well. If it doesn’t work sufficiently, then we go to new pills and the third step is Clozapine as the heaviest antipsychotic...this protocol is working and sufficient in CAP but many psychiatrists that refer patients to our organization are unhappy with our prescribing old pills. They say, ‘we didn’t expect you to give the old pills to the patient. Why didn’t you give the patient the new medication?’...[they say so] because the pharmaceutical industry claims that the new pills have no adverse reaction and they believe them. (P8)

Obviously, not all psychiatrists are willing to be ‘on fashion’ in prescription because old medications are as good as the new ones or, at least, not worse than them. They may not switch from an already efficient medication to the new one unless when the compliance is different (when the patient tolerates the latter better for whatever reason).

Concerta® is the newer extended-release form of Methylphenidate used in treating ADHD. Child and adolescents seems to have better compliance with Concerta than simple form of Methylphenidate. Even in this case for P22 and P13 Methylphenidate (Ritalin®) is still the first choice.

The preference of Concerta® is its long-time effect and nothing else. So I prescribe Concerta® not commonly and only in the following situations: if Ritalin doesn’t work, if the patient develops rebound [which then would require prescribing high dose of Ritalin], if older adolescents are really ashamed to take medication at school, if it is not possible to take Ritalin three times a day, if the patient has low IQ, and if parents can afford paying it. (P22)

... Maybe [before switching to Concerta®] we should be clearer to the parents, saying that Concerta® actually does have the very same thing as Methylphenidate has and more than 80% of cases the same side effects. So please let me give a [or another] fair chance; try to change the dose; try to give it at 8 o’clock instead of 7; try to buy for your children the beeping watch that tell you the right time of taking
Accordingly, P10 recommends psychiatrists to be a ‘late prescriber’ and to have an ‘evolutionary’ prescribing pattern. “If the old one does not work, then try the new one” (P10). Using this pattern, the new medication does have its place in the psychiatrists’ arsenal of medication but probably not as the first choice or not as early as when it is introduced to the market.

**Industry’s reluctance to the old drug:** According to the FDA, new medications are generally available in brand name. The industry invests on post-marketing research on efficacy and safety of the new drugs either for promotional purpose or as an obligation from the regulatory bodies. For the old drugs, the industry is not interested in research because they are usually generic and no longer protected by patent. Given the perceived good effect of older medicines, psychiatrists express enthusiasm for this kind of drug research but pharmaceutical industry seems reluctant to support them. P10 reports a case:

Post-traumatic nightmares are extremely difficult to attack and treat. If you can control the nightmares, the patient would be more apt to get treatment [compliance]. To control the nightmares you can have counseling, cognitive behavioral therapy, and also pharmacotherapy. But medication was very expensive for that. I worked in a last resort hospital and I did a placebo-control double blind study with a cheap generic medication (Ciproheptadine). I asked for some founds from the pharmaceutical industry but they were not interested in that at all. They said that there is no patent pending for this medication. It is a generic product and can be made by any pharmaceutical company. So, we are no longer interested in it…and I did the study on my own.

In other circumstance, I wanted to compare Ciproheptadine with Topiramate, an expensive anticonvulsant medication I had used [off-label] for treating post-traumatic nightmares. This time they came to me and showed their interest and asked me to provide with them my experience and statistics on that because if

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proven, there would be millions of euros for them…It is obvious; Why would the company pay me to do a trial for a medication that other companies can also make and benefit? (P10)

As discussed before, research for developing new medications has been increasingly dominated by the industry. Psychiatrists are afraid of lack of enough independent evidence for prescribing new medications especially the very recent ones like Equasym® or Aripiprazol (Abilify®). For the old medication it is not only the research but also the very marketing efforts, which seem to be abandoned. P18 cannot even remember the last time he heard promotion for Diazepam [an old antianxiety medication]. “It must be 20 years ago” he says. Nonetheless, irrespective of whether their motivation to prescribe new medication is hope, fashion, or something else, psychiatrists need new drugs and yet often wait for the newer.

5.3 Summary of chapter five

In general, the uncertain efficacy of psychopharmaceuticals is an agreed upon issue. However, psychiatrists may seldom question drug efficacy when they see a certain medication is not working well. Psychiatrists believe that safety and newness are two important promotional messages for psychopharmaceuticals. The better-than-other’s promotional strategy magnifies the importance of side effects of the available choices and differentiates the new product. There is also a perceived overemphasis on side effects and a subsequent hypervigilance to certain side effects with a periodic shift to another medicine every now and then. This may influence psychiatrists’ prescription choices since it is potentially able to rearrange their pharmacological priorities. For brand-new products, the newer-is-better strategy is perceived to be more apparent. This process is also magnified by the psychiatrists as well as their distraught patients with their ongoing hope to pursue more efficacious medicines. For some psychiatrists prescribing new medicines resembles a fashion. Given the dominance of the industry in doing drug research, a great majority of respondents believe that the pharmaceutical industry is reluctant to study the old medicines for there are no longer patent or other financial incentives to economically justify sponsoring such research.
Chapter six

DISCUSSION AND CONCLUSION

When you study the use of medications, you will find a lot of irrationality in their marketing. (P26)

6.1 Psychiatry and promotion; from bio-psycho-social to bio-bio-bio model

Unlike somatic fields of medicine, the territory of psychiatry encompasses blurred boundaries between normality and abnormality, resulting from objectification of (often subjective) disorders of mind and behavior. The field of psychiatry has increasingly broadened its scope parallel to the consolidation of capitalism and technological advancements in the twentieth century (Moncrieff 1997). Simultaneously, neuroscientific and statistical rationality has dominated the epistemology of psychopathologies and has made medicines “central to modern psychiatric practice and to much psychiatric thought about the nature and causation of mental disorders” (Moncrieff 2003: 1). This ‘biological fundamentalism’, as Lakoff says (2005: 69), rigorously cuts off the causal chain of psychopathologies and ‘attributes’ them to the chemical imbalance in neurotransmitters in brain, which needs to be corrected by psychopharmaceuticals. This drug-centered hegemony best serves pharmaceutical promotion as an irrevocable part of the Neoliberal economy and politics (ibid.). So far as reduced psychopathology to neurotransmitters is concerned, treatment choices could be eliminated to pharmacotherapy. This idea is well popularized through pharmaceutical promotion.

The results of this study shed light on these processes and reveal that pharmaceutical promotion intertwines with biological psychiatry and they facilitate each other. In other words, the hegemony of biological psychiatry has provided a fertile ground to promote pharmacological solution for the ill psyche and vice versa (see figure 6).

14 Inspired by an article from John Read: http://www.critpsynet.freeuk.com/1005read.pdf
Figure 6. More than three decades ago, the promotion of modern biological psychiatry was illustrated in drug promotion. This is an advertisement for an antipsychotic in the American Journal of Psychiatry in 1976 (volume 133, issue2) published in two front pages.

6.2 Prescription behavior

This study provides a rather thick description of prescribing behavior for it reveals professionals’ perspectives on the appropriateness of prescription. Psychiatrists perceive rational prescription as cautiously taking ‘all’ aspects of prescription into account and constantly maintain a balance among them. The pillars of rational prescribing are:

- Need or indication: Need stresses the crucial first step in prescription which is often neglected; what is the purpose of prescribing medication? Whether the diagnosis is accurate and whether the medication is really needed.
- Drug efficacy and side effects: Although pharmaceutical industry might manipulate scientific evidence by “shaping the eventual massages conveyed by the articles”
Conclusion

(Sismondo 2007: e286), prescription should yet be based on the combination of evidence, personal experience, proper exchange with colleagues, and fine-tuning of dosage. Also having in mind that the efficacy and safety of most of the psychopharmaceuticals are dubious.

- Patient’s benefit: Compliance, preferences, culture, belief system, and socioeconomic status
- Drug cost: Reimbursement and availability of cheaper therapeutic options
- Ethical issues and professional codes

More importantly, rational prescription means acknowledging the fact that pharmaceutical promotion is able to touch all these ‘semantic domains’ and still being able to maintain balance and recognize where there is conflict of interest and where there is not. It is undoubtedly a difficult task and requires criticality and constant awareness, which is the most common theme of this study and stressed by all respondents. It implies a perpetual conscious process to unpack the influence of the industry, more probably appealed to the doctors’ unconscious. Psychiatrists have the knowledge and professional skill to bring these processes up to their conscious and meticulously investigate the sociopolitical construction of the influence. This self-vigilance and introspection requires psychoanalytic approach toward their selves and constantly interrogating one’s own prescribing patterns. In so doing, a slight paranoia, derived from vigilance, awareness, and knowledge toward their interaction with the industry, seems to be reasonable. Psychiatrists are supposed to be more aware than other fields of medicine because of their knowledge of mental processes of influence and the ability of excavating human’s psyche.

Irrational prescription, on the other hand, is generally believed to be more common among Dutch psychiatrists. It is the consequence of uncriticality and ‘believing in pharmaceutical industry’. It is perceived when there is over-reliance on the efficacy and safety of medicines and when prescription serves to medicate symptoms and adopt the notion of ‘quick fix’ in treating psychiatric illnesses. The question would then appear no longer as ‘is it bipolar disorder or schizophrenia?’ but as ‘is it a Lithium or an Olanzapine response profile?’ (Lakoff 2005: 174). Conflict of interest between the industry’s inevitable appetite of profitability and the psychiatrists’ pursuit of patients’ benefit is so pervasive that
Conclusion

adopting commercial rationality is perceived as an instance of irrationality in prescribing correlated with tremendous downgrading of professionalism. Moreover, those who conceptualize the conflict of interest as an absolute risk for their profession, exclude themselves from any potential positive influence such as communication, updating knowledge, being aware of the latest promotional strategies, etc. This, in itself, may be entitled as vulnerability – if not irrationality – in prescribing behavior. Irrational prescription notwithstanding, has negative influence in healthcare outcome, quality, and expenditure at collective level.

Prescription behavior varies significantly among psychiatrists. For the younger respondents such as residents, evidence is the most important and for more experienced psychiatrists, their own experience is given the top priority. Younger colleagues seem to be better trained to critically question their own prescription. Moreover, they haven’t developed their own ‘clinical folklore’ yet.

Child and adolescent psychiatrists tend to be more cautious and conservative toward medication. They all believe that medication is not the first step in treatment because there is less evidence for the effectiveness and safety of pharmacotherapy in children. They seem to be more cautious in pharmacotherapy than adult psychiatrists and, at the same time, perceive more redirecting influence from the (parents of) patients and (parents of) patients’ organizations.

Almost all psychiatrists believe that academic colleagues should be more critical. Nonacademic psychiatrists however believe that their academic colleagues are less critical than what they are supposed to be. Reciprocally, academicians believe that nonacademic colleagues are not critical enough probably due to the less access to scientific evidence.

Framing prescription behavior over time, psychiatrists believe that they are no longer conservative to prescribe pills compared with 10-15 years ago. This change reveals the effect of promotion and the availability of more choices nowadays, though most are blockbusters. As far as shifting from authority-based to evidence-based guidelines is concerned, psychiatrists see some changes in favor of more appropriate prescription. As
such, just very recently, they witness a collective determination toward prescribing more rationally. However, uncritical prescribers are still dominant among colleagues.

### 6.3 Promotional influence

Strained by the DTCA ban in the Netherlands, intense and diverse promotional strategies have been triggering physicians in order to differentiate certain products and to speed up adoption of promoted (new) medicines. Psychiatrists perceive the extent of the promotion beyond the very medications. Any interaction with the industry ranges from *artsenbezoekers’* direct promotion to subtle influence on the construction of evidence in scientific literature is seen as overt or covert channels of influence. Influence is believed as an irrevocable part of interaction and thus inevitable.

**Structure and agency**: Literature often argues physicians’ denial of being influenced by pharmaceutical promotion or even feeling insulted when they are pointed (Mansfield 2007). My respondents do not deny the influence and its probable negative consequences. What this anthropological study reveals is the sociopolitical structure of influence as well as the distinctive agencies expressed by those who perceive this inevitable hegemonic structure differently. In other words, within the context of dominant commercial identity of drug promotion and its inherent competing interest with the medical profession, this anthropological study reveals the distinctive ways of politicization of perceived influence of promotion when it is brought into the consciousness. Influence is thus given different agencies. Some psychiatrists prefer to stay away from all kinds of interactions with the industry. For them, being influenced can evoke an emotional reaction because it is a metaphor for irrational prescription or a metonym for jeopardizing their freedom of choice. Therefore, negative politicization is a response to maintain socio-professional values or a reaction to the perceived threatened professional authority. The constant switching between professionalism and emotionalism is evident in too many accounts.

Those who consider themselves liberal, have a less dramatized reaction to the influence. This group believes that psychiatrists can communicate and interact with the industry to keep their knowledge updated and develop drug research while acknowledging the commercial reality of promotion and inevitability of influence. Interaction with the
Conclusion

industry in their point of view does not threaten socio-professional values. The threat, they argue, is in being uncritically too in favor of or emotionally too against the industry.

As this study tries to show, criticality refers to constantly considering the semantics of awareness (of the influence). Awareness, to that end, means:

- Understanding the depth and the complexity of influence and relating prescribing patterns to higher cosmopolitan circuits of Neoliberal political/economic structures.
- Acknowledging the inevitability of influence even if hesitation to interact with the industry is preferred.
- Interrogating one’s self prescribing using a psychoanalytical approach to see the primary motivations (as opposed to secondary conscious ones) that shape prescribing decisions. This reflection, in turn, requires viewing prescribing behavior as really a behavior rather than a power or merely an excretion of physicians’ knowledge and experience.
- Sharply distinguishing the competing interest from parallel interest in the interactions with the industry.
- Drawing the cognitive boundaries of influence beyond the compelling forms of promotions, encompassing drug efficacy, safety and the overall construction of scientific evidence.
- Tracing channels and the effects of promotion over time.

To conclude, criticality and awareness are seen as the ‘weapon of psychiatrists for their everyday forms of resistance’ in their practice and in their interaction with the industry. Similar to what Tan argues, this study shows that psychiatrists’ prescription decision is “shaped by perceptions that are constantly in flux, quite often influenced, but not necessarily totally constrained, by macrostructures” (1999: 257). The promotional influence is thus conceptualized differently as contribution, challenge, or threat, which I have chosen for the title of this thesis as well.
6.4 Recommendations

As concluding remark, I itemize some suggestions, which may help to better interact with the industry:

- More comparative studies between the old and the new medications and systematic reviews are recommended.
- Stricter state control on the production of evidence in medical literature is suggested. For instance, research centers should be prohibited to let their industry-sponsored research results be drafted, edited, or mediated for publication by the industry. (Sismondo 2007)
- More educational courses and seminars are needed to enhance physicians’ awareness. How to deal with the pharmaceutical industry should also be included (or more stressed) in the educational curricula of medical students and residents in training.
- There should be an independent center to evaluate the literature’s methodology and translate the sophisticated methodologies to serve the routine needs of clinicians.
- While the industry influences physicians, they can also actively counter-influence the industry. They can ask for more decent promotion including more objective and clearer information.
- Oppositional views towards pharmaceutical industry may often be replaced with certain criticality to meticulously investigate channels of influence. Criticality in this sense should not be limited to merely overt influence like in congresses or in visiting *artsenbezoekers*.
- The influence should be openly negotiated among the colleagues (without excluding one’s self). Only in this way can the individual and collective insights be broadened.
- This relatively small scale study is unable to generalize findings. Therefore, larger scale studies encompassing more involved parties (especially health insurers and marketers) and on the other fields of medicine are recommended. A proper mix of qualitative and quantitative methodology is particularly recommended toward more thoroughly studying this topic in a multidisciplinary context.
ABSTRACT

Introduction: Drug promotion is a distinctive feature of the pharmaceutical industry. It represents a controversial scientific-commercial nature drawn from the dominance of biological psychiatry and the commercial reality of marketing. It interacts with medical profession and influences professionals’ with the likelihood of inappropriate prescription. Anthropological studies, in which the influence is contextualized, would enable us to navigate areas with little clarity in the available – mostly quantitative – literature.

Method: This study aims to qualitatively describe Dutch psychiatrists’ perceptions and opinions toward pharmaceutical promotion and its interaction with their practice. 26 psychiatrists, residents included, were selected on the basis of purposive sampling method and interviewed using an adjustable in-depth semi-structured interview technique. With assured confidentiality, the data was then analyzed embracing the main themes embedded in the respondents’ accounts in accordance with the critical theoretical perspective.

Findings: Drug promotion may influence prescription decision and its prioritization at personal, peer-related, patient-related, and pharmacological levels. Rational prescription is viewed as maintaining a proper combination of introspection, knowledge, and vigilance of the ‘why-ness’ of prescribing medicines based on the individual patient’s profile, perceived efficacy, safety, and drug cost. Criticality and constant awareness of the influence are thus crucial to rational prescribing, though is not the dominant feature among Dutch psychiatrists. The structural conflict of interest between drug industry and psychiatrists evokes different agencies. Conservatives conceptualize the influence as a potential threat to their practice and their professional authority, thus hesitate to interact with the industry. Liberals keep communication considering strict criticality and caution. Younger colleagues seem to be better trained to critically scrutinize their own prescribing behaviors. Child and adolescent psychiatrists tend to be more cautious toward pharmacotherapy. Academic psychiatrists are generally supposed to be particularly critical, though non-academicians are not that sure. Psychiatrists nowadays clearly prescribe pills more than 10-15 years ago and quite recently are moving toward prescribing medicines more properly. Channels of promotional influence are diverse, intense, and innovative, often appealing to their unconscious. Skepticism is pervasive to the objectivity of scientific evidence and literature as a result of the dominance of industry-sponsored drug trials. While psychopharmaceuticals are strongly dubious in efficacy, it is their claimed newness and fewer side effects that are central to their promotions.

Conclusion: Pharmaceutical promotion and its influence on medical profession will be demystified when we understand how its power is derived from the way it is implemented and perceived. Whether promotional influence is conceptualized as contribution, challenge, or threat, criticality is needed to prevent irrational consequences. As long as prescribing behavior is seen as really a ‘behavior’ and not merely an excretion of physicians’ knowledge and experience, it is open to constantly influence and being influenced.

Key words: Pharmaceutical industry, Pharmaceutical promotion, Prescribing behavior, Psychiatry, Medicines, Influence, Evidence, efficacy
ANNEXES

REFERENCES
LIST OF ABBREVIATIONS
CHARACTERISTICS OF RESPONDENTS
INTERVIEW TOPIC LIST
NOTES ON CLINICAL TRIALS
REFERENCES


LIST OF ABBREVIATIONS AND EXPRESSIONS

ADHD: Attention Deficit Hyperactivity Disorder
Artsenbezoekers: Drug company representatives
APA: American Psychiatric Association
CAP: Child and Adolescent Psychiatry
CATIE: Clinical Antipsychotic Trials in Intervention Effectiveness
DPD: Drug Promotion Database
DSM-IV: Diagnostic and Statistical Manual (of psychiatric disorders, version four)
DTCA: Direct-to-Consumer Advertisements
FDA: (US) Food and Drug Administration
IQ: Intelligent Quotient
Lilly: The short form of Eli Lily & Company, a big US-based pharmaceutical company
NVvP: Nederlandse Vereniging voor Psychiatrie (Dutch association of psychiatrists)
PTSD: Post-Traumatic Stress Disorder
R&D: Research and Development
SDB: Social Desirability Bias
SSRIs: Selective Serotonin Reuptake Inhibitors
STAR*D: Sequenced Treatment Alternatives to Relieve Depression
TCAs: Tricyclic Antidepressants
X: Any anonymized name
<table>
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<th>Respondents</th>
<th>Position</th>
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**LEGEND**

**Position:**
- **A:** Academic clinician
- **P:** Practicing psychiatrist
- **R:** Resident
- **S:** Senior/teaching professor

**Field of expertise:**
- **C:** Child and adolescence
- **CC:** Cross-cultural/refugees
- **E:** Emergency/acute
- **F:** Forensic
- **G:** General
- **M:** Mood disorders
- **Ps:** Psychotic disorders

*Including residency training period
© Including 15 years research experience in psychiatry
INTERVIEW TOPIC LIST

Introduction
- Aim of the study
- Privacy and anonymity
- Exploration and no judgment
- Ask for recording interview

Practice and experience
- Duration of practice
- Settings of practice

Ideas, opinions and experiences
- Factors influence prescription patterns
- Different channels of promotion they perceived or experienced
- Reaction to company representatives the last time they met
- Quality of promotion and information
- Conflict of interest
- Ideas about new medicines
- Factors that harm prescription
- Ideas about the case of Seroxat®

The situation over time
- How evaluate the current situation of promotion compared with the past
- Current and past situation of prescribing patterns at individual and collective level
- Change in prescription over time
- Change in professionalism
- Views about the ideal situation

Training and interest
- Ever read any material
- Ever had any training, conference, etc.
- Any writing, discussion with colleagues

Final issues
- Any advice for colleagues, authorities, drug companies, etc.
- Implications of this project
- Any comment for similar future research
- Any comment to my research
NOTES ON CLINICAL TRIALS


Pre-clinical studies: It involves in vitro (i.e., test tube or laboratory) studies and trials on animals.

Phase 0: It is a recent designation for exploratory, first-in-human trials to see whether the agent behaves in human subjects as was anticipated from preclinical studies.

Phase I: These trials are the first-stage of testing in human subjects, usually in a small (20-80) group of healthy volunteers. This phase includes trials designed to assess the safety (pharmacovigilance), tolerability, pharmacokinetics, and Pharmacodynamic of a therapy. These trials are almost always conducted in an inpatient clinic.

Phase II: Once the initial safety of the therapy has been confirmed in Phase I trials, Phase II trials are performed on larger groups (20-300) and are designed to assess the activity of the therapy, as well as to continue Phase I safety assessments in a larger group of volunteers and patients.

Phase III: Studies are randomized controlled trials on large patient groups (300–3,000 or more depending upon the condition) and are aimed at being the definitive assessment of the efficacy of the new therapy, in comparison with current 'Gold Standard' treatment. Phase III trials are the most expensive, time-consuming and difficult trials to design and run, especially in therapies for chronic conditions. Once a drug has proven satisfactory over Phase III trials, the trial results are usually combined into a large document containing a comprehensive description of the methods and results of human and animal studies, manufacturing procedures, formulation details, and shelf life. This collection of information makes up the "regulatory submission" that is provided for review to various regulatory authorities for marketing approval.

Phase IV: These trials involve the post-launch safety surveillance and ongoing technical support of a drug. Phase IV studies may be mandated by regulatory authorities or may be undertaken by the sponsoring company for competitive or other reasons (for example, the drug may not have been tested for interactions with other drugs, or on certain population groups such as pregnant women). Post-launch safety surveillance is designed to detect any rare or long-term adverse effects over a much larger patient population and timescale than was possible during the initial clinical trials.
2. Questions for critical appraisal of clinical trials (Elwood 1998)

Description of the evidence
- Study design
- Patient recruitment and evaluation
- End-point evaluation
- Statistical method

Internal validity
- Are the results likely to be affected by observation bias?
- Are the results likely to be affected by confounding?
- Are the results likely to be affected by chance variation?
- Is there a correct time relationship?
- Is there a dose-response relationship?
- Are the results consistent within the study?
- Is there any specificity within the study?

External validity (generalization of the results)
- Can the study results be applied to the eligible population?
- Can the study results be applied to the source population?
- Can the study results be applied to other relevant populations?

Comparison of these results with other evidence
- Are the results consistent with other evidence, particularly evidence from studies of similar or more powerful study design?
- Does the total evidence suggest any specificity?
- Are the results plausible in terms of biological mechanism?
- If a major effect is shown, is it coherent with the distribution of exposure and the outcome?
3. Seeding trials (Marsden 2005)

Hawthorne studies showed that whatever the researchers asked participants to discuss and trial resulted in an increase in productivity. The team of Harvard researchers, led by Elton Mayo realized that their results had nothing to do with what was being trialed and everything to do with running research trials. By singling out a small group of employees to participate in an exclusive trial, participants felt valued, special and important. The special attention they received gratified their ego and created a positive emotional bond with what they were trialing. The practical upshot was that the research trials effectively transformed the research participants into advocates for whatever it was they were trialing. A series of further trials found this phenomenon to be more or less systematic, and the research team coined the term ‘The Hawthorne Effect’ to describe the goodwill and advocacy that research trials generate among research participants.

It is this Hawthorne Effect harnessed by seeding trials that transforms opinion leaders into loyal adopters and powerful word of mouth advocates. By turning the opinion-leading target buyers into product or service evangelists using the Hawthorne Effect, a brand can create a powerful volunteer sales force.

The Hawthorne Effect: How to influence people

If the psychology of the Hawthorne Effect all seems a bit abstract, try it for yourself and see how powerful it is. The next time you want something from someone (a salary increase, a date or whatever), first do some ‘research’ with them by asking them for their advice on some matter. It doesn’t actually matter what it is that you ask them their advice on; the important thing is to be seen to be listening to what they have to say, and then to tell them that you appreciate their opinion. Then, when they have finished giving you their advice, simply ask them for whatever it is you want from them. The chances are that your ‘research’ will have triggered the Hawthorne Effect and you will get what you want. By asking them for their opinion you will have not only created goodwill but also flattered their ego, and at a subconscious level, they will feel indebted to you. This psychological indebtedness makes them significantly more likely to agree to whatever it is you are asking of them. By seeing the Hawthorne Effect in action, you’ll realize that it as a very powerful influence technique; you’ll also know to watch out the next time someone asks you for your advice and then asks you for something!