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Reconciling a “pleasant exchange” with evidence of information bias: A three-country study on pharmaceutical sales visits in primary care

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ABSTRACT

Objectives: To examine and compare the experiences and attitudes of primary care physicians in three different regulatory environments (United States, Canada, and France) towards interactions with pharmaceutical sales representatives, particularly their perspectives on safety information provision and self-reported influences on prescribing.

Methods: We recruited primary care physicians for 12 focus groups in Montreal, Sacramento, Toulouse and Vancouver. A thematic analysis of the interview data followed a five-stage framework analysis approach.

Results: Fifty-seven family physicians (19 women, 38 men) participated. Physicians expected a commercial bias and generally considered themselves to be immune from influence. They also appreciated the exchange and the information on new drugs. Across all sites, physicians expressed concern about missing harm information; however, attitudes to increased regulation of sales visits in France and the US were generally negative. A common solution to inadequate harm information was to seek further commercially sourced information. Physicians at all sites also expressed sensitivity to critiques from medical students and residents about promotional interactions.

Conclusions: Physicians have contradictory views on the inadequate harm information received from sales representatives, linked to their lack of awareness of the drugs' safety profiles. Commonly used strategies to mitigate information bias are unlikely to be effective. Alternate information sources to inform prescribing decisions, and changes in the way that physicians and sales representatives interact are needed.

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1. Introduction

Physicians need timely access to balanced, accurate and evidence-based drug information to inform prescribing decisions [1]. In a survey of physicians in the United States (US) in 2006–07,

most (76%) agreed that sales representatives are a valuable source of information, especially on new drugs [2]. Information provided by sales representatives is often selective, with inadequate mention of possible harm [1,3,4]. This situation may lead to suboptimal prescribing with potential negative consequences for patient health. There is research evidence that more frequent contacts with sales representatives are associated with increased drug costs and prescribing volume or poorer prescribing quality [5,6].

A previous prospective cohort study led by Mintzes examined the quality of information provided to primary care physicians by sales representatives in Canada (Vancouver and Montreal), the US (Sacramento), and France (Toulouse) [1]. In the three North American sites, physicians reported that sales representatives had

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failed to mention any harmful effects of promoted medicines in two-thirds of promotions. Recognized serious adverse effects were rarely mentioned, in only 5–6% of promotions, at all four sites. Despite the limited information on harm, physicians generally judged the scientific quality of the information to be *good* or *excellent* and indicated their readiness to start or increase prescribing the promoted drug.

Regulation of pharmaceutical sales visits differs between countries and spans approaches relying primarily on government regulation (the United States (US) and France) [7,8], co-regulation between industry and government or industry self-regulation (in Canada de jure the former but de facto the latter) [9,10]. Additionally, although the Food and Drug Administration's (FDA) Office of Prescription Drug Promotion oversees all promotional activities, only a subset of the submitted materials can be reviewed due to resource limitations [11]. The Canadian and French systems both require sales representatives to undergo accreditation, but in the US there is no formal requirement for this, although most employers offer in-house and product-specific training. In France, to encourage the appropriate use of medicine and reduce costs, the national Health Products Payment Committee (CEPS) has also co-signed a legally sanctioned contractual agreement with the pharmaceutical industry association (LEEM) referred to as the *Sales Visit Charter*, which governs sales visit activities and information provision [12].

The current qualitative study aimed to further investigate our previous prospective cohort study findings [1] through focus groups with primary care physicians. Focusing on primary care physicians is highly relevant since they are responsible for ongoing care of the leading chronic care conditions. Understanding how primary care physicians view visits and information provided by sales representatives is crucial if reforms are to be undertaken that are acceptable to doctors. We chose a qualitative approach in order to obtain nuanced and thorough responses about a variety of issues related to the interactions that would not be available through surveys or questionnaires. We explored physicians' experiences and attitudes towards the sales visit, and their reasons for seeing sales representatives. We asked their opinions on the key study findings, and especially the lack of mention of serious harm. We also probed the findings on stated likelihood to prescribe and on positive opinions of information quality. Finally, we examined differences and similarities in the opinions and attitudes of physicians in the three countries, given the differences in regulatory oversight of sales visits. We conclude with recommendations for reforming the way that doctors and sales representatives interact, and for alternative ways of informing doctors about best practices in using medicines.

2. Methods

We conducted 12 focus groups (three in each research site) in October and November 2012 with a purposive sample of physicians who had participated in the previous cohort study. We aimed for a variety of age and experience levels and for gender balance. In Vancouver and Sacramento, groups were conducted in English, and in Montreal and Toulouse, in French. Ethics approval was provided by the University of British Columbia Research Behavioural Research Ethics Board, the ethics committee at the CHU de Québec Research Centre, the Institutional Review Board at University of California-Davis, and the University of Victoria Human Research Ethics Board.

2.1. Physician recruitment

Personalized letters were sent to all physicians who had participated in the cohort study, followed up with phone calls, faxes, and emails. Refreshments were provided and participants were given

an honorarium equivalent to \$150 (CAN), to thank them for their participation.

2.1.1. Focus group data collection

Prior to the focus groups, the team developed, pilot tested, and revised a semi-structured interview guide to investigate: 1) Physicians' perceptions of sales representatives and reasons for seeing them; 2) their opinions of and responses to key study findings; and 3) their perceptions of the influence of interactions with sales representative on prescribing decisions. Pilot testing of the interview guide took place with a group of practising physicians and researchers based at the University of British Columbia.

In France, we also asked whether physicians' experiences had changed following restrictions on the sales visit introduced in 2005, and about repercussions of a recent, widely publicized drug safety scandal [13]. The interview guide is included in eTable 1 (in the Supplementary material).

Each group was 60–90 min in length. Two professional facilitators and the research coordinator, all with experience moderating focus groups, served as moderators (See eTable 2 in the Supplementary material). Groups were conducted in meeting rooms in universities, hospitals, and at one site in a hotel. Following introductions and signing of informed consent forms, the moderator asked participants to describe their most recent sales visit, and to comment on the benefits or negative aspects of seeing sales representatives. This question was intended as a "warm up" exercise to get participants to start thinking about a specific recent sales visit prior to the discussion. Participants were unaware of the findings of the aforementioned cohort study [1], as these had not been published at the time. Participants were then provided with summarized key study findings, including a list of the most frequently promoted medicines at their study site, and four site-specific charts, handed out one at a time (See eFigure 1 in the Supplementary material). The moderator posed open-ended questions on participants' opinions of these results.

Focal questions and prompts further explored physicians' assessment of information quality and what would prompt them to prescribe or not prescribe the promoted medicine. Moderators asked participants if they had any positive or negative comments/experiences and allowed equal time for positives and negatives. To keep the discussion open and the participants feeling they could share positive or negative comments freely, moderators took care to be neutral in their questioning. Moderators held debriefing sessions following each focus group to review the main themes, and to begin assessing the level of thematic saturation. Focus group discussions and debriefing sessions were audio recorded and transcribed verbatim by two professional transcribers (English and French). Transcriptions remained in the original language for analysis but quotes were translated into English for this article. We did not return transcripts to participants for comments; however, we provided time at the end of each group where the moderator summarized the discussion and gave participants the opportunity to clarify or add further comments.

2.1.2. Data analysis

We carried out a thematic analysis using the five-stage framework analytic approach: 1) data familiarization, 2) identifying a thematic framework, 3) indexing, 4) charting, and 5) mapping and interpretation [14]. A coding team of five researchers and assistants (including two whose first language was French) first cleaned, anonymized, and reviewed the transcripts to ensure consistency with audio recordings and to familiarize themselves with the data. With input from research team members, they jointly developed the thematic framework using an iterative process of review to identify recurring themes across and within group interviews. Two people reviewed each transcript independently, then the five team

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