

Peer Influence Conferences: *Employing the Power of Social Networks to Accelerate the Innovation-Decision Process*

Many pharmaceutical brand managers identify “peer influence” as a valuable marketing strategy. Unfortunately, because the term is poorly defined, a discussion of “peer influence” often yields more questions than answers. This report provides answers to several important questions: What pharma marketing challenges drive the need for a peer influence strategy? What is “peer influence,” and what makes it so powerful? What format elements are most likely to allow and encourage true peer influence? What types of products are best served by a peer influence strategy? By developing a thorough understanding of the power of peer influence conferences, the discerning pharmaceutical marketer will be better able to employ this unique marketing force.

21st Century Pharma Marketing Challenges

Marketing a prescription drug in the United States is a complicated and expensive process. According to IMS Health, pharma companies spent more than \$30 billion on U.S. promotion in 2004, eclipsing 2003 spending by more than \$5 billion.¹ Moreover, indicators suggest that the industry is destined to continue setting new spending records in years to come.

In their efforts to “out-promote” each other, drug marketers have compounded marketplace noise by continuously increasing spending on sales reps. But because of over saturation, that strategy may have finally encountered the law of diminishing returns. James Robinson of Healthbanks, Inc. laid out the hard facts regarding sales force oversupply:

- “Since 1995, the number of pharmaceutical reps has grown 94% to more than 90,000”
- “High-prescribing physicians receive three to five times as many calls from reps as they did 10 years ago”
- “Only 7% of rep visits with a prescriber lasted more than two minutes”²

Sadly, many physicians frequently view today’s pharma sales rep as little more than a sample delivery agent—another ineffective voice in a chorus of increasingly easy-to-ignore advertising messages.

As we approach the last half of the decade, the sales force bubble may be about to burst. Consider recent news stories:

- Eli Lilly and Company has implemented several sales force-related cost saving measures, including reorganizing the sales force, rebalancing territories, and closing all U.S. regional/district sales offices.³
- Pfizer announced in April 2005 the enactment of “modest” sales force headcount reductions. Although the announcement lacked specifics, Pfizer officials said the goal is to “pare the number of reps visiting physicians down to two per physician for each product.”⁴
- GlaxoSmithKline CEO Jean-Pierre Garnier surprised the industry by forecasting: “If they [Pfizer] cut their domestic sales force by 30%, then we are in a new era, because lots of companies will follow suit. In fact we already are—we’re launching five new drugs this year without increasing our sales force.”⁵

In addition to massive spending on sales reps—which accounts for the lion’s share of expenditures—drug marketers also work to impact prescribing habits using samples, journal advertising, conference exhibits, e-detailing, CME, promotional products, and other tools. As a result, it is estimated that the average physician is exposed to more than 500 commercial messages per day via journal ads, radio and television commercials, web banners, email spam, newsletters, brochures, etc. But how often does a physician actually *change*

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behavior as a result of the typical commercial message? Perhaps only once every several days—after receiving literally thousands of messages.

The Value of Peer Influence

On the other hand, how often does a physician act as a result of a recommendation made by a respected friend or knowledgeable expert? Research has found that a physician will enact a behavior suggested by a trustworthy colleague about once out of every three times. More than anything else, it is the social power of peers talking to peers that leads to adoption of new ideas. As renowned marketer and author, Paddy Lund, put it, “*Even those deaf to the bragging cries of the marketplace will listen to a friend.*” This is the value of peer influence. Peer influence is more credible than even the best salesperson. Peer influence breaks through marketplace clutter, in part, because it is more credible than marketplace clutter.

But increased credibility accounts for just a small part of the impact of peer influence. According to studies conducted by psychologist George Silverman, the most profound and important difference lies in understanding the two phases of the innovation-decision process. While traditional marketing activities are effective in the *Knowledge Phase* of the innovation-decision process (i.e. awareness and understanding), peer influence affects the *Verification Phase* (persuasion, decision, implementation, and confirmation).⁶ In other words, **peer influence helps non-prescribers move beyond information gathering, into verification.** When non-prescribers and reluctant prescribers hear and discuss the experiences of active prescribers, they vicariously gain product experience, giving them the confidence they need to begin active prescribing themselves.

Pharma marketers are increasingly recognizing the value of peer influence; the Wall Street Journal recently reported that in 2004, doctors acted as speakers in 237,000 pharma-sponsored meetings and talks, almost four times the number in 1998.⁷

Moderated Live Promotional Conferences

The tremendous power of peer influence is the driving force behind Arista Medical Conference’s flagship product—**moderated live promotional conferences (MLPCs)**. Through decades of experience, the Arista team has learned that MLPCs are a superbly effective way to harness the power of peer influence to move non-prescribers and reluctant prescribers into the verification phase of the innovation-decision process.

Although there are several variations on the MLPC model—four primary versions are presented below—all successful

MLPCs are carefully constructed using five key elements: Setting, Moderator, Influencer(s), Format, and Content.

Setting

“Setting” includes issues of group size, location, start-time, and duration. The best MLPCs occur in a setting where the participants are focused solely on the conference itself for at least 60 minutes.

- **Group Size:** The group size most conducive to peer influence is 10-15 participants. Meetings with fewer than 8 participants risk untoward gaps in discussion or an over-reliance on one willing discussant. Meetings with more than 15 participants can be verbally “crowded,” encouraging the less verbose participants to disengage from the conversation.
- **Location:** Meetings may be successfully conducted either onsite or via teleconference. Onsite conferences are particularly beneficial when a product demonstration is necessary, and are preferred by a subset of participants. Additionally, onsite meetings are quite effective when a local opinion leader can beneficially affect the behavior of early- and late-majority physicians. However, in many cases teleconferences are a more effective venue, for several reasons. First, teleconferences are easier to recruit for, since geographic proximity is unnecessary. Second, participants can’t see each other’s expressions, so they may be more open and less intimidated. Third, nationwide teleconferences provide a level of anonymity that fosters openness and a willingness to share and disagree. Fourth, unlike onsite meetings, teleconferences can be scheduled to start at a variety of times (see below), providing important scheduling flexibility. Finally, teleconferences are usually (but not always) less expensive than face-to-face conferences.
- **Start-time:** The three most common MLPC start-times—in order—are evening, lunchtime, and breakfast. The benefit of lunchtime and breakfast meetings is that they occur during or before the course of the workday, thereby allowing participants to immediately implement decisions that are made during the conference. The downside of lunchtime and breakfast meetings is that because they occur in or near work time, participant late-joiners and no-shows are higher, meetings must be shorter, and participants are often very distracted. Clearly, most physicians prefer to attend MLPCs that start between 6 PM and 10 PM local time.
- **Duration:** Teleconference MLPCs usually run 60 minutes; onsite MLPCs often run 90-120 minutes. Compare the power of 60-120 minutes of focused attention to Healthbanks’ study of the duration of the typical rep visit—“Only 7% of rep visits with a prescriber lasted more than two minutes.” This is part of the power of MLPCs.

Moderator

Successful MLPCs are led by an expert moderator who understands the dynamics of peer influence and is adept at leveraging the experiences of the influencers while maintaining an objective posture. The moderator must recognize that the purpose of peer influence is to help non-prescribers move beyond information gathering, into verification. When non-prescribers and reluctant prescribers hear and discuss the experiences of active prescribers, they vicariously gain product experience, giving them the confidence they need to begin active prescribing themselves.

Occasionally, product managers encourage MLPC moderators to take on an aggressive selling role in conferences. Decades of experience and thousands of programs have shown, however, that overly aggressive moderator advocacy is counter-productive, and actually hinders persuasion. Here's why:

- During an MLPC, the moderator is rightly considered by participants to be an agent of the sponsoring company; as such, comments by the moderator are viewed by participants as company-generated messages
- While company-generated messages are an efficient means of creating awareness and knowledge, they are not as effective in persuading an individual to adopt
- Instead, vicarious trial, via the experiences of colleagues, can substitute, at least in part, for personal experience
- More than anything else, it is the social power of peers talking to peers that leads to adoption of new ideas.

A recent unpublished trial proves the point. In a study that identifies the differential effect of moderator style, a large pharma company with a category-leading product reviewed the effectiveness of approximately 100 sessions of a single MLPC series conducted by a diverse moderator staff. The study measured differences in the post-conference prescribing of doctors who attended MLPCs led by highly assertive, sales-oriented moderators vs. those led by less assertive, attendee-oriented moderators. The study results indicated that the conferences most effective at changing physician prescribing were those led by moderators who were less focused on winning the argument, and more focused on generating peer-to-peer discussion in which users influenced non-users.

Moderating MLPCs requires a unique skill set (questioning, probing, deflecting, redirecting, rephrasing, timing, etc.) that is developed and honed over years of training and experience. As a result, moderators able to lead conferences that actually foster peer influence and drive prescribing are rare. Arista continuously scans the pool of pharmaceutical-industry moderators, recruiting and hiring only those with the professional skill set required to lead successful peer-to-peer conferences.

Influencer(s)

In order for true peer influence to occur, each MLPC must include at least one active prescriber who is able and willing to discuss his own real-world experiences. In a speaker-based meeting, the key influencer is the speaker (although peer influence is enhanced when other participants also relate their positive experiences). It should be noted that while *paid* speakers understand their role as influencers, other advocates are not paid, nor are they aware of their vital role as influencers in the MLPC. In non-speaker conferences, it is best to ensure the presence of two or three product advocates within a group of 10-12 participants. Typically, moderators learn of attendees' prescribing habits either through client-provided data or through in-meeting strategic questioning.

Format

Format is vital to the success of MLPCs. Format dictates the order of discussion, the interaction between moderator, participants, and speaker, and the series of questions that the moderator will pose in order to stimulate true peer influence.

Unfortunately, many so-called "peer influence" conferences are nothing more than didactic lectures followed by Q&A—a format typically marked by the regurgitation of marginally important data, but very little discussion and virtually no true peer influence.

On the other hand, conferences designed with a fully interactive format are far more likely to provide true peer influence. A flexible format allows the moderator to identify advocates, to uncover real objections and questions (bottlenecks to product use), and create a dynamic interactive environment that allows influencers to discuss their own experiences and their own progression from non-user to trial to user to advocate. As non-prescribers and reluctant prescribers hear and discuss the experiences of active prescribers, their questions are answered; they vicariously gain product experience, giving them the confidence they need to begin active prescribing themselves.

Content

Content refers to the printed/projected information provided for review during the MLPC. While high-quality content is important, what really makes the content valuable and memorable is the right setting, the right format, the right moderator, and the right influencer(s).

Because the content serves primarily as a discussion starter and as background support, it is often not necessary to create new and unique content for MLPCs. Rather, MLPC content usually consists of a single item of previously created and approved enduring materials, e.g. slides, product monographs, clinical reprints, and even product package inserts. In face-to-

face meetings the content is distributed or screen-projected; in teleconferences the content is hard-copy FedExed to participants or occasionally delivered via web.

For any particular program series, the choice of setting, content, format, etc. is based on the product lifecycle position, target audience, competitive situation, key messages, and budget. Arista has developed four foundational models of MLPCs as shown in the table below and explained in some detail below the table.

Table: Arista’s Moderated Live Promotional Conferences		
	Expert-to-Peer	Peer-to-Peer
Onsite Conference	Academic Interchange Symposium™ (AIS)	Clinicians’ Roundtable Symposium™ (CRS)
Telephone Conference	Academic Interchange Teleconference™ (AIT)	Clinicians’ Roundtable Teleconference™ (CRT)

AIS: Academic Interchange Symposium™

The Academic Interchange Symposium (AIS) is a live onsite conference convened in an academic or social venue. Each AIS is hosted by an onsite Arista moderator, and features a live presentation by an expert speaker (onsite or via telephone). The AIS normally supports an audience of 8-12 clinician participants, and is usually scheduled to span 90-120 minutes. Participants are often provided a meal and/or a practice-related gift voucher in accordance with AMA, OIG, and PhRMA guidelines. The moderator role is to 1) guide the discussion, 2) uncover bottleneck issues, 3) ensure that the speaker answers bottleneck issues and discusses his own product use and experience, and 4) identify additional product advocates and to draw out their prescribing experiences.

An interesting variant of the AIS is the Medical Center Briefing (MCB). In this venue, the target audience is the housestaff (residents and fellows) of a teaching hospital. MCBs are usually convened in or near the target institution.

AIT: Academic Interchange Teleconference™

The Academic Interchange Teleconference (AIT) is a live conference conducted via telephone. Each AIT is hosted by an Arista moderator, and features a live presentation by an expert speaker. The AIT normally supports an audience of 10-20

clinician participants, each joining the teleconference individually from his/her home or office. All participants receive supporting slides and prescribing information in hard copy or electronically. AITs vary in duration depending on program goals, but are usually scheduled for 60 minutes. Participants are typically provided a medically-relevant item in accordance with AMA, OIG, and PhRMA guidelines. The moderator role is to 1) guide the discussion, 2) uncover bottleneck issues, 3) ensure that the speaker answers bottleneck issues and discusses his own product use and experience, and 4) identify additional product advocates and to draw out their prescribing experiences.

An interesting variant of the AIT is the Academic Lunchtime Teleconference (ALT). In this 30-minute venue, client sales representatives across the country deliver lunch to their local participants’ offices, and each office’s entire clinical staff enjoys lunch (in lieu of a medically-relevant item) while engaging in the conference. To be sure, the ALT is a brief meeting consisting of a lecture followed by Q&A, and therefore has less true peer influence potential than the standard AIT. Nonetheless, the ability of an advocate user (the speaker) to openly discuss his product use—along with open Q&A—does have peer influence value beyond simple education, and therefore we consider the ALT to be a peer influence offering.

CRS: Clinicians’ Roundtable Symposium™

The Clinicians’ Roundtable Symposium (CRS) is a live onsite conference convened in an academic or social venue. Each CRS is hosted by an onsite Arista moderator. The CRS normally supports an audience of 8-12 clinician participants (of whom 2 or 3 are known advocates), and is usually scheduled to span 90-120 minutes. Participants are often provided a meal and/or a medically-relevant item in accordance with AMA, OIG, and PhRMA guidelines. The moderator role is to 1) guide the discussion, 2) uncover bottleneck issues, 3) identify product advocates willing to discuss their own product use and experience, and 4) create group discussion focused on answering key bottleneck issues.

CRT: Clinicians’ Roundtable Teleconference™

The Clinicians’ Roundtable Teleconference (CRT) is a live conference conducted via telephone or phone + web. Each CRT is hosted by an Arista moderator, and normally supports an audience of 8-12 clinician participants (of whom 2 or 3 are known advocates), each joining individually from his/her home or office. All participants receive supporting slides and prescribing information in hard copy or electronically. CRTs vary in duration depending on program goals, but are usually scheduled for 30, 45, or 60 minutes. Participants are usually provided a practice-related gift voucher. The moderator role is to 1) guide the discussion, 2) uncover bottleneck issues, 3) identify product advocates willing to discuss their own

product use and experience, and 4) create group discussion focused on answering key bottleneck issues.

Matching Peer Influence to Proper Brand Challenges

Peer influence has particular benefit in certain types of brand challenges, including:

New product in a high interest category

A new product in a high interest category is particularly well suited to the use of peer influence strategies. Specifically, investigators and national opinion leaders are able to verify the claims made by the marketers, giving participants the “OK” to begin trial and adoption.

New drug class

Although traditional marketing programs can support the *informational* phase of the action adoption sequence, most clinicians (except true innovators, which are few) still need to progress through the *verification* stage, especially for a drug in a new class. Verification comes through trial, and peer influence provides that trial vicariously.

Drug with a perceived high risk

The perceived risk can be discussed with peers to give it proper perspective. Also, by discussing collective observations, all participants share the risk.

Real but marginal improvements over competitors

Marginal improvements may seem unimportant at first glance, but hearing about others’ experiences can point out the clinical importance of those seemingly small differences.

Credibility questions

If clinicians have had suboptimal experience with the product, or if they don’t trust the evidence, independent peer influence may be the only way to reinitiate the verification phase.

Mature products with a new story

Again, peer influence may be the only way to get clinicians to “tune in” to a product that they already know about.

Peer influence conferences are valuable marketing tools in many, but not all, product situations. Ultimately, the appropriateness of MLPCs for any given brand challenge can only be determined within the context of an open discussion between the brand team and a trusted peer influence professional. Page 1 of this article includes contact information for Steve Crow, Director of Professional Communication at Arista Medical Conferences. Whether your question is small or large, Steve is available to discuss your questions and provide thoughtful answers.

Summary

Peer influence holds particular value for pharmaceutical marketers because it allows a non-prescriber the opportunity to gain experience with the product vicariously, speeding its evaluation and adoption. Arista has built its flagship programs on the power of peer influence, and is a leader in continuing to understand and employ this unique marketing force.

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