Marketing of Prescription Medicine

- a consumer perspective

Lotte Damsgaard
Mia B. Sølvsten
Signe Pedersen

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Group members:
Lotte Damsgaard
Mia B. Sølvsten
Signe Pedersen

Supervisor:
Bodil S. Blichfeldt
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Aalborg University
Institute for Culture and Global Studies
Fibigerstræde 2
9220 Aalborg Ø

Aalborg University

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Lotte Damsgaard

Mia B. Sølvsten

Signe Pedersen

Summary

The pharmaceutical companies' marketing of their prescription medicine is subject to heavy legislation and governmental intervention, especially in Denmark, where direct communication with end-consumers is illegal. So far the pharmaceutical companies' marketing effort has been mainly directed at health-care professionals, who have been expected to interpret health-information on behalf of their patients. However, in the past years the EU has suggested a more liberalized legislation to ensure the EU citizens' equal rights in receiving objective and correct information concerning benefits and risks of prescription medicine. In 2010 the EU Parliament approved the first edition of a proposal for a modification of the EU directive, which will allow the pharmaceutical companies to inform the public directly about prescription medicine – a practice, which has so far been illegal. If the EU-proposal becomes a reality, this will in a Danish context change the possibilities for the pharmaceutical companies to communicate with the public. In the wake of this proposal, the possible implications for end-consumers of such a change is publicly discussed and lines can be drawn to discussions in the US and New Zealand of the legal practice of direct-to-consumer advertising (DTCA). In the US much quantitative research has been done to contribute with a consumer perspective to the discussion. However, hardly any qualitative research has been conducted in order to understand consumers' attitudes in-depth and of our knowledge none such research has been conducted in a Danish context. We find it puzzling that the views of the end-consumers are not included in the debate concerning marketing aimed at the end-consumers coming from the pharmaceutical companies, since it revolves around and concerns them. Thus this thesis is explorative and aims at narrowing this knowledge gap in trying to understand the end-consumers' attitudes and the constructions hereof, toward this form of marketing including both DTCA and the proposal. In the wish of understanding this topic in a Danish context from a consumer perspective and understanding these end-consumers' attitudes in-depth, the methods applied were different types of qualitative interviewing. Preliminary explorative interviews were conducted with five US end-consumers, in order to sensitize researcher to the field, along with qualitative interviews with four Danish GPs who was included in order to provide a different angle on the topic and as they are also key persons in the end-consumers' consumption of prescription medicine. Three focus group interviews were carried out with 20 Danish informants in order to attain the wished insights into their attitudes and the construction of these.

Our findings suggest that the informants have predominantly negative attitudes toward the idea of DTCA, which seems to be linked to a variety of aspects such as the nature of medicine as a product, the possible influence of advertising and the GPs' role. Thus these attitudes are of great complexity in the sense that these informants' attitudes toward DTCA are anchored in

a range of related attitude-objects, whereby complex constructions underlie this direction of attitude. A likewise complexity also seems to be present in the construction of the informants' attitudes toward the proposal, as different aspects are also considered in forming these attitudes. However, the informants seem to be more equally divided between having positive and negative attitudes toward the proposal compared to DTCA, which seem to be connected to e.g. the media channel suggested in the proposal as well as a notion about whether the pharmaceutical companies can present objective information. Due to the complexity of these attitudes, to gain insight into these aspects as well as other interesting findings the reader must continue on in exploring these through this thesis.

List of Content

1 Problem area: *Active Ingredients of the Pill*

Complex, *challenging* and *controversial* are terms, which could be associated with the pharmaceutical industry in relation to both the nature of the industry and the marketing of the industry's products – in particular prescription medicine. In this regard the industry has been object for criticism as exemplified in the following quote:

> *"Of course it is important that the consumers can obtain the information they need. But it is problematic that it comes from the companies, which make a profit on it. Because they have only one objective with their marketing: to sell their products"*[1] (Forbrugerrådet 2008).

Thus, the pharmaceutical industry has been critiqued in relation to both their contact with the consumers, but also their relationship with physicians. *"The hidden economic bonds increase the distrust to the entire medicinal field. Physicians should only be obliged to attend to the patients' interests (…)"*[2] (Andersen 2010a:1). In this way, the practices of the pharmaceutical industry have been subject to criticism, but they have also been referred to with respect (Weber 2006:1; Dukes 2006:v-vi; Dougall & Straughan 2006:76). This possibly stems from the very nature of the industry, which can be seen as double-edged. On the one hand the pharmaceutical companies provide cures for life-threatening diseases e.g. vaccines for cancer (Hildebrandt 2009; fpn.dk 2011) and are trying to save and improve the lives of many people (Blackett & Harrison 2001:38; Hollon 1999:383). In this way the products in question might have a large effect on consumers' lives. Thus they are expected to display ethical responsibility (Nussbaum 2009:67). On the other hand they are for-profit businesses, which need to make a profit in order to keep up with the speed on the market of this industry due to e.g. the fast pace of patent expiry (Moss & Schuiling 2004a:55; Blackett & Harrison 2001:38/46; Moss & Schuiling 2004b:369-370/378). Thus the pharmaceutical companies have to ensure that they obtain adequate resources to keep on with the development of new products (Blackett & Harrison

[1] Own translation.
[2] Own translation.

2001:38; Moss 2007:316) in a market that has a high level of competitiveness (Moss & Schuiling 2004a:55-56). Therefore, like any other for-profit business, the pharmaceutical industry engages in marketing practices to sell their products and make a profit (Weber 2006:6-7).

Additionally, the pharmaceutical industry is also subject to heavy legislation and governmental intervention, which furthermore complicates the marketing of prescription medicine (Blackett & Harrison 2001:37). These restrictions and legislations differ between countries. The US and New Zealand have liberal approaches to pharmaceutical marketing as they allow direct-to-consumer advertising (DTCA) making it legal for the pharmaceutical companies to direct their marketing efforts directly at the consumers e.g. by using TV-advertisements (Mintzes 2001:i; Harker & Harker 2007:46; Thirstrup 2010:1). In the EU member states including Denmark, which is the context of interest in this thesis, the legislation is more rigorous (Forbrugerrådet 2009a; OJ 2001). For further elaboration see paragraph 2.1. This means that it is illegal to advertise and inform the general public about prescription medicine (Retsinformation 2005). Hence the pharmaceutical companies have promoted their products to health-care professionals, who are then expected to interpret drug information on behalf of their patients (Cunningham & Iyer 2005:412). The physician is therefore a sort of intermediary between the consumers and the pharmaceutical companies (Auton 2007:67; Hoek et al. 2004:222; Lundstrom & Wright 2005:323; Mintzes 2001:42; Pitt & Nel 2007:7; Beltramini 2006:341). However, even though it is illegal to market prescription medicine directly to the consumers, the pharmaceutical companies have found approaches, which can affect the consumers. These are e.g. providing information on websites about specific illnesses, which the pharmaceutical companies develop medicine for, developing patient friendly medicine and CSR-strategies (Andersen 2010b:4; Andersen 2010c:4; Moss & Shuiling 2004b:376; Nussbaum 2009:74; Strøm 2010:26-29). In past years, the EU has suggested a more liberalized legislation to ensure the EU citizens' equal rights in receiving objective and correct information concerning benefits and risks of medicine (European Commission 2008:3-5). In the fall of 2010, the EU Parliament approved the first edition of a proposal for a modification of the EU directive, which will allow the pharmaceutical industry to inform the public directly about medicine - a practice, which until now has been illegal (European Commission 2008:5; Andersen 2010b:4; Lif 2011a). As a member of the EU, Denmark has to follow the adopted EU-directives and thus the new proposal is likely to affect the future Danish legislation. In relation hetero, a discussion of the proposal will follow in paragraph 2.1. including e.g. whether information from the pharmaceutical industry can be viewed as marketing. This recent proposal to change the legislation in regard to the consumers has made us interested in this stakeholder group, and thus we narrow our focus to the consumers.

The proposal and the current practice of DTCA are debated in both Denmark and the US. The arguments for and against can in main points be seen below:

Opponents	Proponents
• Doctors being pressured to prescribe certain medicine (Cunningham & Iyer 2005:413; Hollon 1999:382-384; Kravitz et al. 2005:1999; Mintzes et al. 2002:279) • Consumers obtaining unnecessary medicine or less favourable medicine (Cunningham & Iyer 2005:412-413). • Lead to overconsumption of medicine (Andersen 2010b:4-5; Mintzes 2001:27) • Increases health concern among consumers (Andersen 2010b:4; Andersen 2010c:4; Forbrugerrådet 2009b). • Consumers will turn to GP more often, raising medical cost (Hollon 1999:383) • Oversimplifies complex issues (Kaphingst & Dejong 2004:143-144). • Confuses consumers as they will not fully comprehend it due to lack of knowledge (Kaphingst & Dejong 2004:143-144). • Pharmaceutical companies are not the right source for consumer education (Mintzes 1998:2).	• Will not lead to overmedication as GPs are intermediary (Andersen 2010b:5; Holmer 1999:381). • Educates consumers about new treatments and health conditions (Holmer 1999:380; Dubois 2003:99/101; Lif 2009; Lif 2011a). • Empowering consumers to make better health-care decisions for themselves (Holmer 1999:380-381). • Gives a better basis discussion with GP about own health (Holmer 1999:381) • Increase treatment for under-diagnosed conditions (Cunningham & Iyer 2005:412-413). • Consumers have the right to access information about their health (Andersen 2010b:4). • Pharmaceutical industry can provide the public with the best and newest knowledge about illnesses and medicine (Andersen 2010c:4).

Figure 1: Overview of arguments for and against marketing of prescription medicine (Own construction)

In a Danish context *The Danish Association of the Pharmaceutical Industry (Lif)*[3] is found to be a proponent of the EU-proposal, which might be expected as Lif has the objective of safe-guarding the interests of the pharmaceutical industry (Lif 2011b). Thus, advancing the possibilities of the industry. On the other side, opponents are e.g. the *Institute for Pharmacotherapy*[4], *The Consumer Council*, and *Danish Patients*[5] (Forbrugerrådet 2009b; Andersen 2010c:4), which are all organizations attending to the interests of consumers or patients (IRF 2010; Tænk 2011; Danske Patienter 2011). In this regard, one might find it interesting, that these abovementioned organizations have taken this particular stand, as both the arguments for and against seem to attend to the interests of the consumers or patients, it does not seem as though there is a clear-cut answer to whether or not marketing of prescription medicine to the consumers is beneficial as seen in the figure above.

[3] In Danish *Lægemiddelindustriforeningen*, abbreviated *Lif*, which it will henceforth be referred to as.
[4] *Institute for Pharmacotherapy* (Institut for Farmakoterapi) is a part of the *Danish Medicines Agency* (Lægemiddel-styrelsen).
[5] *Forbrugerrådet* and *Danske Patienter.*

In relation hereto the arguments presented above seem to be assumptions about the consumers' role in this practice, thus the arguments seem to be conveyed on behalf of the consumers. However, the consumers appear to be interested in their own health and information about it (Braus 1998:27; Harker & Harker 2007:46; Holmer 1999:380; Wolfe 2002:524). In this way, people appear to take a more active approach to their healthcare and want knowledge about the medical options (Wolfe 2002:524; Blackett & Harrison 2001:46; European Commission 2008:4). Consumers are among others using online resources to obtain the desired knowledge on diseases and pharmaceutical information in order to make treatment decisions and manage their health (Blackett & Harrison 2001:45; ManhattanResearch 2008:2-3). As an example, the website "Netdoktor" concerning general healthcare can be mentioned, which exists in many different European countries such as Denmark, Sweden, Germany, UK, and Spain.[6] In the US, examples could be www.webmd.com and www.medicinenet.com. Furthermore a vast amount of websites concerning specific health issues can be mentioned - among other websites created by pharmaceutical companies e.g. www.halsbrand.dk, www.kolesterol.dk and www.gigtogdig.dk.[7] In 2006, *Statistics Denmark* conducted a study of Danish citizens' use of IT, which showed 28 % had used the Internet within the last month to search for health information (Statistics Denmark 2006:37/51). This could indicate that health is an issue, which is present in the minds of the consumers, since over one fourth of the population has searched for health information within the last month. The cause of this behaviour could be several aspects. One explanation could be a tendency for people wanting to be in control and be perfect, which also includes the body (Andersen 2010b:4; Andersen 2010c:4; Rutsky 2005:71; Boye 2009:61). Furthermore health issues portrayed in the media might also be connected to the search-behaviour of the consumers. The consumers are exposed to health issues through various channels and forms including advertisements for Over-the-Counter (OTC) medicine, TV-programs concerning health. Examples could be the TV-programs "The Biggest Loser" (The Biggest Loser 2011), "Seeking a Diagnose"[8] (DR Sundhed 2011) and "Embarrassing Bodies" (Channel 4 2011). Furthermore public campaigns studying public health such as "KRAM-study"[9] could also affect the consumers' awareness about health issues. Hence it seems that the Danish consumers are involved in their own healthcare and the decisions concerning their body and health (Voss & Ravn 2007:2321). However, we are aware that the consumers' interest and the information published can be mutually influencing, thus in some cases in their interest in health might be sparked by published information, nevertheless it could also be interest in health that makes them interested in health information.

[6] www.netdoktor.dk, www.netdoktor.se, www.netdoktor.de, www.netdoctor.co.uk, and www.netdoctor.es

[7] These three websites concern heartburn, cholesterol and arthritis.

[8] In Danish "Diagnose søges"

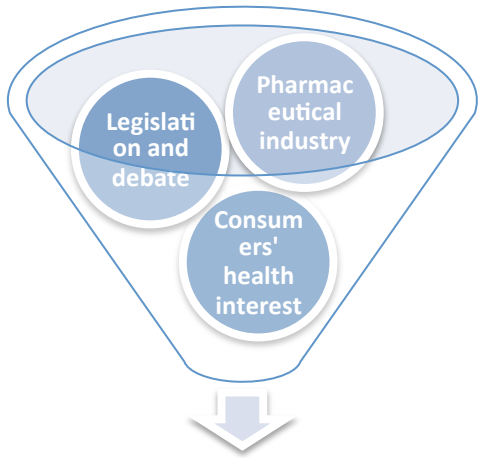
[9] In Danish "KRAM-undersøgelsen", which focuses on diet, smoking, alcohol, and exercise (KRAM 2011)

Though the consumers are involved and interested in their own health, the global debate concerning the pharmaceutical companies' direct information to the consumers often does not try to understand the consumers' viewpoints and attitudes in-depth, where the studies we have found through a review of the literature, have only addresses it from at quantitative perspective. We find it interesting and puzzling that the views of the consumers are not included in the debate concerning information aimed at the consumers coming from the pharmaceutical companies, since it revolves around and concerns them. Especially, when Danish consumers appear to be involved with their own health, it might be important to ask the consumers about what they think and not excluding them. Hence this thesis will focus on this knowledge gap by studying these issues from a qualitative point of view concentrating not just on the *how* but also on the *why* and thereby including the consumers' perspectives and attitudes (Lexchin 1999:276; Rehne & Møldrup 2008:32).

1.1. Problem Formulation

Though the above delineation, a narrowing of the field of interest has taken place by clarifying the three main areas of the field, which are seen in the figure below,

Figure 1: Focusing the field of interest (Own construction)



In this way, the insight into the nature of the pharmaceutical industry, the legislation and the appertaining debate as well as the consumers' focus on health issues will constitute the frame for the focus of this thesis. Consequently, this has led us to the following problem formulation:

> *We wish to understand the informants' attitudes and the constructions of these toward consumer-directed marketing of prescription medicine.*

The purpose of this thesis is to obtain an understanding of the informants', as Danish end-consumers, attitudes toward marketing of prescription medicine directed at the end-consumers from pharmaceutical companies. In the wish to understand these attitudes we more specifically will have a look at the informants' attitudes toward the abovementioned EU-proposal and the attitudes toward DTCA prescription medicine aimed. The first of these two perspectives has current relevance and could thus in the near future become a reality for the Danish end-consumers. The interest in the second perspective is connected to the notion that the proposal could be a step toward increasing liberalization in this legislative field as seen in an US context, which can be seen in paragraph 2.1. Thus the focus is on a context where the practice is non-existing due to legislative restrictions but also a context, which might be heading toward changing into being more liberalized in this field. Additionally, the Danish end-consumers could also be affected by DTCA due to globalization e.g. travelling and Internet use (Dens et al. 2008:58; European Commission 2008:4). It should be emphasized that the goal is not to understand Danish end-consumers in general but rather to explore the topic in a Danish context from a consumer perspective through the informants. For this preliminary exploration of the field the informants come from the Aalborg area, which will naturally affect the findings. However, we do not find that the limited geographic area as a hindrance in obtaining the wished preliminary insights. Thus, we wish to understand the informants', as end-consumers, attitudes toward the topic and moreover get insight into aspects that could affect these constructions. By interpreting the informants' subjective attitudes, we wish to get an understanding of the end-consumers' point of views. As indicated earlier, the focus on understanding end-consumers' attitudes in a qualitative manner seems to be an unutilized way of approaching this topic. Thus this thesis has an explorative nature (Arbnor & Bjerke 2009:89) in exploring what this field contains of issues (Hesse-Biber & Leavy 2011:163; Denzin 1978:40; Andersen 2008:22) and therefore the wish is to get an insight into the phenomenon in order to understand the informants' attitudes. Hence we have included a US consumer perspective through preliminary explorative interviews and interviews with Danish GPs as these insights could enable a deeper comprehension of the field. In this way, the constructed knowledge of this thesis could contribute to narrowing the knowledge gap in the field.

The increased knowledge of this field from this perspective might be of value to several audiences. First of all it provides a general contribution to the understanding of the topic by providing a different angel to the issue. Moreover, such knowledge might help giving the end-consumers a "voice" in the debate, whose perspectives have been neglected so far. Additionally, understanding the informants' attitudes might also give input to the legislation process on a political level (Arnould et al. 2005:15-16/21) as the legislation in question is founded in looking out for the interests of the end-consumers by giving them information, which could concern their health. Furthermore this knowledge could also function as market research, which

might be favourable for the pharmaceutical companies as it could contribute to bettering the communication aimed at the end-consumers (Moss & Schuiling 2004b:369; Wang et al. 2002:1143; Alwitt & Prabhaker 1992:31; Moore 1983:526; Mehta & Purvis 2000:5; Arnould et al. 2005:15-16/20; Kardes 2001:116; Singh & Smith 2005:377) in a future Danish scenario where more direct information toward the end-consumers, might be allowed. However, we do not aim at making recommendations for specific marketing initiatives. Rather we aspire to extent and deepen the knowledge of the end-consumers' attitudes and the underlying constructions of these, which might contribute to practical initiatives concerning their marketing communication. Lastly, this understanding might also contribute to the knowledge about this non-regular product in relation to marketing.

1.2. Terminology

The subsequent paragraph will elucidate the main concepts contained in problem formulation in order to clarify the understanding of concepts as used in this thesis. Furthermore, these clarifications will also function as a delimitation in regard to some of the concepts.

1.2.1. Attitudes

Attitudes are the centre of this thesis, as we are interested in more than the informants' way of perceiving the topic but are also interested in a more evaluative aspect, which attitudes entail. In this way, attitudes might be of greater importance in relation to composing of legislations as well as corporate communication and marketing, as people's attitudes might influence their behavioural intentions (Fishbein 1967:481-482), since attitudes are a way of taking a stand in relation to a given topic. Additionally, a review of previous studies and literature revealed a knowledge gap in terms of people's attitudes toward marketing of prescription medicine from a qualitative standpoint, which we aspire to try to reduce.

Defining attitudes will be done more thoroughly in our theory paragraph 5.2. concerning exactly this. However, we argue that attitudes can be seen as people's evaluations of a given object (Fishbein & Ajzen 1975:8/216; Petty & Cacioppo 1996:95; Thurstone 1931:263; Osgood et al. 1957:189). The evaluation can is both directional such as positive/negative (Kardes 2001:85; Katz & Stotland 1959:428; Petty et al. 1997:611; Ajzen & Fishbein 2000:3) and extreme such as little/much (Kardes 2001:85) and the object can be specific as well as abstract (Kardes 2001:85; McGuire 1985:239) e.g. a specific advertisement or advertising in general. Attitudes affect people's behavioural intentions (Fishbein 1967:481-482), which might lead to a given behaviour (Fishbein 1967:482; Doob 1947:143). The formation of attitudes can be effected by a range of aspects such as context (Argyriou & Melewar 2011:2; Feldman & Lynch 1988:422; Reed et al. 2002:375; Schwarz & Bohner 2001:3/5; Arnould et al. 2005:630), beliefs (Fishbein 1967:477; Ajzen & Fishbein 2000:1/12-13; Fishbein 1963:233), norms, values (Payne 1982:384; Tversky & Kahnemann 1974:1130), personal relevance (Limbu & Torres 2009:51;),

influence of other people (Schiffman & Kanuk 2004:253-267; Allport 1935:810-811; Howard & Gengler 2001:198) or media channels (Friman 2010:13; James & Kover 1992:81; Mehta & Purvis 1995:5; Mehta 2000:67/71; Mittal 2004:40) and experience (Allport 1935:819; Argyriou & Melewar 2011:6; Fazio et al. 1978:49/51; Reed et al. 2002:386; Schiffman & Kanuk 2004:267; Bagozzi et al. 1991; Fishbein & Ajzen 1975:10). In this way, attitudes can be viewed as constructions.

1.2.2. Marketing

As seen in Sargeant and Kotler & Keller marketing is a concept that is defined and understood in different ways (Sargeant 2009:33-34; Kotler & Keller 2009:45), most often with the common characteristic of meeting the needs of the customers profitably (Sargeant 2009:33/35; Kotler & Keller 2009:45/59). In this thesis a holistic approach to marketing will be implemented meaning that "everything matters" including the product and range of elements associated with the creation, delivery and consumption of it as well as all the ways that attention is brought to it, it is talked about and the relationships established with the consumers (Kotler & Keller 2009:59-60; Levitt 1960:50; Weber 2006:4). Even though the wide understanding is chosen, we will only, as mentioned, focus on DTCA of prescription medicine and the information provided by the pharmaceutical companies as suggested in the EU-proposal, however the holistic approach is chosen to include the provision of information, which will be discussed in paragraph 2.1. Thus when we the following write marketing of prescription medicine it is these two aspects we mean. Nevertheless, despite this focus and narrowed meaning for this thesis, other aspects of marketing such as CRS, websites about illnesses, developing patient friendly medicine (Andersen 2010b:4; Andersen 2010c:4; Moss & Shuilling 2004b:376; Nussbaum 2009:74; Strøm 2010:26-29) will not be fully disregarded as the informants might touch upon such other aspects and in this way these will be taken into consideration, that when using the term marketing of prescription medicine it is the two abovementioned aspects we mean.

1.2.2. Prescription Medicine

The general content of definitions of prescription medicine emphasizes that it is medicine, which can only be purchased, usually at the pharmacy, if the person has a prescription from a doctor or an equivalent health personal (medicinmedfornuft.dk 2011; IRF 2011; Merriam-webster.com 2011; Bihari 2008; medterms.com 2011). This consistency in content does however still make room for the possibility of great diversity between different types of medicine (Lunding 2011; pro.medicin.dk 2011). Some types of prescription medicine may only be needed once like antibiotics and other forms may need to be consumed consistently such as medicine for hypertension or diabetes. This diversity can also be seen as medicine in the Danish legislation is understood as a product, which is supplied to individuals in order to prevent, diagnose, alleviate, treat or cure an illness, symptoms, pain, or to affect bodily functions

(Retsinformation 2009; Retsinformation 2005). These diverse functions of medicine can refer to types of medicine, which have been further explained by IRF. The prevention function refers to medicine, which can prevent a break out of a disease including cholesterol-lowering medicine and birth-control pills in the sense that these prevent pregnancies. Painkillers can be a form of medicine, which have an alleviating purpose, whereas medicine toward depression and diabetes help treat a disease. Medicine, which can cure a disease, could be penicillin and medicine, which influences the bodily functions, could be contrast agents used in a medical examination (IRF 2011). Thus, these different functions of medicine, which is also applicable for prescription medicine, can have an influence on the use of the medicine. These might consequently affect on the end-consumers' attitudes toward marketing of diverse prescription medicine. Hence, we will take this diversity into consideration in the construction of knowledge as people's attitudes could be affected by the kind of prescription medicine they are thinking of.

1.2.3. End-Consumers

When deciding on how to term a group of people, whose attitude toward DTCA of prescription medicine we want to study, the most important distinction is the fact that they should be ordinary people of the general public – no matter whether they take or have taken prescription medicine regularly, irregularly or never. A vital part of defining this group is thus the fact that prescription medicine, as mentioned in the definition of this, are to treat a variety of diseases whether these are temporary or chronic, life threatening or daily irritation. Hence, using the term *patients* would not be appropriate as we argue that people do not need to be ill in order to be exposed to marketing from medical companies and/or have an attitude toward the concepts. The term *consumers* thus seem more fitting, as prescription medicine still is a product, which people need to go buy. Moreover, it has been argued that patients are turning into consumers due to DTCA of prescription medicine and their increasing involvement in their own health (Hollon 1999:384; Auton 2007:64). However, as GPs function as intermediaries in order for people to actually buy the product, and as the exact brand is highly dependent on the decision of the GP (Auton 2007:67; Hoek et al. 2004:222; Lundstrom & Wright 2005:323; Mintzes 2001:42; Pitt & Nel 2007:7; Beltramini 2006:341), we found the term *end-consumers* best fitting as GPs are also a sort of consumers as well in the sense that the pharmaceutical companies need to "persuade" these into choosing their products and brand as well, before these will reach the *end-consumers* (Auton 2007:67). In relation hereto, due to time and money constraints we have chosen to focus our efforts on end-consumers living in the Aalborg area. Thus, being aware give insights into the entire Danish population.

2 Context: *Preparing for Surgery*

2.1. Legislative Landscape

This paragraph will aim at illuminating the legislative conditions for the end-consumers surrounding marketing of prescription medicine. Such legislative contexts are important to clarify, as it is part of the context and life-world for the end-consumers. Thus this context could influence the end-consumers' attitudes and how they intent to act. Both the European and Danish context will be included as this is the main frame of reference. However, the American legislative context is also incorporated, as an understanding hereof is important in the wish to obtain a preliminary insight in to the phenomenon through explorative interviews. Furthermore, Danes might also be affected by what is happening in the US due to the globalization e.g. through the Internet, which transcend national boundaries and thus national legislations (European Commission 2008:4). The description will take its point of departure in a directive issued by the European Union (*EU*), as well as in an American context, which will be based on different articles treating the US legislation.[10]

2.1.1. The European and Danish Context

In 2001 the EU issued directive 2001/83/EC (OJ 2001), followed by minor changes in 2004 (OJ 2004a; OJ 2004b), in regards to creating a community code relating to medicinal products for human use, where advertising is an aspect that is dealt with (OJ 2001). This directive puts forward various guidelines (OJ 2001), which the individual EU countries have to implement on their own terms (EU-oplysningen 2010). One of the main aspects of the directive is that advertising directly to the general public is prohibited for prescription medicinal products (OJ 2001:92; Bendall & Hodges 1993:402). In this case the directive defines advertising as *"(…) any form of door-to-door information, canvassing activity or inducement designed to promote the prescription, supply, sale or consumption of medicinal products (…)"* (OJ 2001:91). The directive additionally clarifies that advertising does not include labelling and patient information leaf-

[10] We have chosen to focus on articles treating the US legislation – firstly, as this is not our main focus and secondly as the US legislation is rather comprehensive (Hutt 1993:565).

lets, concrete information concerning e.g. pack changes, warning of sides effects, trade catalogues and price lists, as long as it does not contain information about the medicinal products, and finally information concerning health and diseases, provided that there are no direct or indirect references to medicinal products (OJ 2001:92; OJ 2004b:51; Bendall & Hodges 1993:402). Additionally, information from the pharmaceutical industry to the public, about prescription medicinal products is currently only allowed through public campaigns regarding health and diseases in Denmark (Forbrugerrådet 2009b). However, direct advertising to the public for over-the-counter medicine (*OTC*) has currently been allowed since 2003 (Forbrugerrådet 2009b; Lif 2011a; Egekvist 2008). This means that even though direct information and advertising toward the end-consumers for prescription medicine is not allowed, the Danish end-consumers are still used to some communication coming from the pharmaceutical industry. As a result of this EU directive a Danish law concerning medicinal products was issued in 2005. Most important for the topic of this thesis, is the ban on public advertising for prescription medicine (Retsinformation 2005).

2.1.1.1. The Proposal

In 2008 the EU issued a proposal concerning a modification of the abovementioned directive in which the main focus was to harmonise rules about information given to end-consumers in the EU countries. The background of this proposal was thus founded in information about prescription medicine differing to a great extent in the various EU countries in terms of quality, amount and access (European Commission 2008:4), which thus indicates that the member states interpret and implement the directive differently, as mentioned earlier. The proposal should enable end-consumers to receive objective information from reliable sources, where physicians should still be the primary source of information (European Commission 2008:4). Furthermore, the European Commission proposed that the pharmaceutical industry should be allowed to give such information (European Commission 2008:4-5). However, this dissemination of information should not be allowed using through TV and radio, as this information should not be mistaken for advertising. Moreover, information through these channels does not protect the consumers against unsolicited information. Instead the consumers should actively seek this information, through the Internet (European Parliament 2011a). As DTCA would still be banned, another part of this proposal concerned the need for a clear distinction between information and advertising in order to ensure that the pharmaceutical industry would not try to use such information for advertising purposes (European Commission 2008:5). The European Commission put the following criteria for the quality of such information forward:

> "*All information provided to citizens should fulfil specific criteria concerning the quality of the information. The information provided should be objective and unbiased, patient-oriented, evidence-based, up-to-date, accessible, transparent, relevant and consistent*

with approved information." (European Commission 2008:7).

As such, this quotation thus could illustrate an implicit notion concerning citizens having the right to receive objective and correct information about medicinal products as this concerns their life and health. Furthermore, this proposal is a way of controlling the pharmaceutical companies' possibilities of communicating with the end-consumers. However, one could wonder whether information coming from the pharmaceutical companies could be objective and unbiased as information coming from companies can be seen as strategic, meaning that the communication is planned and often have an objective (Christensen 2010:28; Danske Patienter 2009:2). Thus this information from the pharmaceutical companies might be formed in order to e.g. strengthen position, advance their interests (Christensen 2010:28) or in order to get other people to act in a certain way (Nielsen 2010:15) e.g. buying a product (Christensen 2010:28) and therefore information might as well be used for marketing purposes. In this regard it has been argued that the purpose of marketing is e.g. to inform people (Beltramini 2006:334). Exactly this notion is what the practice of *content marketing* is based on, namely as this concerns delivering information needed to know by consumers in a relevant way (Pulizzi & Barrett 2009:xvii). Hence, one could assume that the pharmaceutical companies use every possibility within the legislation to market themselves, as noted in the following quote: *"Companies market their products through all the ways in which they bring attention to their products, all the ways they spread the word about the benefits of their products, and all the ways that they establish relationships (...)"* (Weber 2006:4). Thus, we argue that providing information can also be seen as a form of marketing, which could make it difficult to distinguish between these two. Hence such a distinction might not function sufficiently as a safeguard in securing that the pharmaceutical industry will not violate the legislation (European Commission 2008:6-9; Bendall & Hodges 1993:401). In 2010 the EU Parliament approved the first edition of this proposal (European Parliament 2010b).

2.1.1.2. The Danish Debate

As mentioned this proposal caused a debate in Denmark. On one side was Lif, arguing that TV and radio spots would not be preferable as they do not wish DTCA to be allowed, as there is a big difference between when the consumers are being exposed to DTCA and when they seek information themselves through e.g. the Internet (Andersen 2010b:4; Toustrup 2008:8; Lif 2009; Lif 2011a). However, they also argue that well-informed patients could lead to better treatments by creating a better dialogue with the GPs (Toustrup 2008:10; Lif 2011a). Moreover Lif argues that end-consumers have the right to receive objective and reliable information and since this group is better informed than ever, the pharmaceutical industry might be a good source for this, as this industry through research already has comprehensive knowledge about medicinal products, which might as well benefit the end-consumers (Lif 2009; Lif 2011a). As mentioned earlier, as Lif is an organization attending to the pharmaceutical indus-

try, one might find their stance obvious, as this is a for-profit industry meaning that it would probably be preferable to be able to advertise directly to the end-consumers in order to make more profit. However, by stating that they do not wish such information through TV and radio spots, Lif might want to express their ethical responsibility and thus come across as politically correct. Opposite, *The Consumer Council* argues that this will give the pharmaceutical industry an opportunity to market their products illegally, under the cover of it being information, which is problematic as it can be hard to monitor. Moreover it might lead end-consumers to use medicinal products that they do not need. *Denmark's Apothecary* agrees and adds that the information send from the pharmaceutical industry would not be objective, but rather unilateral (Toustrup 2008:8-10; Huset Markedsføring 2009), which is in line with our argumentation above.

To sum up, the Danish (and European) context in regards to marketing of prescription medicine is in a state of possibly changing into a more liberalized situation, where the pharmaceutical companies might be allowed to contact the end-consumers directly. Moreover, this could be an indicator of a future Danish scenario where the relationship between the pharmaceutical industry and the end-consumers becomes closer as the more contact from the industry to the end-consumers is allowed. Thus it is relevant to study the end-consumers' attitudes toward this practice, which is focal point of this thesis.

2.1.2. American Context

In the US, DTCA of prescription medicine has never been illegal and the first public advertising concerning pharmaceutical products was launched in the early 1980's (Mintzes 2001:6; Masson 1991:159). These were required to include a considerable amount of information about the product (Palumbo & Mullins 2002:423; Mintzes 2001:9; Hutt 1993:590). DTCA of prescription medicine can be defined as "*(...) any paid form of non-personal communication of prescription medicines by manufacturers and distributors, the effect of which is to induce the prescription, supply, purchase and/or use of those prescription medicines."* (Harker & Harker 2007:76). Thus through the use of DTCA the pharmaceutical companies can promote themselves and their products. In this regard the US legislation states that the advertising cannot have false and misleading claims and must provide a fair balance of risk and benefit information (Mintzes 2001:6; Cunningham & Iyer 2005:415; FDA 1999:1-2). In the 1997 *The U.S. Food and Drug Administration* (FDA)[11] started a trial run where DTCA concerning prescription medicine were allowed without including a complete list of risks as long as "*adequate provision*" was made for the end-consumer to receive complete information elsewhere, making the pharmaceutical marketers more inclined to use broadcast media (Cunningham & Iyer 2005:415; Baylor-Henry & Drezin 1998:92; Mintzes 2001:9; Hutt 1993:590; FDA 1999:1-2). As

[11] FDA is a part of the U.S. Department of Health & Human Services (FDA 2011).

information was increasingly given directly to the end-consumers posing a risk of a weaker physician-patient relationship, the US law today states that instructions and warnings should also be given to physicians, as these might be able to reduce risks posed by medicinal products (Cunningham & Iyer 2005:413-414; Hutt 1993:590). Hence, the GP is still seen as a key person in the use of DTCA in the US.

In summary, DTCA has never been banned in the US and has for the last approximately 14 years been used on broadcast media and through the years the expenditures on DTCA have grown to a large extent (Palumbo & Mullins 2002:423; Handlin et al. 2003:227-228; Gould & Friedman 2007:101; Auton 2004:17).

3

Methodology: *Spinal Cord*

3.1 Philosophy of Science – The DNA

DNA is the foundation for every cell in the body and the same can be said for philosophy of science when conducting scientific research. In this paragraph we will clarify our DNA, the underlying assumptions and pre-understandings for the way we comprehend the world. The aspiration of this thesis is to generate knowledge about the Danish end-consumers' attitudes and their underlying constructions toward marketing about prescription medicine coming from pharmaceutical companies. To produce this knowledge we will discuss these underlying assumptions, as the way we perceive reality and our outlook on what is acceptable knowledge, will influence the process of creating knowledge and the conclusions we reach.

The field of philosophy of science is concerned with questions concerning the nature of the entities studied, how these should be studied and what is acceptable knowledge – thus the premise for scientific research and knowledge (Gilje & Grimen 2002:16-17). In this regard Guba distinguishes between four paradigms, which are different approaches to conducting scientific inquiries. Guba understands paradigms as: *"(…) a basic set of beliefs that guides action, whether of the everyday garden variety or action taken in connection with a disciplined inquiry."* (Guba 1990:17). As basic beliefs guide action, which in our case is a disciplined inquiry, this means that the assumptions included in the basic beliefs will affect each aspect of this thesis. Hence the choices and decisions we make e.g. concerning methods and theory will be founded in these basic beliefs, which will permeate every step of our inquiry. As we are interested in the end-consumers' attitudes and the underlying constructions of these we adhere to the paradigm of *Constructivism* of the four paradigms that Guba sets forth in regards to disciplined inquiry (Guba 1990:18/27) due to our basic beliefs on ontology, epistemology and methodology, which according to Guba are the aspects that forms a paradigm. To return shortly to Guba's definition of a paradigm, this could be said to in some way be constructivist in itself as the assumption behind the definition is that basic beliefs guide action. This assumption might not be completely accepted by positivists as they adhere to a realist ontology thus

wanting to know how things really are independent from one's own mind (Guba 1990:19). In having an objectivist epistemology, thus wanting to obtain objective knowledge about reality *out-there* (Polkinghorne 1989:15/22), then they might not agree that the knowledge they obtain is framed by the researchers own basic beliefs. Thus Guba's definition of paradigm fits with the ideas of constructivism, which he also adhere to himself (Guba 1990:17).

We will now in turn clarify our constructivist stand on the three categorizations of ontology, epistemology and methodology (Guba 1990:18).

3.1.1. Ontology

Taking a closer look at our constructivist ontology, social "reality" does not exist as a fixed entity with a "true" nature. Instead several realities exist as individuals construct their own reality in their minds. This means that objectivity is not in focus, as individuals have their own subjective experiences of reality, out of which one is not more valid than other (Guba 1990:27; Kvale 1989a:76; Hirschman 1986:238; Collin 1997: first page; Polkinghorne 1989:15). Hence we hold, like central in constructivist positions, a relativist position (Guba 1990:27). As we are interested in the end-consumers' subjective constructions of attitudes in the context of the marketing on prescription medicine, then we agree that an absolute truth about the attitudes of the Danish end-consumers in relation to this topic does not exist due to the end-consumers' subjective construction of reality. Adhering to this ontological stance, the knowledge is thus not created focused on absolute truth since we wish to increase our knowledge about the end-consumers' constructions and interpretations. Furthermore the knowledge we produce should not be viewed to be more valid than other constructions in the sense that it is our construction of a specific part of reality, which we will return to later in this paragraph.

Furthermore the multiple constructed realities are affected by the end-consumers' life experiences and the context of the individual, including both the societal and the immediate local context. Thus individual knowledge and the realities are produced from a specific social and historical standpoint (Guba 1990:27; Delanty 2005:138/140; Wenneberg 2000:23; Berger & Luckmann 1999:15; Bo 2008:55). Moreover, this ontological perspective proposes that the Danish end-consumers' attitudes toward direct-to-consumer marketing on prescription medicine are based on the individual end-consumer's life experiences and their context. As a consequence, the end-consumers' attitudes is likely to be affected by their knowledge and a societal context - thus whether it is legal to market prescription medicine to the end-consumers or not, could affect their attitudes toward this subject. The attitudes formed by the end-consumers in respectively US and Denmark could thus differ due to the varying legislation, as the context of their subjective reality constructions diverge. Hence their attitudes should be understood in relation to this context.

As indicated above, social context affects the constructions of realities, which means that subjectivity and sociality is connected. People experience and construct reality in interaction with other human beings in their context, which forms their social reality (Overgaard & Zahavi 2009:93/96; Berger & Luckmann 1999:79). Thus the meanings created by individuals are not just subjective but are inscribed in a social world. The creation of reality is hence founded on inter-subjective understandings as well as contextual and cultural meaning systems (Bo 2008:65; Schwandt 2001:134-135; Taylor 1971:57). In practice, this ontological point of view means that the end-consumers' attitudes and constructions of reality are never completely independent from the social world, which they are a part of and in which they interact. Furthermore, it is posed by Schutz that people make use of typifications, which is a form of immediate know-how in understanding and interacting with the social world. These are more or less general "types" and common understanding of such types, such as flowers, shops, doctors etc. However, these typifications are open to be changed by subjective experiences (Overgaard & Zahavi 2009:102-103; Schutz 1970:116-117). This potential for change is founded in the notion that the subjective constructions of reality and social phenomena are not stable, but is being continuously constructed by the individuals (Bo 2008:30/62; Wenneberg 2000:87; Delanty 2005:145; Hirschman 1986:238). Thus the Danish end-consumers are likely to share some inter-subjective understandings due to similarities in their social context, which could include general understandings of prescription medicine. These general understandings make it possible to interact. However, their attitudes might still differ and be varied due to individual experiences. Additionally, the inter-subjective understandings might also develop in the course of an interview between the researcher and the interviewee and if it is a focus group interview then perhaps also with the other informants as meaning is created in a dialogue (Kvale 1997:54-55; Schwandt 2002:195). This process will be further reflected on in paragraphs 4.2. and 4.5. Hence this inquiry is a construction based on the social interactions taking place during the interviews, meaning that knowledge is constructed (Hirschman 1986:238; Kvale 1997:41). This is closely related to our way of understanding communication, which belongs to the interaction paradigm, which argues that meaning is constructed in the interaction of communication (Frandsen et al. 1997:36). In this way, the receivers actively interpret the communication directed at them in relation to their context (Frandsen et al. 1997:36/40-41; Schramm 1963:7-11), and hereafter the receiver will "send" feedback to the sender (Schramm 1963:13-14). Hereby communication is a dynamic process where information and meaning is mutually exchanged and created (Frandsen et al. 1997:36/40-41).

3.1.2. Epistemology

Another aspect of our paradigmatic stance is epistemology. Epistemology concerns assumptions about knowledge building and what is seen as acceptable knowledge (Langergaard et al. 2006:76; Bryman 2004:11; Hesse-Biber & Leavy 2011:38). In this regard, the nature of the

relationship between the inquirer and the entity of interest becomes important (Guba 1990:18). In adhering to constructivism, subjectivity is a fundamental prerequisite. As the entity of interest is individuals' subjective constructions of reality, the way to access these for the researcher is to interact with the informants (Guba 1990:26-27; Hirschman 1986:238/240). The knowledge created is thus a construction from the interaction between the inquirer and the inquired, which means that the researcher(s) will then undoubtedly affect the knowledge construction (Kvale 1997:45-46; Guba 1990:27; Hirschman 1986:238; Bo 2002:70). This collaborative process of constructing meaning is connected to the ideas of the hermeneutic spiral, meaning that it is a continuous process of moving back and forth between our pre-understandings and the new acquired knowledge (Kvale 1997:57-58; Gilje & Grimen 2002:178; Blichfeldt & Heldbjerg 2011:4; Giddens 1976:144-145). This process will also be present in our thesis as a result of our epistemological stance. Our pre-understandings of this field of attitudes toward marketing of prescription medicine are going to be revised when the knowledge of the field increases as the creation of knowledge is a forthcoming process in collaboration between the researcher and the inquired. One example of this process could be changing the interview guide between interviews, if one interview has lead to new knowledge, which is interesting to follow up on in the next interview.

As knowledge is dependent on subjectivity according to constructivism, then scientific knowledge has the same criteria. Hence researchers have their own constructions of reality, which also exist in the interaction with the informants. The researcher's construction of reality includes e.g. the mental framework founded in theory, which affect the knowledge construction (Guba 1990:25). Hence we are confined by our specific outlook on reality, which affects the knowledge we produce. In regard to our thesis, this means that the constructed knowledge will have a specific outlook on reality in relation to the topic e.g. it is present in the choice of theory, which affects this construction. Furthermore the final thesis will also be shaped by the following of the agreed-upon procedures, which surrounds the paradigmatic stance and qualitative research (Salner 1989:52/55). We also recognize that we ourselves are social actors, and thus we are affected by our context and individual experiences, which will inevitable, be a factor in the knowledge construction and interaction with the end-consumers. However, we will try to be aware of our pre-understandings and what impact it might have on the construction of knowledge, as we are interested in knowledge of the end-consumers' attitudes.

In continuation hereof, Guba argues that in such a knowledge construction process, the *"(…) inquirer and inquired (…) are fused into a single (monistic) entity."* (Guba 1990:27). Guba's claim that the inquirer will fuse into a single monistic entity with the inquired, however seems a bit bombastic. We agree that a constructivist knowledge creation entails a collaborative construction of knowledge with the inquired, but the degree of involvement with the inquired

might not always go so far as indicated by Guba. For instance, in our case where the relations with our informants lasts for a limited time, we believe that there will still be a distance between inquirer and inquired, although a sort of relation is tried established before and during interviews with the informants in order to make them feel comfortable and in order to understand and come close to their constructions. A "fusion", in Guba's terms, will not take place in regard to our thesis. Nevertheless, we are aware that meaning and understanding will be constructed in a dialogue between us and the informants (Salner 1989:62), as we as researchers need to interact with the informants in order to get access and insight into their subjective constructions of reality. Thus, our pre-understandings will affect the interaction with the informants as they are a prerequisite, also when it comes to the interpretation of informants' constructions, but we will try to be aware and reflexive about the role of these understandings and values (Schwandt 2002:195; Bryman 2004:22; Gilje & Grimen 2002:262). Being mindful of our biases and values is also an aspiration as it is a way of trying to enhance the *credibility* of this thesis, as it is part of the *prolonged engagement* technique (Lincoln & Guba 1985:302-303), which be presented later on. However, the purpose is not to be fused into an entity with the informants in Guba's terms. The aim by including ourselves and participating in the dialogue is instead to come close to the informants to attain knowledge about the informants' attitudes and constructions of reality in relation to direct-to-consumer marketing on prescription medicine coming from the pharmaceutical companies. This means that *"(…) the goal is to understand the phenomenon in its own terms (…)"* (Hirschman 1986:241). Hence the aim is always to understand the informants, but we need to use ourselves as researchers in order to get an insight into the subjective meanings. This also means that the knowledge we aim at producing is knowledge grounded in the informants' constructions and realities, but we acknowledge that we by choice of e.g. theory creates a framework for understanding these realities.

In posing that the knowledge produced in a collaboration between the inquirer and the inquired, the distinction between ontology and epistemology is difficult to sustain as what can be known and the researcher who are to know it are intertwined (Guba 1990:26-27). This means that when the subject matter is individuals with their own subjective constructions, knowledge also become constructed. However, it does not mean that we are radical constructivist, as we also think that a physical world exists independently of our constructions of it, but the knowledge of this world is an interplay between the researcher and the physical world in itself (Wenneberg 2000:97/137/142). As we are interested in the individuals' attitudes, the knowledge of these will be a construction due to the process of the inquiry.

3.1.3. Methodology

Lastly, the question of methodology is considered, which concerns how the researcher should attain knowledge (Guba 1990:18). In constructivism this focuses on the ways in which the

researcher should identify individuals' constructions aiming to create as informed and sophisticated constructions as possible. This process includes the emphasis of portraying the informants' constructions accurately and hereafter to compare these in order to reach more sophisticated constructions (Guba 1990:27-28). This means that we aim to get an as accurately insight into the different end-consumers' attitudes of marketing of prescription medicine as possible, in order to compare and contrast them to reach constructions of a more generic character. The knowledge we produce is constructions, which hold the subjective constructions of the individual end-consumers, framed by our theoretical point of view. What Guba here puts forth about reaching sophisticated constructions, can be connected to the terms *empathy* and *intuition* that Hirschman uses. The former is required to by the researcher in order to learn and understand the informants' constructions of reality. The latter is used when interpreting these understandings, which results in a more sophisticated construction, possibly aimed at another audience e.g. other researchers (Hirschman 1986:240). The process furthermore aspires to constantly sophisticate the construction by being open to new information, understandings and worldviews from the informants (Guba 1990:26-27). This way of thinking can be connected to the ideas of the hermeneutic spiral, which includes the process of moving back and forth due to the attainment of new knowledge, thus creating a knowledge-building process (Hesse-Biber & Leavy 2011:4). As mentioned in relation to our research, we aim at gaining insight into the understandings and constructions of the end-consumers, and we will try to interpret these by comparing them and include theory in order to reach a more sophisticated construction. These sophisticated constructions merge different individual attitudes of the end-consumers with our theoretical perspective thus including a variety of aspects into a more coherent construction leading to the final conclusions about the attitudes toward marketing of prescription medicine of the Danish end-consumers. These might take the form of new insight into the field or theoretical contributions.

3.2. Validity Criteria

The criteria for evaluating and validating what good research is, is often based on notions from positivism (Kvale 1997:226; Hirschman 1986:244; Kvale 1989b:7; Salner 1989:47; LeCompte & Goetz 1982:31). Thus qualitative research has also been evaluated through these notions even though the fundamental beliefs that guide qualitative research differ (Kvale 1997:226; Hirschman 1986:244; Bryman 2004:272; Kvale 1989b:7; Salner 1989:47: Lincoln & Guba 1985:289-290; LeCompte & Goetz 1982:31; Morgan 1983:392-393). This discrepancy has made qualitative researchers reconceptualise the verification criteria of validity, reliability, and generalizability (Kvale 1997:226-227; Morgan 1983:396-403; Bryman 2004:273; Golafshani 2003:602; Emerson 1981:362). Lincoln & Guba propose a specific set of criteria suited for a naturalistic paradigm, which is similar to the constructivist paradigm (Lincoln & Guba 1985:300-301). Thus the discussion of validity should proceed from the paradigmatic assumptions on which this

thesis is based (Salner 1989:49; Lincoln & Guba 1985:293-294; Taylor 1971:35/37/39-40/61/78/80; Morgan 1983:396; Kirk & Miller 1986:14).

We are attentive to the existence of other ways of evaluating qualitative research including the concepts of validity and reliability (Silverman 2001:226/231-233; Kvale 1997:231-246; LeCompte & Goetz 1982:35-51; Mason 1996:21/24/145-159). However, as we adhere to the constructivist paradigm, we will use the four criteria put forward by Lincoln & Guba as these concord with the fundamental assumptions underlying this paradigm (Lincoln & Guba 1985:301), which are *credibility*, *transferability*, *dependability*, and *confirmability*. Some of these criteria are being presented early in this thesis as they can be useful in several stages of the study e.g. in relation to the methods used in this thesis (Lincoln & Guba 1985:330) thus the different aspects of the criteria will be included in the relevant paragraphs, but presented here to enhance understanding when included later on. However, it should be mentioned that the criteria of trustworthiness are open-ended meaning that they can never be completely fulfilled. Nevertheless, one should strive to persuade the reader of the study of its trustworthiness by attempting to follow the guideline of each criterion (Lincoln & Guba 1985:329). Hence, many of the aspects of the validity criteria will be discussed in the end of the thesis to evaluate the study on the basis of these concepts thus reflecting upon how and to what degree the thesis live up to these.

3.2.1. *Credibility*

The first criterion of *credibility* is focused on an adequate presentation of the multiple realities of the informants.

> *"In order to demonstrate "truth value," the naturalist must show that he or she has **represented those multiple constructions adequately**, that is, that the **reconstructions** (for the findings and interpretations are also constructions, it should never be forgotten) that have been arrived at via the inquiry are **credible to the constructors of the original multiple realities.**"* (Lincoln & Guba 1985:295-296).

Hence, in enhancing the understandings of the realities of the informants and making the interpretations more credible, Lincoln & Guba suggest that we should look firstly at how the inquiry is carried out and secondly have the interpretations of the multiple realities approved by the informants themselves (Lincoln & Guba 1985:296). Lincoln & Guba have suggested five different techniques for enhancing *credibility*.

3.2.1.1. Prolonged Engagement, Persistent Observation, and Triangulation

The first technique is concerned with activities for increasing the likelihood that credible findings are produced, which include *prolonged engagement*, *persistent observation* and *triangulation*. *Prolonged engagement* consists of using sufficient time in the area of the study in order

to get to know the culture and context of the phenomena studied (Lincoln & Guba 1985:301-302). Hence, as also mentioned in paragraph 3.1. the end-consumers are intertwined with their context, which means that we cannot understand the end-consumers' attitudes without somewhat understanding their context. Additionally, *prolonged engagement* also aims to detect distortions of both the researchers and the informants (Lincoln & Guba 1985:302-303) and focusing on building trust with the informants (Lincoln & Guba 1985:303). The rationale of *persistent observation* is to identify the relevant characteristics of the issue being studied and getting to know these in detail (Lincoln & Guba 1985:304). These techniques will be included in the paragraphs throughout the thesis where relevant and finally evaluated on just before the conclusion.

The last element of this first activity of enhancing *credibility*, which Lincoln & Guba present, is *triangulation* by using different sources, methods and multiple researchers as proposed by Norman Denzin (Denzin 1978:294-295; Lincoln & Guba 1985:305). The different types on triangulation will be included, where relevant. The overall choice of using triangulation in this thesis is founded in the wish of getting richness and depth into the analysis, as this way of understanding triangulation is connected to the constructivist paradigm (Brannen 1995:12-13; Bryman 2011:4; Fielding & Fielding 1986:33). The different methods and sources for providing knowledge hence function as complementary perspectives on the research problem thus being more than one-dimensional, which is also connected to the notion that the constructed knowledge is affected by the way it is created e.g. the method, the inquirers, and context (Brannen 1995:12/16; Bryman 2011:4; Mason 1996:149; Flick 1998:230). This is connected to our relativist position, meaning that different constructions have value (Fielding & Fielding 1986:30). In consequence, it is a way of trying to enhance *credibility* by attempting to represent adequately the multiple constructions of the end-consumers, and not as a mean of producing a single account of a phenomenon by aggregating and adjudicate between knowledge from diverse methods, which is thus termed valid (Brannen 1995:13; Bryman 2011:4; Silverman 2001:235; Fielding & Fielding 1986:31/33; Mason 1996:148-149).

3.2.1.2. Peer Debriefing, Negative Case Analysis, and Referential Adequacy

In regard to the next three techniques: *peer debriefing, negative case analysis* and *referential adequacy* this thesis already can be claimed to have low levels of *credibility*. The second technique of *peer debriefing* means that analytic sessions should be conducted, where a peer works as the devil's advocate thus exploring implicit aspects of the study and consequently illuminating biases, meanings and the basis of interpretation. These critical questions can concern every part of the inquiry (Lincoln & Guba 1985:308-309). Moreover Lincoln & Guba suggest that the debriefer should be a peer to the researcher, know a lot about the area of inquiry and methodology (Lincoln & Guba 1985:308-309). Due to time constraints and the lack of presence of a peer with the suggested characteristics we have not engaged in *peer debriefing,*

thus this technique does not help increasing the *credibility* of the thesis. However, as we are three researchers writing this thesis, we aspire to use each other as the devil's advocate in the hopes of reducing personal biases by asking critical questions toward the choices made during the process of creating this thesis. Additionally, the researcher creating this thesis could be argued to have the suggested characteristics. Nonetheless, we are aware that an outside peer might be better in exploring the implicit aspects as we are all immersed in the process.

Negative case analysis aims at reducing the number of exceptional cases making the hypothesis more refined (Lincoln & Guba 1985:309-313). Due to the explorative nature of this thesis, we will not be operating with hypotheses, which will be revised each time new knowledge is attained. Additionally, advancing hypotheses might prove difficult due to of the focus on attitudes on marketing of prescription medicine as these might be highly complex and as diverse constructions might exist. Nevertheless, the similar thought process of the hermeneutic spiral will be adopted as mentioned in paragraph 3..1.2. thus adapting to the new acquired knowledge during the process of making the thesis.

The fourth technique of *Referential adequacy* is about achieving raw data that is not used in the study, which can then later on be examined by critiques and compared to the interpretations of the study (Lincoln & Guba 1985:313-314). We will not make use of this technique for increasing *credibility* of our thesis, as our amount of data will not be overwhelming, thus we have already chosen to use all of our raw data for our own analysis. However, we plan on attaching the transcriptions, thus enabling other to check the basis for the interpretations made.

3.2.1.3. Member Checks

Lastly, and what Lincoln & Guba term as the most important technique for enhancing *credibility*, is *member checks*. Letting the informants check the interpretations and conclusions and getting their feedback as well as receiving agreement of these, strengthens the *credibility* of the study (Lincoln & Guba 1985:314-316; Bloor 1983:157).This technique will be commented on at the end of the thesis.

3.2.2. Dependability, Confirmability, and Transferability

Dependability is the second criterion put forward, which can be seen as the equivalent to reliability. *Dependability* can concern both the process of the inquiry and the final findings and the interpretations. *Dependability* can be enhanced by taking an auditing approach, which in relation to the process of the inquiry means that the researcher should keep records of all phases of the research (Lincoln & Guba 1985:317-318; Bryman 2004:275). Thus this approach indicates transparency in the research process (Bo 2002:70; Mason 1996:145; Kirk & Miller 1986:72). In practice, we aspire to be clear in the paragraphs as to how and why we go about

the study in a specific way, and thus we aim at giving thorough explanation of our considerations in trying to ensure transparency. In relation to the product i.e. the constructed knowledge, an auditing approach can also be taken, hence examining that the interpretations are supported by data and are internally coherent, which is further explained in *confirmability* (Lincoln & Guba 1985:318). Moreover Hirschman suggests that the interpretations of the study could be compared with results from other similar studies to underscore *dependability* (Hirschman 1986:245-246). Nonetheless, comparing with similar studies is not an option in our case, as similar studies in regards to the country chosen and the qualitative approach do not exist. The two last criteria of *confirmability* and *transferability*, will be commented on in the evaluation at the end of the thesis.

3.3. Design

The purpose of the following paragraph is to clarify and discuss the plan for how to answer the problem formulation in the best possible and most convincing way, which can be referred to as our research design (de Vaus 2001:9). This paragraph will therefore contain an explanation of the different steps in answering the problem formulation, which will focus on *how* and *why* we will do it. The arguments for the specific methods chosen will only briefly be mentioned, as these will be thoroughly discussed in the later paragraph 4.

In order to get an overview of the structure of the thesis, the figure below is included to show the main elements.

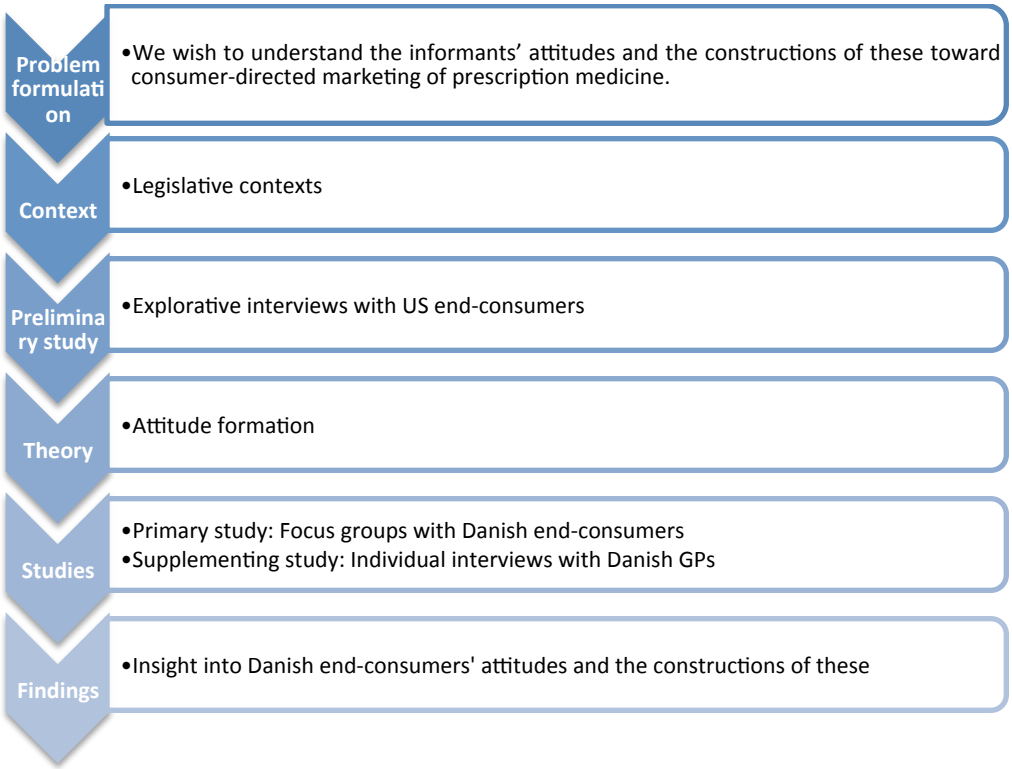


Figure 2: Overview of thesis (Own construction)

However, this paragraph and figure should not be understood as fixed plan, but rather as way to create an overview, as the creation of knowledge is an emergent process in continuation of our constructivist epistemology connected to the idea of the hermeneutic spiral as seen in paragraph 3.1.

As mentioned earlier, this thesis takes its point of departure in trying to narrow a knowledge gap in the field of interest by wishing to get an in-depth insight into the end-consumers' attitudes by using a qualitative approach. Conducting qualitative research, which is often applied when having a constructivist stance as mentioned in paragraph 3.1., will be helpful in trying to achieve an in-depth understanding of the end-consumers' subjective constructions of meaning (Silverman 2001:32/38; Hesse-Biber & Leavy 2011:4, Hammersley 1992:165; Kvale 1997:15/282). Asking them about *their* realities might give insight into the reasons underlying their constructions of attitudes. The use of a qualitative approach will be elaborated thoroughly in paragraph 4.1.

In relation hereto, the choice of Denmark as the context of this thesis is an interplay between different aspects. As a member of the EU, Denmark will be affected by the modification of an

EU directive and furthermore the proposal brought a debate in Denmark among different interest groups about the proposal's influence on the end-consumers as seen in paragraph 1 and 2.1. Moreover, Denmark is most possible for us to study as we live here and since we are also end-consumers it has our interest as we in the future might be exposed to the information coming from the pharmaceutical industry in Denmark and are thus going to experience the potential liberalization of the legislation. Being a part of the context in which we study the social actors, might increase our understanding of the consumers' attitudes and behaviour, as these are always founded in a cultural and historical context (Guba 1990:27; Delanty 2005:138/140; Wenneberg 2000:23; Berger & Luckmann 1999:15; Bo 2008:55, Silverman 2001:235, Garfinkel 1967:66-68). Additionally, having intimate and profound insight of the context and language of the end-consumers could be advantageous in understanding their attitudes (Salner 1989:61/67). Having this cultural understanding as we live in the same geographical area as our informants could help enhancing the *credibility* of this thesis as knowledge of the culture and context is a part of the technique of *prolonged engagement*. On the other hand there might be a danger in sharing the same cultural pre-understandings as the persons interviewed, because some constructions are common sense to us (Garfinkel 1967:49-50; Overgaard & Zahavi 2009:100) and thus we might forget to question it. As a consequence we will, as stated in paragraph 3.1., try to be aware of our pre-understandings and be open to other constructions and new knowledge.

As we adhere to a constructivist paradigm, which entails that people' subjective constructions are affected by the context surrounding them (Guba 1990:27; Delanty 2005:138/140; Wenneberg 2000:23; Berger & Luckmann 1999:15; Bo 2008:55, Silverman 2001:235, Garfinkel 1967:66-68), it is firstly crucial to delineate the different legislative landscape concerning marketing of prescription in respectively a Danish and an American context. As these differences might affect their attitudes and behavioural intentions, it is important to clarify these conditions before interviewing and interpreting interviews in order to obtain a better understanding of the informants' perceptions and meanings - not only as this tells us something about their lives but also as US end-consumers are exposed to different actions than the Danish consumers, and due to this might have different attitudes toward it. Therefore as the legislation is a context that can affect the end-consumers and thus have an impact on their constructed attitudes and perhaps behavioural intentions (Silverman 2001:235, Garfinkel 1967:66-68, Bloor 1978:548).

In order to obtain a more profound understanding of the field of interest we will conduct explorative interviews with US end-consumers. Furthermore, these insights will also be useful in preparing for the interviews with the Danish GPs and the focus group interviews with Danish end-consumers. Thus, inspiration for aspects, which might be vital and rewarding to bring up in the interviews with the Danish groups, might be drawn from these preliminary interviews

(Kvale 1997:104/107). This is not only in order to get inspiration for new aspects, that we have not in advance thought of, but also in order to eliminate aspects, which we originally thought were important but, which during these explorative interviews, were revealed not to be (Hirschman 1986:241, Hesse-Biber & Leavy 2011:11). However, we are aware that these insights will not be completely comparable due the different contexts (Kvale 1997:54). Complete comparability is however not of our interest and thus these interviews will hopefully be able to function as hints in relation to what we could focus on when conducting the focus group interviews. Thus the aim of these interviews is to extend our knowledge beyond our pre-existing knowledge from literature.

Interviews with Danish GPs are included as supplementary primary empirical data as their insights might provide a broader understanding of the field of interest. Furthermore they are incorporated as they are a central player in relation to the end-consumers' consumption of prescription medicine. Moreover, we have chosen to focus specifically on GPs and not physicians or doctors in general as the GPs are assumed to be in closest contact with the end-consumers in their everyday life. Furthermore, as GPs can be assumed to treat most of the condition marketed directly to the end-consumer (Wilkes et al. 2000:119), they might thus be more prone to be presented with the general health worries of the end-consumers, which e.g. could be due to health information read online. Hence, the GPs might influence end-consumers' attitudes and the underlying constructions, thus it could be important to attain knowledge about this relationship from the GPs' perspective. Furthermore these interviews are of interest, as these would perhaps help us achieve an insight into, how GPs experience that the end-consumers relate and respond to the great access to information concerning health and illnesses, which might be helpful in the puzzle of understanding the end-consumers' attitude. However, we are aware that these interviews are the constructions of the GPs and thus not give us directly insight into the end-consumers' attitudes, but these insights could be helpful in achieving an understanding hereof.

The primary method for answering the problem formulation will be focus group interviews. We will conduct focus group interviews as the group dynamic in such interviews might lead the conversation onto topics that the informants would otherwise not have thought of, which might be helpful for the individual informants in making it easier to talk about a possible future situation, which they have not yet experienced and been exposed to (Hesse-Biber & Leavy 2011:11, Kvale 1997:108).

Consequently, we wish to make use of a qualitative multi-method design (Hesse-Biber & Leavy 2011:176). Linked hereto is the triangulation of different sources, which can be understood in two ways; firstly to use the same method or type of source on different parts of the same event to obtain different data areas. Secondly, the use of different sources or methods to get

the same type of information (Lincoln & Guba 1985:305; Fielding & Fielding 1986:24-25; Denzin 1978:295; Brannen 1995:12). In relation hereto the second mentioned type of triangulations is to use of different methods for data collection (Denzin 1978:302; Lincoln & Guba 1985:306). Despite Denzin's claim that the triangulation of methods can take any form, Lincoln & Guba hold that the inclusion and combination of methods should be logically in relation to the paradigm, thus inclining mostly toward qualitative methods (Lincoln & Guba 1985:306-307). We wish to make use of triangulation in the form of using different sources such as the US end-consumers, the Danish end-consumers, and the Danish GPs in order to get insight into the topic in focus and this data will be attained to different types of methods i.e. different forms of interviews. As mentioned triangulation is one technique for enhancing *credibility*, thus using individual interviews alongside focus group interviews and different sources we hope to obtain a profound knowledge of the field of interest, richness and depth, which triangulation is useful for (Brannen 1995:12-13; Bryman 2011:4; Fielding & Fielding 1986:33) to achieve credible understandings of end-consumers' attitudes.

4

Method: *Elements for the Cure*

In this paragraph we will firstly look into the nature of qualitative research and hereafter touch upon the methods used in constructing knowledge in order to answer the problem formulation.

4.1. Qualitative Research

In wanting to attain knowledge about individual constructions in this case attitudes, qualitative research is often used as it is devoted to understanding social reality and the constructions here in i.e. meanings from the point of view of the individuals studied (Denzin & Lincoln 2005:3-4/8/19; Berg 1998:3/7; Hammersley 1992:160-172; Flick 1998:2; Hesse-Biber & Leavy 2011:4; Kvale 1997:15). Qualitative research is thus concerned with obtaining a deep understanding of social phenomena and the social world (Hesse-Biber & Leavy 2011:3). In qualitative research, there are some common preferences (Silverman 2006:56; Hammersley 1992:160-72; Mason 1996:3-5), such as analysis of words and images, preference of naturally occurring data and a relatively unstructured approach to empirical research. Generally, the purpose of qualitative research is to *understand* social actors (Fontana & Frey 2000:645; Berg 1998:11) and get an insight into the pluralisation of life worlds (Flick 1998:2; Trost 1996:17). Furthermore there often is a preference for research developing or refining theories from empirical studies (Flick 1998:2; Hammersley 1992:160-172). Qualitative research encompasses a wide range of methods, which shares the above noted preferences (Silverman 2006:56; Berg 1998:3; Flick 1998:5/7; Denzin & Lincoln 2005:2-4). However, there are considerable differences among the qualitative approaches, which make them individually suited for different research purposes (Flick 1998:1). In the paragraphs below, we will justify our choices of qualitative methods through discussions and reflections upon how these are suitable in gaining the desired knowledge.

4.2. The Qualitative Interview

As the choice of method should depend on the purpose of the study (Silverman 2006:34; Case 1975:145; Flick 1998:1) and the paradigmatic stance, the method applied in this thesis for gaining in-depth knowledge about end-consumers' attitudes toward marketing of prescription medicine and subjective constructions hereof, is the qualitative interview. The qualitative interview can be conducted in different ways, dependent on the purpose of it, and in this thesis the qualitative interview will be applied in different contexts; in initial explorative interviews with US end-consumers, in interviews with Danish GPs and in focus groups with Danish end-consumers.

Although it can be argued that attitudes can be measured through a quantitative approach such as surveys, the data obtained through this method are often standardized and fixed categorizations of attitudes put forward by the researcher, which offers limited ways to know the subjective sense of the end-consumers' attitudes (Holstein & Gubrium 1995:53). Thus, "*Qualitative interviewing is particularly useful as a research method for accessing individuals' attitudes and values - things that cannot necessarily be observed or accommodated in a formal questionnaire."* (Byrne 2004:182). As the purpose of this thesis is not only to gain insight into *what* the attitudes are, but also to gain knowledge of *why* they are as they are, the qualitative interview is thus better suited for gaining insight into the complexities and meaning systems, which lie behind end-consumers' attitudes (Holstein & Gubrium 1995:52-53; Hesse-Biber & Leavy 2011:3-4/9; Kvale 1997:19/41; Smith 1972:113). As noted in paragraph 3.1., the context is important in individuals' subjective constructions of meanings and in this regard the qualitative interview allows informants to unfold their meaning constructions. This method can render the informants' linkages visible between their attitudes and their context, stocks of knowledge and interpretations of events and experiences (Holstein & Gubrium 1995:52; Byrne 2004:182). In close connection hereto, the method of qualitative interview offers the possibility of giving insight into the subjectively meaningful differences of attitudes and the basis of these in different life worlds (Holstein & Gubrium 1995:52). Furthermore, as this thesis is of an explorative nature since it is an under-researched topic in a Danish consumer context, applying a method, which allows for emergent knowledge constructions and lets the complexities and relevant issues unfold might be beneficial, rather than working with fixed categories and highly structured formats (Holstein & Gubrium 1995:52; Hesse-Biber & Leavy 2011:163). In this way, this method is advantageous in a number of ways to suit the purpose of this thesis.

4.2.1. Constructing Meaning and Knowledge within the Interview

As this thesis aims at understanding the attitudes and constructions hereof from the informants', as end-consumers, points of view, our interviews aims at including a high degree of openness to the informants' accounts or narratives, allowing high flexibility (Silverman 2006:110; Noaks & Wincup 2004:80). Thus the interviews are semi-structured and take their

points of departure in the knowledge obtained from the process so far studying the literature. Thus we constructed interview *guides*, which included probes, however, still trying to maintain the flexibility (Silverman 2006:110) and openness to the viewpoints of the informants (Flick 1998:76), which we are interested in. This is due to the basic explorative dimension of this thesis and the wish of getting informants to unfold their attitudes, emphasise what they believe is relevant and give meaning to the issues in question during the interview (Holstein & Gubrium 1995:55; Flick 1998:76).

The construction of meaning and knowledge is done through language and the concepts integrated here in, as this is the mean by which people understand reality, and add meaning to their experience of the world, communicate and obtain knowledge (Burr 2003:7-8/46-47; Polkinghorne 1989:24/28). By talking to the informants and having them articulate their experiences, meaning is created. The very word *interview* indicates that meaning is constructed in active interaction between the interviewer and the informant, hereby collaboratively constructing the meaning of interview narratives which lead to negotiated, contextually based results and insights (Holstein & Gubrium 1995:59; Fontana & Frey 2000:646; Stewart & Cash 2008:1-2; Flick 1998:26; Kvale 1997:15; Kamberelis & Dimitriadis 2005:893; Marková et al. 2007:45). This is also connected to the constructivist epistemology. Thus through language in the interaction of the interview, scientific knowledge about social subjective knowledge can be experienced (Polkinghorne 1989:27). As the language and the narrative are central in the interview, what an interview produces is not the direct access to the informants' events, experiences and attitudes, but are particular representations or accounts of an individual's view or opinion (Byrne 2004:182; Kitzinger 2004:128; Flick 1998:9). Thus in aiming to understand the informants' attitudes, it makes sense to analyse the representations and accounts in relation to the content and *what* they emphasize, but also the form of the informants' accounts, that is *how* they construct meaning and make sense of the social phenomena (Holstein & Gubrium 1997:27; Silverman 2006:131) e.g. how the informants seem to make sense of prescription medicine as a product.

4.2.2. The Role as an Interviewer

As the researcher and the informant construct knowledge in a collaborative process during the interview, it is pertinent for the interviewer to be aware of her role in the process. When conducting our interview we are attentive toward trying to establish and maintain trust and rapport with the informants, because this can affect the informant's inclination to talk freely and construct meaning (Fontana & Frey 2000:655). As a part of this notion, we will attempt to see the world from the informants' point of view while still keeping in mind the purpose of the research (Fontana & Frey 2000:655). Thus the interviewer's ability to listen is important (Krueger 1993:73; R&D sub-Committee on Qualitative Research 1979:119; Axelrod 1975:439-440; Berg 1998:110; Krueger 1988:30/73; Greenbaum 1988:52; Edmunds 1999:71-72; Greenbaum

2000:32). It is also argued that non-reflective listening e.g. nodding and smiling can encourage the informants to speak in an elaborative manner, as body language could indicate interest and openness to what they have to say (Fern 2001:81). Furthermore using reflective or active listening (Wooldridge 1991:6; Hesse-Biber & Leavy 2011:185; Fern 2001:80-82) e.g. by saying "What I hear you say is.." can be a way of trying to understand the informants better (Stewart et al. 2007:98). Also summing up or repeating what the informant has said, show that one is listening and furthermore give the possibility of increasing the understanding of the informant's point of view. Importantly we attempt to allow the informant room to talk (Noaks & Wincup 2004:80; Rapley 2004:25). Thus the role of the interviewer is of great importance to the quality of the interviews and thereby the findings. Thereby the interviewer's skills and experience become important in the research process, both when it comes to knowledge and human interaction with aspects such as sensitivity, empathy and ability to communicate (Kvale 1997:110/112). Interviewing is a craft, which necessitates acquiring knowledge and learning through practical experiences (Kvale 1997:112-113), whereby lack of the latter might be a limitation when conducting interviews. Thus an acknowledgement of the relatively lack of experience among the researchers of this thesis, meaning that more experienced interviewers might have produced interviews of higher quality, is appropriate.

4.3. Explorative Interviews

At the initial stage, five explorative single interviews with US end-consumers were carried out, thus being a part of the intercultural aspect. The purpose of these explorative interviews was to get an understanding and outlining of the field in focus for the thesis and thus identifying relevant and interesting question for further research (Andersen 2005:21). By conducting explorative interviews our wish was to broaden the knowledge and understanding of attitudes toward marketing of prescription medicine and get an insight into the explanations and subjective constructions underlying the attitudes, which as mentioned has been a topic qualitatively under-researched. In research situations like this, where the field and topic is under-researched and unknown and the researcher therefore wishes to establish a comprehensive acquaintance with the field which is initially unfamiliar to him, exploratory research is well suited (Hesse-Biber & Leavy 2011:163; Kvale 1997:104,107; Denzin 1978:39; Singleton et al. 1988:298-299; Silverman 2006:45; Andersen 2005:21). Another reason for applying and making use of explorative interviews is linked to the wish of improving the *credibility* of the thesis, as these explorative interviews could help identifying relevant characteristics and detail affecting the attitudes toward marketing of prescription medicine, which is a part of the technique of *persistent observation*. Hence, such interviews were conducted in order to provide other perspectives on issues besides that of academic articles and writings. Furthermore, they were carried out to make us attentive to aspects that we had not thought of, as we are not exposed to this particular practice, whereby the intercultural aspect of conducting these might be ben-

eficial. As these US end-consumers are a part of a context where the practice exists and is a part of their everyday lives, such explorative interviews could give a valuable insight into social phenomena relating to the topic from end-consumers' point of view, thus sensitising us to the field of our research. Consequently, we applied the explorative method as a mean for helping us to develop and sharpen the further research process, as the purpose of these explorative interviews was to identify and specify the problems in the field studied (Andersen 2005:21). Thus these interviews become a mean of hopefully ensuring that the findings arise out of and remain grounded in the end-consumers' subjective constructions, which we are interested in (Denzin 1978:39).

4.3.1. Recruitment and Selection of Informants

In conducting research there are always natural constraints and limits on the options of the researcher. In the explorative interviews, we wanted to interview US end-consumers about their experiences and attitudes in relation to DTCA of prescription medicine, as they are a part of a context where the practice exists, hereby making them acute observers to the topic, which according to Denzin is important (Denzin 1978:39). The informants were recruited by convenient sampling, by using our network (Bryman 2004:100; Stewart et al. 2007:54). A fellow student who is an American kindly helped us in establishing contact to US end-consumers, who then volunteered. The final number of informants was five Americans. Unfortunately, due to technical failure, one was not recorded and thus only four transcriptions can be found in appendix A.[12] The interviews were conducted via the Internet telephone service *Skype*. As meaning is constructed in the interaction between the informant and the interviewer and as context has influence on this meaning construction, this interview form is not the optimal for increasing understandings and meanings. However, because of time and money limitations, we chose this solution. The participating informants were all females in their twenties. They were raised in the US, but two of the informants are currently working and living in countries outside the US. This could perhaps affect their memories and perspective of DTCA of prescription medicine. However, we perceive their acquaintances with the practice of DTCA of prescription medicine to exist, which is primary in this connection.

4.3.2. Conducting the Explorative Interviews

By its very nature, the explorative interview is relatively open and minimally structured, due to the purpose of exploring a new field (Kvale 1997:104; Denzin 1978:4). Because of this, the interview guide was constructed in terms of four broad questions, with sub-question, which can be seen in appendix 9.1.1. These questions were formulated in a way that ensured possibility for the informants to bring out what they believed was important in relation to this the given aspect of the topic. Subordinately to these, there were potential prompts, in case the

[12] The appendixes with letters, can be found on the enclosed CD.

informants had a hard time reflecting on the topic or in case the informants brought about some aspects, which we would like her to elaborate on, e.g. *"Do you reflect upon such advertisements?* (*The sender, the specific product and the disease it is meant to treat)*". The primary approach was to listen to and pursue the account of the informants, and search for new dimensions and point of views in relation to the topic (Kvale 1997:104,107). However, as noted in paragraph 3.1. as the interviewer will always have some preconceptions and ideas of a given topic, on which one will communicate from, which mean that an interview will never be completely explorative, whereby the researcher is an inevitable part of the knowledge construction in interviews. However, in conducting the interviews we were mindful of the informants leading us in new directions and adopting a new line of inquiry, when more information and better understandings were acquired, being an important in explorative interviews (Denzin 1978:40). Furthermore, this allowed for the hermeneutic spiral process to proceed e.g. by revising the interview guide from interview to interview.

4.3.3. Findings

As hoped for, the explorative interviews provided us with further knowledge of the field and they indicated some aspects to pursuit and being attentive toward in our further empirical research.

As noted earlier in paragraph 3.1. the social and cultural context can influence the construction of knowledge and thus cultural meaning systems can affect people's pre-understandings and thereby their attitudes and perceptions of social practices. Furthermore, sometimes people do not question the existing practices and their own perceptions because they are a natural part of their social reality. This was experienced during the interviews, as three informants indicated that they had not really thought about the practice before the interview (App. A, Mary:6; Lily:19-20; Grace:44).

During the interviews we furthermore became aware of some of our own pre-understandings as we experienced an informant questioning our pre-understanding of the possible problems in implementing a practice like DTCA of prescription medicine in the Danish context. In this way, she questioned whether there could be problems in *not* having such practices implemented in Denmark: "*(…) if it's the norm for you guys to not advertise for it, then, and if there has been no harm in not advertising (…)"* (App. A, Grace:42). This quote led us to be aware of our own pre-understandings as we had not thought about that there could be harm in not having the practice in Denmark. Thus in the meeting between different cultural contexts, different pre-understandings and constructed realities of the practice of DTCA of prescription medicine became apparent, and we became aware of new aspects of the topic. In this way, even though the intercultural aspect is not the leading element in this thesis, these four interviews showed how even a more implicit intercultural perspective ensures a far more profound

understanding of the cultural context for the research, in this case the Danish context. Besides becoming aware of cultural and contextual differences and pre-understandings that might exist toward the topic of DTCA of prescription medicine between the US and Danish context, we also found some overall topics and patterns in the explorative interviews, which we will apply in our further research. However, we are attentive that these might not be directly transferable. The topics are summarized below and for further elaboration of our findings, see appendix xx.

- *Personal relevance in relation to attention:* Personal relevance influences whether the US consumers reflect upon DTCA of prescription medicine.
- *Media channels:* The US consumers noted that media channels differ in the way they present medicinal products through DTCA.
- *Get nervous from information:* Some mention that one should be careful when searching for information on the Internet about symptoms related to illness, as one can find information, which might make one scared as this information could indicate that you are very ill.
- *GPs' role:* Some believed that the GP should always be the intermediary or guarantor for giving consumers the right information and the right prescription medicine.
- *Pharmaceutical companies' role:* The US informants seemed to believe that pharmaceutical companies have an ethical responsibility e.g. in relation to informing about dangers and side-effects.
- *Differences among medicinal products:* Among the informants there was consensus about it being more legitimate to advertise for some prescription medicine products than for others.
- *Information vs. marketing:* Some informants reflected upon a distinction between the practices of *informing* consumers and *marketing* prescription medicine. In this regard, these informants think it is okay to inform consumers about health and related treatment but are not all fond of the advertising practice on traditional broadcast media.
- *Consumer belief:* One informant's attitude toward DTCA of prescription medicine was affected by her belief about a condition, which were derived from lack of knowledge.
- *Different actions of differing severity prompted:* The practice of DTCA of prescription medicine was claimed to prompt different actions of different severity e.g. seeking on the Internet or go to the GP.

Having noticed the above-mentioned aspects, we will use these as inspiration for theory to look into and in the preparation for interview guides for the focus groups and the interviews with the Danish GPs.

4.4. Interviews with Danish GPs

As a part of our research we conducted qualitative interviews with four Danish GPs, and thus this is one of our sources in using triangulation in this thesis, as seen in paragraph 3.3. The reason for using this source, is that they can contribute with a different angle and perspective to the issue of marketing of prescription medicine in relation to the end-consumers, and thus the advantage is that they can provide this thesis with richness and in-depth understanding of the topic in focus, as mentioned in paragraph 3.2.1. can contribute to strengthening the *credibility* of the study as deeper insight into the topic is gained. Additionally, these interviews might also contribute to relevant characteristics in relation to the topic, particularly as the end-consumers are dependent on the GP for a prescription. This position as an intermediary in the consumption of prescription medicine (Dens et al. 2008:48; Calfee 2002:175) was another reason why we have conducted these interviews with the Danish GPs. The objective with these interviews was also to get insight into the relationship between GP's and the end consumers, as this relationship might affect the end-consumer's attitudes toward marketing of prescription medicine. In connection hereto, Lee et al. has argued that the GP can function as a socialization agent, and thus influence people's attitudes (Lee et al. 2007:111). In this way, these interviews are a part of constructing knowledge about this topic. Conducting these interviews, we did not know in advance exactly what knowledge these would provide us with, but we were open to the knowledge they might give us, which might be functioning as a supplement to the informants' accounts. Moreover these interviews might support or provide different perspectives or issues to the research. In the analysis these interviews are applied as supportive in the primary analysis of the focus group data and thus a review of the findings from these will not be found here, as was the case for the explorative interviews with the US end-consumers.

These GPs were recruited through *convenience sampling* (Bryman 2004:100; Stewart et al. 2007:54), as we used our network to establish contact to the GPs. In this regard, one of the researchers personally knew two of the male GPs who participated and the remaining two GPs were recruited trough two of the researchers' personal relations. Three male GPs and one female GP participated in an approximately 30-45 minute long interview. As we are not interested in objectivity due to our constructivist stance, the use of acquaintances is possible (Blichfeldt & Heldbjerg 2011:29), and might even provide further insight into the topic as the informants might bring up aspects and elaborate hereon, that they would not have, if they did not know the researcher due to the already existing rapport between these two (Blichfeldt & Heldbjerg 2011:15). In conducting these interviews, we used a semi-structured interview guide, as seen in appendix 9.1.3., to ensure flexibility in order to get insight into the GPs and furthermore try to follow the suggestions in relation to the role as an interviewer as seen in paragraph 4.2.2.

4.5. Focus Group Interviews

As mentioned, focus groups interviews is the main method used to construct knowledge in this thesis. Even though there are many definitions of focus groups (Lederman 1990:117), there is broad agreement that a focus group is a gathering of a group of people (Rigler 1987:97), for a discussion of a given topic for approximately two hours (Churchill & Iacobucci 2005:81; Davidson 1975:141; Kotler 2000:107; Tynan & Drayton 1988:5; Welch 1985:245; Macfarlane Smith 1972:109; Sampson 1978:29; Holstein & Gubrium 1995:70; Payne 1975:435; Szybillo 1975:448; Bellenger et al. 1976:8; Goldman 1962:62), where *interaction* is key (Frey & Fontana 1993:21; Wilkinson 1998:112; Davidson 1975:141; Peterson 1975:147; Madriz 2000:836/841; Sampson 1978:29; Berg 1998:104; Morgan 1997:20; Peterson 1975:147), as people are affected by their context and the people surrounding them in many aspects (Krueger 1988:23). This discussion is supervised by a *moderator* (Berg 1998:100) who will ensure that the discussion is focused on specific elements of a topic (Wells 1974:138/140; Tynan & Drayton 1988:5; Frey & Fontana 1993:30; Wolf 1975:143; Rigler 1987:97; Sampson 1978:29; Stewart et al. 2007:36; Krueger 1988:73; Lederman 1990:118), as *focus* is another key characteristic (Stewart et al. 2007:9/45; Morgan 2001:146).

Focus groups is a qualitative method (Morgan & Krueger 1993:11; Davidson 1975:141; Hesse-Biber & Leavy 2011:164; Krueger 1988:29-30; Morgan 1998a:29; Edmunds 1999:2), which examines a topic in-depth (Knodel 1993:37; Stewart et al. 2007:11; Peterson 1975:146; Bellenger et al. 1976:7; Edmunds 1999:2) to find out as much as possible about a given topic (Morgan & Kruger 1993:7) with a wish of specifying, explaining and understanding (Morgan & Krueger 1993:9; Krueger 1988:96). Therefore, in relation to our study, focus groups are beneficial as they are suited for studying complex (Morgan & Krueger 1993:16; Jarrett 1993:186; Peterson 1975:146/147; Madriz 2000:840; Macfarlane Smith 1972:103; Morgan 1998a:58), subjective structures such as attitudes, opinions, feelings, thoughts (Jarrett 1993:186; R&D sub-Committee on Qualitative Research 1979:116; Berg 1998:104; Krueger 1988:29-30; Morgan 1997:20; Edmunds 1999:3; Lederman 1990:126), which we are interested in. Moreover, focus groups enable listening to informants' point of view (Morgan & Krueger 1993:12; Madriz 2000:840; Hesse-Biber & Leavy 2011:181; Krueger 1988:29; Morgan 1997:17; Morgan 1998a:9; Edmunds 1999:2; Lederman 1990:118/126). In this way, focus groups are good for exploratory research (Stewart et al. 2007:40-41; Fontana & Frey 1994:365; Morgan 1997:17) when the researchers know little about the topic being studied (Hesse-Biber & Leavy 2011:163; Stewart et al. 2007:52). Thus they are good at exploring people who have not been heard in regards to a specific topic (Morgan & Krueger 1993:15; Morgan 2001:142) and exposing the professionals to the reality of the consumers (Morgan & Krueger 1993:16; Morgan 1998a:57). Hence the use of focus groups is also beneficial as we deal with end-consumers whose point of views, have not been qualitatively explored in relation to the topic. However,

obtaining in-depth insights into the individual informants' attitudes might not be easy, when using the focus group method, as several individuals voice their opinions simultaneously, thus it might be difficult to understand these complex constructions. Nevertheless, we have still chosen this method due to the nature of the chosen topic. Thus, focus groups are advantageous, as these are good in constructing knowledge about a topic that is otherwise difficult to obtain (Hesse-Biber & Leavy 2011:165; Kitzinger 1994:112; Lengua et al. 1992:163; Berg 1998:116; Krueger 1988:27; Goldman 1962:64). As the practice of marketing of prescription medicine is non-existent in Denmark, the end-consumers most likely have not thought about it, which could make it hard for them to reflect upon. In this regard, the informants might become more aware, explicit and clarified of their own attitude toward the aspect by listening to the other informants (Morgan & Krueger 1993:17-18). Therefore the synergy (Berg 1998:101) created by the interaction between informants and the spontaneity (Hesse-Biber & Leavy 2011:166; Berg 1998:104; Hess 1971:233; Goldman 1962:62) inspire and stimulate the informants in their way of thinking as they respond and create responses in relation to each other (Wells 1974:134-135; Dupont 1975:431; Axelrod 1975:441; Szybillo 1975:448; Berg 1998:101; Marková et al. 2007:46; Krueger 1988:18; Hess 1971:232; Stewart et al. 2007:46). In this way, the context of the focus group affects the meaning and knowledge constructed (Morgan 2001:151; Kamberelis & Dimitriadis 2005:893; Stewart et al. 2007:39; Dahlgren 1988:292). As we will initiate the contact for the purpose of the study (Morgan 2001:150; Hesse-Biber & Leavy 2011:166; Morgan 1997:14; Morgan 1998a:31) and as were will be present during the focus group (Stewart et al. 2007:35; Madriz 2000:836; Morgan 2001:151; Morgan 1997:48; Goldman 1962:64), which might inhibit the free flow and naturalness of the interaction (Stewart et al. 2007:35; Madriz 2000:836; Morgan 2001:151), there is the question of how natural focus groups are (Morgan 1993:228). Yet, this unnatural-ness might not be a problem in our case, as it is a topic that people will most likely not discuss without being directly asked about it (Morgan 1998a:31). Lastly, focus groups are good in exploring topics that the informants do not deliberately think about (Templeton 1975:444) and thus the method of focus groups is favourable in relation the chosen topic.

As we have now argued for the use of focus groups in relation to our topic, the following paragraph will explain how we wish to conduct our focus groups, in close relation to the purpose of our study.

4.5.1. Contact and Selection of Informants

The choice of informants was based in whether they are everyday end-consumers no matter their level of knowledge on the topic, which we wish to study (Krueger 1993:71; Hesse-Biber & Leavy 2011:178; Stewart et al. 2007:51) as this will affect the trustworthiness of the study (Krueger 1993:71 Welch 1985:247; Peterson 1975:147; Bellenger et al. 1976:10). In this regard we did not list down any characteristics other than we would like both men and women, thus

seeking a broad variety of informants in order to get an insight into broad variety of views. However, we considered individuals using different types of prescription medicine as this, as mentioned in paragraph 1.2.2., might influence their attitudes but as people might use a range of different products and maybe several at a time, this criteria seem untenable as they would not be easily divided into groups. Moreover, it could also be a sensitive criterion to use, which could scare off informants as we would then have to ask about their medical history.

Initially, we made use of *purposive sampling*, where the focus is to choose informants according to the purpose of our thesis (Morgan 1998b:56). This was done by e-mail (Stewart et al. 2007:55) sent out to educational institutions and by putting up flyers in super markets, libraries and educational institutions (Morgan 1998b:90). However, as only nine informants volunteered, we contacted some of our acquaintances for their help, hence we used ourselves as intermediary (Bloor et al. 2001:31-32) where eleven more volunteered. In this way, we made use of a sort of *convenience sample*, as we found informants in ways most convenient for us (Stewart et al. 2007:54). When recruiting informants, we were naturally aware that people are self-selected and thus the informants volunteering and attending might be a specific group of people, in the sense that people who volunteer for such focus group interviews, might be of a specific personality (Morgan 1998b:90-91; Macfarlane Smith 1972:106). Hereby these might have a specific interest in the topic, be interested in talking about the topic, be interesting in helping us or simply they might just be outgoing hereby making them have a specific point of view.

In this regard the question of using acquaintances arises (Tynan & Drayton 1988:6). As we are not interested in objectivity due to our stance in philosophy of science, the use of acquaintances is possible (Blichfeldt & Heldbjerg 2011:29). This could perhaps even be an advantage when wishing to get a deeper insight into people's life worlds and attitudes. However, we tried to divide the informants equally into the groups in terms of whether they were acquaintances or strangers by having maximum two or three people knowing each other in a group. Hereby we tried to ensure that informants were not left out by acquaintances creating cliques and individual conversations (Wells 1974:137; Stewart et al. 2007:57; Templeton 1994:212; Morgan 1998b:67; Morgan 1992:188), and as it would decrease the risk of the focus group getting too internal between the moderator and the acquaintances. Moreover, informants who did not have pre-existing knowledge about each other would need to explicitly and elaborately explain and talk about aspects, which would otherwise be taken for granted, such as thoughts, feelings and opinions (Morgan & Krueger 1993:6; Bloor et al. 2001:22; Morgan 1998a:49; Morgan 1998b:67-68; Morgan 1992:187-188) adding to our construction of knowledge during the focus group (Morgan 1998b:67-68). In connection hereto, strangers might have felt more able to speak more freely and openly as were likely never to meet the other informants again (Bloor et al. 2001:24; Montell 1999:63). However, at the same time people might have been

more hesitant sharing with strangers (Wilkinson 1998:120) and thus be more likely to attend if they knew another informant making them more comfortable (Payne 1975:435) hereby making them more open and honest (Blichfeldt & Heldbjerg 2011:15/17). This might be advantageous when the topic is a personal one, which ours is at the risk of turning into (Bloor et al. 2001:23). In this way, the informants might "*(…) not have introduced some issues if they had not known the researcher; or at least that they would not have elaborated on these issues to the same extent (…)*" (Blichfeldt & Heldbjerg 2011:15) thus allowing for a deeper insight. Having strangers among acquaintances might have helped decrease the risk of over disclosure among acquaintances, hereby hopefully creating a fine balance between being honest, open and sharing without feeling a pressure to share too much. This is important as, we were aware of not pressuring the informants to reveal any details of their personal life e.g. which medicinal products they have been taking, hereby trying to prevent over-disclosure by encouraging self-disclosure in an appropriate amount (Krueger 1988:23; Morgan 1998a:90-91; Morgan & Krueger 1003:7). Finally, recruiting informants that we already knew saved us both time and cost, also when it came to rate of attendance as the acquaintances might have felt more obligated to show up or perhaps not quite as nervous as would a stranger (Bloor et al. 2001:23/32), which might have been the reason underlying the great rate of attendance, as all informants volunteering showed up.

Out of the 20 informants volunteering we placed seven informants in two groups and six informants in a third group, which was done in order to have the advantages of both small and large groups (Templeton 1994:162-165), as seen in the figure below:

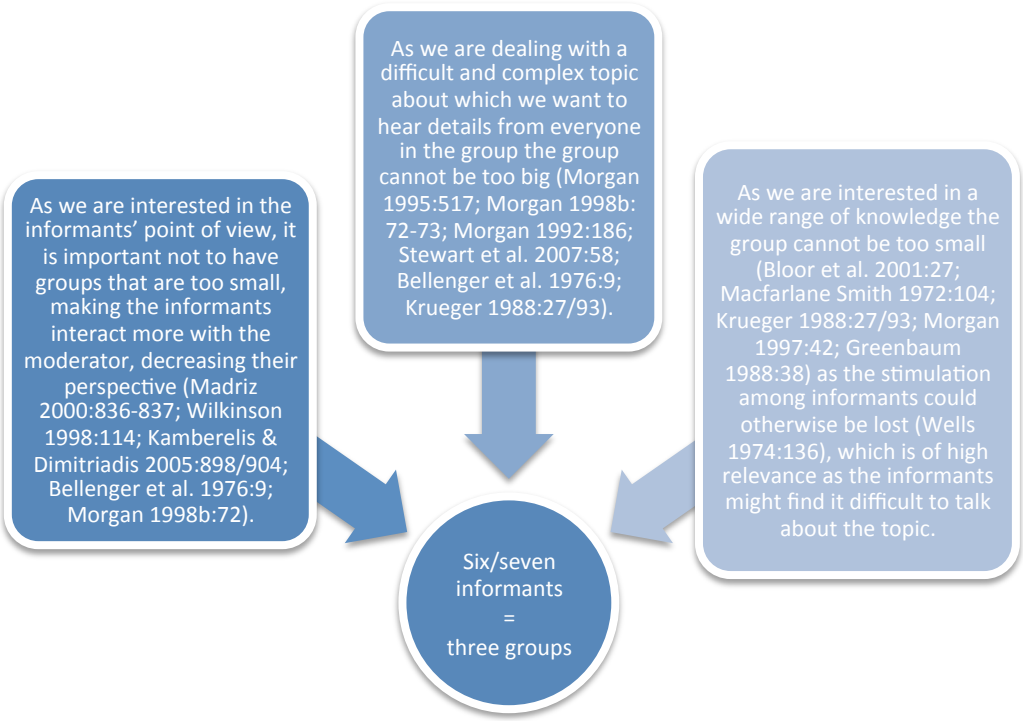


Figure 3: Advantages of small and large groups in relation to our choice of number of informants

Initially, our wish was to conduct more than three groups, but due to constraints of time and money, this became our limitation (Krueger 1993:70-71). However, three groups might possibly also be enough to start exploring this topic in order to reach a preliminary insight into the field.

4.5.2. Group Composition

In relation to group composition 18 informants were currently students at Aalborg University and two were former students, and 18 of the informants were in the middle of their twenties and three were in their early thirties. Moreover seven were male and thus 13 were female. Hence, even though not deliberately chosen, our informants were more on the homogeneous side. In this regard it has been found that groups with a high level of similar characteristics will more easily discuss the topic as they can identify with each other's experiences (Knodel 1993:40). Yet, as our groups were not completely homogeneous it might at the same time give different viewpoints (Tynan & Drayton 1988:6; Krueger 1988:93; Templeton 1994:165). Having groups entirely made up of university students and former students, might bring a specific light to the knowledge constructed during the focus group, thus limiting the understanding of end-consumers in broader terms. However, students might have the advantage of being more

reflective and critical of a given topic they are to discuss, as this is an embedded element in many university educations. Additionally, one might imagine that these students choice of volunteering might be due to the fact that they might recognize the situation of needing informants and hereby have the wish of helping us out thus being engaged. Closely connected hereto, is incentives to attend, which we will have a closer look at below.

4.5.3. Incentives for Attendance

As it can be difficult to get a group of people to meet at a specific point of time (Krueger 1988:47) and as it is rather easy for informants not to show up at a focus group, we gave the informants reminders and incentives to attend the focus group (Morgan 1995:518; Stewart et al. 2007:55-56;). We send personally written and addressed (Stewart et al. 2007:47/55/96; Krueger 1988:99-100; Morgan 1998b:105) reminder e-mails (Bloor et al. 2001:33; Simon 1987:21; Stewart et al. 2007:47/56; Krueger 1988:99; Morgan 1998b:106; Edmunds 1999:39; Greenbaum 2000:69), which might also a way of creating trust and rapport between us and the informants. As we have a limited amount of money, our incentives were, besides serving food (Morgan 1995:518; Simon 1987:21; Macfarlane Smith 1972:107; Stewart et al. 2007:55-56; Krueger 1988:100; Greenbaum 1988:84; Templeton 1994:28; Morgan 1998b:128-129; Kotler 2000:107) to have an entertaining experience (Stewart et al. 2007:56) by discussing an interesting topic (Morgan 1995:518; Krueger 1988:100). Moreover, each informant participated in a contest for the prize of two tickets to the cinema.

4.5.4. Moderator

Besides a moderator, we had an assistant moderator, (Krueger 1993:69; Krueger 1988:74), with the responsibility of keeping the overview of the group and making sure that the moderator did not miss any vital questions or aspects. Therefore we wished for the assistant moderator to be able to ask questions. As the perfect moderator does not exist, having an assistant moderator was also a way of trying to ensure a high quality of moderating. However, we clearly emphasized that it was a discussion between the informants. Moreover, we also had an observer sit in the back of the room (Stewart et al. 2007:93; Greenbaum 1988:72) to help with the practicalities such as recording devices (Wilkinson 1998:122; Krueger 1993:69/74). Being three during the focus group could naturally have restrained some of the informants, due to imbalance of power, as they might have felt intimidated. Yet, in the beginning of the focus group it was mentioned that especially the observer was not to be noticed and, as we will see later on it did not seem as if the informants had any problems speaking and sharing freely. Moreover, this might also have something to do with the fact that we used ourselves as moderator, assistant moderator and observant, as we will see below.

As mentioned, we moderated the focus groups ourselves as it ensured that our moderator had an in-depth and broad knowledge about the topic of choice, hereby being aware of the re-

search purpose in order to guide the focus group in a useful direction (Morgan & Krueger 1993:5; Berg 1998:110; Krueger 1988:73; Greenbaum 1988:50-51; Kotler 2000:107; Wells 1974:135; Stewart et al. 2007:45/81). In this way, the role of the moderator were circulated between the three of us and thus we had a new moderator each time, as we wish to get the broadest and most varied insight into the subject (Greenbaum 1988:56). In this way we believe that each of us might be able to bring forth different aspects in the focus group as we each have different personal qualities and characteristics and thus have different aspects, which we are indirectly more attentive to. This is highly connected to our constructivist stance in arguing that meaning is constructed in a context and through interaction. In this regard, Goldman note that the moderator should be a trained psychologist (Goldman 1962:64). However, one could argue that, as our informants were mainly students (or else former students) using ourselves, as a moderator might have been beneficial as we are ourselves students. In this way, we might have something in common with our informants, at least our current occupation. This might have made the informants feel more comfortable as they may feel as being on the same level as us, instead of being interviewed by a psychologist, which might intellectually and age-wise be on a different level in terms of communication, understanding and interaction. In this way, students interviewing students, might be helpful in quicker creating rapport between these two parties, beneficial as the informants might thus be more inclined to speaking and sharing freely

Besides having the characteristics of a qualitative researcher described in paragraph 4.2.2., "*The moderator's objective is to focus the discussion on the relevant subject areas in a non-directive manner*" (Cox et al. 1976:79) by facilitating the group (Bloor et al. 2001:48; Greenbaum 1988:52/50) in terms of focusing on the flow of the discussion and only intervening when the discussion goes beyond interest (Stewart et al. 2007:38). Besides, we were as moderators aware of breaking dominant informants' flow of speech, without alienating him/her (Greenbaum 1988:61) as it might affect other informants in relation to what they said or completely have inhibited them (Axelrod 1975:441; Krueger 1993:76; Stewart et al. 2007:43). Moreover we tried to encourage the more silent informants as we wish to get a nuanced picture (Tynan & Drayton 1988:7; Bloor et al. 2001:49; Stewart 2007:30; Wells 1974:141; Wolf 1975:142; Krueger 1993:74/76; Sampson 1978:29). In moderating we tried to ensure that everyone got a say and could speak their opinion, whether it were to agree or disagree (Szybillo 1975:448; Wolf 1975:142; Stewart et al. 2007:89; Krueger 1988:82; Greenbaum 1988:67) as all informants have valuable knowledge to share (Krueger 1993:76). Sometimes, some informants were a bit talkative and eager and could be hard to stop, but a natural balance between these and the other informants were sought by asking the other informants about their point of view. Nonetheless, the more talkative informants were helpful in getting the shyer or less talkative informants to participate as they were stimulated by their statements and as

they should not have to be the ones starting a topic as someone else did it by themselves. In connection to the above, the moderator thus highly affects the quality of the knowledge constructed (Krueger 1993:74; Hesse-Biber & Leavy 2011:185; R&D sub-Committee on Qualitative Research 1979:116; Bellenger et al. 1976:11; Morgan 2001:151; Hess 1971:235; Axelrod 1975:439; Templeton 1994:102), as the focus group might otherwise never get to cover elements of interest (Stewart et al. 2007:38/91; Morgan 2001:148-149; Tynan & Drayton 1988:5; Frey & Fontana 1993:30; Sampson 1978:29; Stewart et al. 2007:91; Morgan 1997:48; Templeton 1994:187). Moreover as social constructivists, we argue that the moderator becomes a part of exploring and researching (Wilkinson 1998:120) and thus the moderator's effect but should be seen as a feature instead of a problem (Wilkinson 1998:120; Burt & Code 1995:9). Thus we come with knowledge, beliefs and understandings (Kennedy 1989:56) which might bring further aspects forward, but still we should not lead the informants into giving specific answers, through our own thoughts and anticipations (Tynan & Drayton 1988:7; Potts 1990:12-13; Stewart et al. 2007:44/64; Axelrod 1975:437; Bellenger et al. 1976:27-28; Berg 1998:111; Greenbaum 1988:58; Templeton 1994:43/200; Edmunds 1999:70/101; Kennedy 1989:57; Fern 2001:94-95).

Moreover, the moderator must try to create a tolerant and friendly atmosphere, as there might be the risk of informants feeling pressured to feel, express and agree with what is socially acceptable in trying to please the moderator and/or the other informants (Lincoln & Guba 1985:302; Potts 1990:12; Morgan 1993:229; Goldman & McDonald 1987:167; Krueger 1988:41). Our awareness and aspiration of trying to create a tolerant atmosphere allowing the informants to say what they mean and feel is connected to the aim of the *prolonged engagement* of the *credibility* criteria, which is to detect distortions as this consensus could be. Hence the creation of much consensus could be a hindrance for the wish to get insights into the informants' multiple realities and understandings. However, in this regard it is important to remember, that focus groups create their own norms and values, which are not necessarily consistent with the ones in society (Goldman & McDonald 1987:168). Related hereto Lincoln & Guba mention that one should be aware of distortions in the form of intended lies (Lincoln & Guba 1985:302-303). However, we cannot guard against such lies and moreover we do not view reality to have a true nature as reality is a continuous subjective construction created in a specific context. Thus this concern put forward by Lincoln & Guba is not of particular concern to us, as we do not look for one truth. Furthermore how reality is perceived can also change e.g. in the course of the focus group interviews as knowledge and meaning is constructed during one such. In pinpointing our argument Goldman & McDonald argue that people might "lie", when thinking about what they might have said in another context, but this is not something they necessarily are conscious about (Goldman & McDonald 1987:166-167). Therefore one can say that informants do not lie during a focus group, but rather frame their answers in

accordance with the given situation and therefore their answers are true in the context they find themselves in, but not necessarily when moved on to another context.

The awareness of trying to make the informants feel comfortable and relaxed (Tynan & Drayton 1988:7; Wolf 1975:142; Macfarlane Smith 1972:107; Berg 1998:110) in order to make them speak their honest opinion (Wells 1974:145) was also an attempt from our side to try to create a relationship of trust with the informants (Krueger 1993:69; Greenbaum 1988:60; Edmunds 1999:73-74). This was attempted by being interested in them and in hearing about their thoughts and feelings (Wolf 1975:142; Krueger 1993:75; Axelrod 1975:439) being flexible and being able to come off as sincere and emphatic (Krueger 1993:73; Greenbaum 1988:53; Edmunds 1999:71-74; Stewart et al. 2007:69; R&D sub-Committee on Qualitative Research 1979:119; Greenbaum 1988:53). Thus we wished to make the informants feel important by telling them that we were interested in them and their point of view and clarifying their significance for the inquiry, hereby being included as a part of the interview guide, as can be seen in appendix 9.1.2. This attempt to build trust with the informants and, as mentioned, trying to build a rapport by thoroughly informing the informants through e-mails and keeping our promises such as conducting the focus group interview as promised beforehand is founded in the wish to enhance the *credibility* of the thesis. Building trust is a part of the technique of *prolonged engagement* as trust is a developmental process (Lincoln & Guba 1985:303). As we were not in contact with the informants for a longer period of time, we were aware and careful toward building trust in the contacts we had with the informants to increase the possibility of getting insight into the informants' attitudes.

4.5.5. Before the Focus Group

The timeframe for the focus groups was chosen to be two hours, which was based in the amount of topics wanting to cover and at the same time having the time to discuss these. Moreover, it was chosen on the basis of the amount of informants participating in each group, as we would like for each of them to have the time to come across with their opinions. Finally, two hours were chosen as we did not want to take up too much of the informants' time and as we did not want it to be too long in terms of the informants' concentration and interest.

Before the interview began we had the informants fill out a self-completion questionnaire, which can be seen in appendix 9.1.3.1. (Welch 1985:248; Bloor et al. 29991:39; Krueger 1988:76; Morgan 1997:57). This might have been helpful in terms of awkward silences giving the informants the opportunity of fiddling with something without feeling pressured to talk to the other informants straight away (Bloor et al. 2001:39). Moreover this should ensure getting the demographic information on the informants, which could be useful in the analysis in increasing understanding of the informants' attitudes (Bloor et al. 2001:39). Hereafter we had the informants write down their thoughts and assess their own knowledge on the topic, which

is also helpful for the analysis as this might help us understand their own knowledge and attitude toward the topic. In close relation hereto, we gave the informants the opportunity of noting whether they have taken any prescription medicine themselves or have any close relations that have, as this might affect their attitude toward the topic, in order to tap into their experience with prescription medicine.

4.5.6. During the Focus Group

Beginning the actual focus group our moderator presented the researchers present and their individual roles (Templeton 1994:28; Stewart et al. 2007:93; Edmunds 1999:79-80). Moreover the moderator told the informants a bit about the topic (Stewart et al. 2007:95; Krueger 1988:64; Morgan 1997:48; Greenbaum 1988:87; Tynan & Drayton 1988:7; Wells 1974:140) in terms of why we are interested in it (Morgan 2001:148) hereby making the purpose of the study clear (Stewart et al. 2007:93; Morgan 1997:48-49; Edmunds 1999:127; Krueger 1998:38). Morover, our informants were promised confidentiality despite being recorded on audio and video (Stewart et al. 2007:94; Berg 1998:110; Edmunds 1999:78-79; Greenbaum 1988:87/144; Greenbaum 2000:128; Templeton 1994:99; Morgan 1998a:88). Yet, what was said during the focus group, can naturally be brought outside of the group afterwards, by some of the other informants, as the informants are not mutually anonymous – however we cannot do much to prevent this (Morgan 1993:239; Berg 1998:114; Morgan 1997:32). Finally, we had a round of introduction about the informants themselves (Wells 1974:140; Templeton 1975:443; Stewart et al. 2007:95; Greenbaum 1988:89; Templeton 1994:28) with the purpose of being easy for them to talk about (Szybillo 1975:448), hereby breaking the silence and making them more confident as they had then already said something (Wolf 1975:142; Krueger 1988:81; Morgan 1997:49). Moreover, the informants got to know each other a little bit better in order to build rapport between them (Fern 1982:11; Stewart et al. 2007:95).

Hereafter we implemented a *funnel structure* (Morgan 1997:41; Morgan et al. 2008:192; Morgan 1997:41; Stewart et al. 2007:76; Krueger 1998:39) where the discussion started off being general and continuously became more specific (Payne 1976:343; Macfarlane Smith 1972:107; Stewart et al. 2007:38/61/76; Krueger 1988:66/82; Greenbaum 1988:89-93; Greenbaum 2000:93; Krueger 1993:77-78; Krueger 1998:39). Even though most of informants declared that they had relatively little knowledge on the topic, as can be seen in appendix G, the strategy of starting broad and referring to a familiar context seemed to lead the informants gently onto the topic and hereby making it easier for them to discuss and by the end the informants had a lot of thoughts concerning the topic. This was done in the following way:

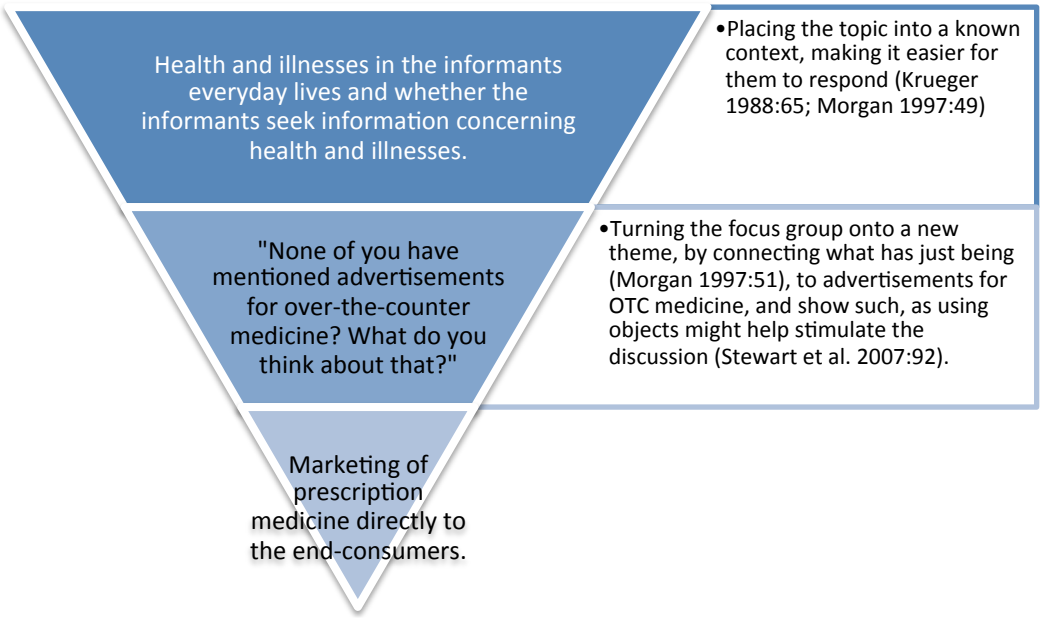


Figure 4: Funnel structure of our focus group

Such a structure was to make sure that the topic was not started straight on, enabling the informants to relate it to elements in their everyday lives making it easier for them to discuss it (Morgan & Krueger 1993:13), especially as the topic in focus for the informants is highly likely not to have been experienced.

4.5.6.1. Interview Guide

The interview guide consisted of themes (Knodel 1993:36; Peterson 1975:148; Payne et al. 1975:434) that entailed open-ended questions in order to get insight into the informants' point of view and explanations of these (Stewart et al. 2007:65; Krueger 1988:60/63) and probes hereto, which enabled our moderator to bring aspects up more naturally (Knodel 1993:37; Krueger 1988:30; Edmunds 1999:12; Greenbaum 2000:87). The interview guide was founded in the insights gained through the explorative interviews, the review of the literature and the theory read, which can be seen in appendix 9.1.2. Thus different sources were used in trying to identify the relevant characteristics, increasing the likelihood of identifying characteristics of relevance as proposed in the technique of *persistent observation*. Hence this approach could enable us to improve the *credibility* of the interpretations. Nonetheless, we still had an open mind in conducting the focus group interviews, hence being somewhat guided by the statements of the informants as this thesis has an explorative nature.

Additionally, it was important for us, that our moderator should be able to adapt the question to the situation and come up with questions during the discussion (Knodel 1993:38; Berg

1998:109; Stewart et al. 2007:83) and hereby be attentive and open to the informants' point of view and learning about these (Hesse-Biber & Leavy 2011:184). Hereby the informants were made able talk freely, thus ensuring that vital elements that were not planned for were not be cut out (Berg 1998:110). Hence our focus group were *moderately structured* (Morgan 1998b:52-53), as our moderator did not follow the interview guide slavishly (Wells 1974:134; Morgan 1997:48; Greenbaum 1988:60; Templeton 1994:64). This is beneficially used in exploratory research, as we will thus learn more about what is important from the informants' perspectives (Stewart et al. 2007:38-39/91; Morgan 1997:39-40; Morgan 1998a:13; Morgan 1998b:46-48; Hesse-Biber & Leavy 2011:183; Berg 1998:104; Morgan 1997:40; Morgan 1992:183; Fern 2001:85).

4.5.6.2. Focusing Exercises

Moreover, we implemented *focusing exercises* where we tried to concentrate the focus group on a specific topic (Bloor et al. 2001:43), in trying to stimulate the discussion (Wolf 1975:143; Greenbaum 2000:105; Morgan et al. 2008:198; Hesse-Biber & Leavy 2011:182; Stewart et al. 2007:92), as the informants often know more than they are able to explain (Miller 1991:10/19). Firstly, when talking about OTC medicine, we showed them Danish advertisements for such, which can be seen in appendix D , in order to spark their interest and hear their comments about these, which might allow for insight into their attitudes toward the topic. Secondly, we had the informants place eight illnesses/medicinal products on a continuum in terms of whether the informants thought it was legitimate to advertise the individual items directly to end-consumers. The reason for including this aspect was that two studies have found that the type of medicine could influence people's attitudes toward DTCA. Here US study consisting of both qualitative and quantitative data, it was suggested from the qualitative data that DTCA of depression medicine was of concern, as people felt that they could see themselves being depressed due to the simplified symptom descriptions (Hausman 2003:231). Moreover, an Australian study concluded that the appropriateness for DTCA of different types of prescription medicine differed. Two were perceived inappropriate: antidepressants and respiratory steroids, whereas heart medication and sexual dysfunction was in the middle. On the other hand anti-obesity, cholesterol reducers, antihistamines, analgesics and smoking cessation were perceived appropriate and indeed the latter very appropriate (Miller & Waller 2004:399-400). The eight chosen in this thesis, are as seen in the figure:

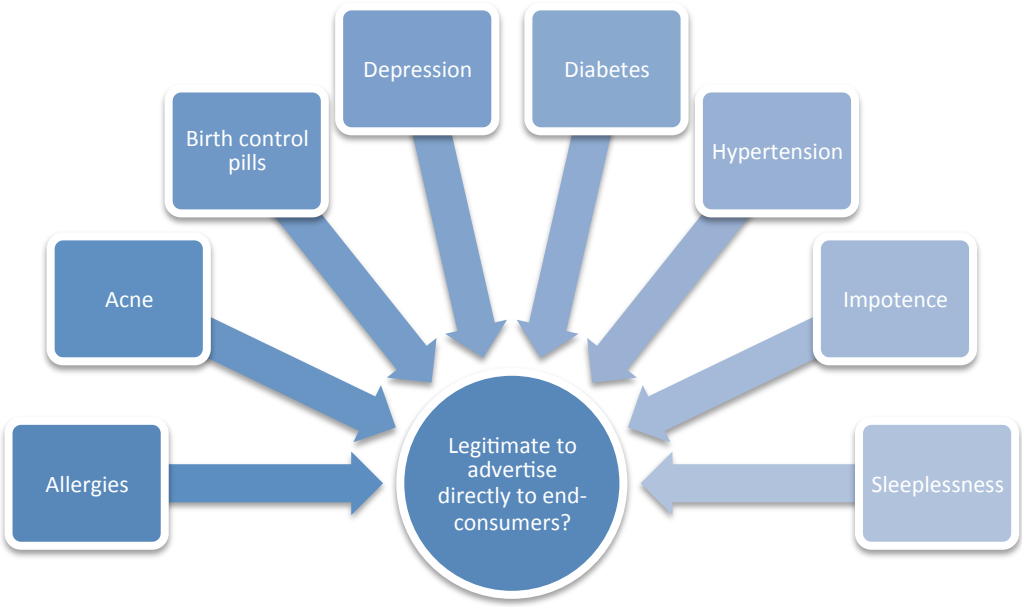


Figure 5: Legitimation of eight different illnesses/medicinal products (own construction)

Some of these were chosen on the basis of the above mentioned studies, and on the basis of the US interviews, where some of these were brought up by the informants themselves. Furthermore these have been chosen as they represent different illnesses/medicinal products in terms of cause, effect and risk, thus including a variety of types of prescription medicine, which is further a product-category that includes great diversity, as seen in paragraph 1.2.2. Each of the informants were asked to place these individually by themselves on a piece of paper and hereafter they were discussed in the group, which can be found in appendix H. By doing it this way, we ensured that both initial thoughts and the discussion were "documented", hereby capturing all thoughts (Krueger 1998:42). Thirdly, the group was shown three different US TV-advertisements for prescription medicine, which can be found in appendix E,

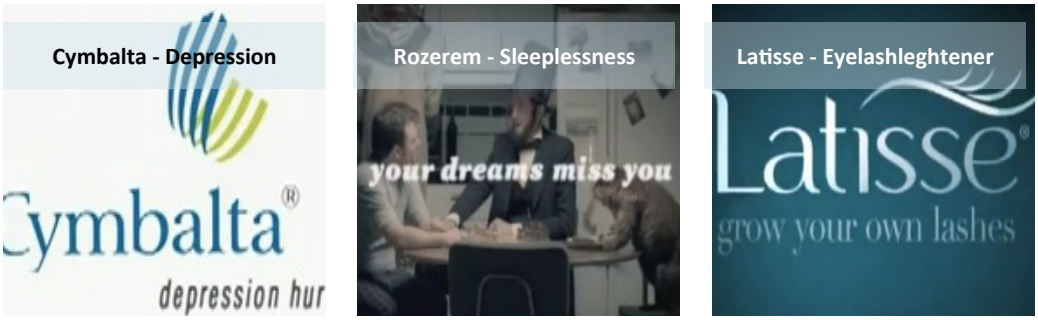


Figure 6: Three US TV-advertisements

These have been chosen as they also represent different illnesses/medicinal products and as the content of the advertisements differ in terms of seriousness and humour. During and after each of these, the informants were asked to write every initial thought about the advertisements, where after the informants' thoughts and opinions about them were discussed in the group. As mentioned, these focusing exercises were implemented in trying to stimulate the discussion, and thus these were carried out in order to obtain the wished understanding of their attitudes.

The informants' talking and sharing was accelerated by the use of these exercise of placing different prescription medicines on a continuum, actually resulting in it taking longer than it should in all three focus groups, even though this was tried to be prevented. In this way, this took time from the final showing of three US TV-advertisements, which meant that there was only time to briefly hear their thoughts concerning them, before ending the focus group. This meant that the last focus group went ten minutes over time, meaning that two informants had to leave a bit before the end of the focus group, thus one informant could not participate in the last talk about the advertisements. After the focus groups we found that the amount of medicines that the informants should place on a continuum could have been downsized considerably as it took up too much time, where some of the last ones were not thoroughly discussed in order not to go over time. Moreover these could have been limited as some of the prescription medicinal products chosen brought similar notions, thoughts and comments, perhaps due to them being similar. Consequently, we could have used more time but should rather have limited the amount of medicinal products that the informants should place on a continuum.

4.5.7. Ending the Focus Group

After the focus group, we shortly debriefed, where we asked the informants for finalizing thoughts and comments (Krueger 1998:26) and lastly thanked them for their time (Krueger 1988:88; Greenbaum 1988:98). By the end of each focus group it was evident that the inform-

ants were eager to talk about and interested in the topic, and thus we could have easily used more than two hours (including break). Further, we had an evaluation schema, which can be seen in 9.1.3.3., where the informants, after the focus group were to evaluate the focus group. This feedback was beneficial as it indicated whether something should be changed or dropped for the next focus group, in order to obtain the best possible understandings (Wells 1974:141), which meant that the interview guide was slightly changed after the first focus group. Some informants mentioned that they would like more information on the topic, and thus we found it advantageous midway to tell about EU proposal concerning liberalizing the current legislation. Moreover we found that, after the first focus group, winding down the group, it was beneficial to ask the informants to summarize their thoughts and feelings in relation to the topic (Morgan 2001:149; Templeton 1975:443; Krueger 1988:88; Morgan 1997:51; Templeton 1994:28), in order to sum up the informants' attitudes as the informants have thus discussed the topic with the other informants. Moreover, this also ensured that everyone got their individual opinions across. This change was also made in the effort to try to represent the informants' constructions of attitudes adequately. Thus it is also an attempt to increase the *credibility* of the thesis, as seen in paragraph 3.2.1.

Hence, made use of an *open-ended approach* in which we learned as we go, meaning that if we learned anything vital in a focus group, this was brought onto the next (Hesse-Biber & Leavy 2011:180-181; Greenbaum 2000:13), as long as it would provide value to the final knowledge constructed (Edmunds 1999:78). In this way, we were open for emergence between groups, where the knowledge constructed in one focus group were reflected upon before the next group (Morgan et al. 2008:191-193), enabling the later constructions of knowledge to be modified in terms of what was learned (Morgan et al. 2008:192), which is a part of the hermeneutic spiral. Hence, this choice of using this process of adopting the new acquired knowledge to revise and the improve the construction of knowledge is also based the wish to enhance the *credibility* of this thesis as this process is similar to that of *negative case analysis* (Lincoln & Guba 1985:309-313), thus enhancing the likelihood for understanding the multiple realities of the informants in order to present these adequately. In this way, we had a *rolling interview guide* as it could be modified continuously (Stewart et al. 2007:62-63; Greenbaum 1988:79) in order to get as much insight as possible as a part of our *open-ended approach*.

4.6. Supplementary Interviews

After having conducted the focus groups, we found that there were certain aspects, which it would be advantageous to obtain more knowledge about through supplementary interviews. In this way, we conducted supplementary qualitative single interviews with four informants from two of the focus groups, Allan, Helle, Lise and Pernille. These were conducted approxi-

mately three months after the focus groups, which might mean that the informants' statements in these supplementary interviews, due to being framed in a different context compared to the focus groups, might differ and other aspects might be included as also indicated in paragraph 4.5.4. This could also be connected to our ontological stance, regarding subjective constructions not being stable but being continuously constructed by individuals (Bo 2008:30/63; Wenneberg 2000:87; Delanty 2005:145; Hirschman 1986:238). These informants were chosen on the basis of that they were quickly accessible in terms of conducting the supplementary interviews, but also as they represented different viewpoints on the topic. During these, a main interviewer, an assistant interviewer and the informant talked about the knowledge constructed during the focus groups, to elaborate on this. Hence the wish was to deepen our understanding. These interviews had the focus on differentiating even more between advertising and information as suggested by the proposal, as we after the focus groups thought that additional knowledge was needed about the latter, as well as these two aspects seemed to be intermixed in some instances by the informants. In this way, the informants were asked specifically about the proposal of legalizing information coming from the pharmaceutical companies and the secondly, about DTCA of prescription medicine. These were thus conducted in order to obtain more refined and deeper understanding about these two different aspects, as this distinction is vital in our thesis as our problem formulation includes these two aspects as seen in paragraph 1.1. These supplementary interviews will thus be used on equal terms with the focus groups during the analysis as these might bring vital understanding hereto.

4.7. Analysis Strategy

This paragraph will clarify and justify how we will transcribe the interviews and how these interviews will be analysed.

4.7.1. From Speech to Text - Transcriptions

Transcribing the interviews is important as relying the research and the analysis on memory only is too risky in terms of ensuring high quality (Bloor et al. 2001:41-42; Wells 1974:137; Krueger 1993:78-79). Moreover, transcriptions will allow for a more systematic analysis (Halkier 2009:70), which is important in our case at aiming at understanding the informants' attitudes and the constructions hereof. The person transcribing the interviews is responsible of transcribing it as precise as possible in terms of what is being said and by whom (Krueger 1993:79). In order to ensure this, we will each be assigned to transcribe the interviews that we have conducted. This might make it easier as the person transcribing has been highly involved in the interview (Edmunds 1999:89; Krueger 1993:112; Halkier 2009:70) and consequently might be best suited for the job (Bloor et al. 2001:61-62). Ensuring who states what is extremely important (Bloor et al. 2001:60-61) and thus, we both have audio and video recording

(Morgan 1997:56). In this regard it must be mentioned, that the supplementary interviews conducted will not be transcribed due to timely constraints.

Naturally, the transcription will never mirror the focus group, as transcriptions is a transformation of a verbal discussion into text (Kvale 1997:167; Halkier 2009:70) which cannot provide all of the knowledge constructed in the focus groups such as nonverbal communication (Edmunds 1999:93; Stewart et al. 2007:111). Transcription is thus a process of (de)selection (Halkier 2009:70) and interpretation in terms of choosing how elaborate to be, hereby making the transcription decontextualized (Kvale 1997:163/166/168). Thus, the process of analysing focus groups can be put on a continuum (own adaption from Krueger 1997:109):

Interview ↔ Transcription ↔ Interpretation forming analysis

In this way the transcription is a sort of "mediator" between the interview and the actual analysis. Thus we will be able to go back to the audio and video recordings during the analysis to heighten that the interpretations are founded in the data as aimed for in the validity criterion of *confirmability* (Hirschman 1986:246). A more detailed description of how the transcriptions will be conducted and should be understood when read, can be found in appendix 9.2.

4.7.2. Creating Meaning

In trying to create meaning from the constructed knowledge each of us will read the transcriptions individually. This is a way of heightening the *dependability* of the thesis as Hirschman argues that this can be increased by focusing on the use of multiple researchers. Even though perfect correspondence should not be expected, because the interaction between the individual researcher and phenomenon studied is unique (Hirschman 1986:245-246). As we are three researchers it gives us the opportunity to try to increase *dependability* by engaging in an analytic approach in which consistencies can be found (Knodel 1993:50). Thus if each of us find the same topics or patterns, meaning that some consistencies are found then *dependability* could be strengthened. Additionally, by looking at the transcriptions independently, we might also find a broader variety of aspects than we would if done collectively thus heightening the possibility that different meaning constructions in relation to the end-consumers' attitudes are found. Hereafter we will discuss our findings together (Knodel 1993:50). Applying this form of analysis strategy is also based in the aim of increasing *credibility* of this thesis by actively using triangulation of multiple researchers, which as mentioned lead to finding a broader variety of aspects, thus creating richness and depth as linked to constructivist paradigm, but might also reduce personal biases as the other researchers can perhaps pinpoint these. As a result, the probability of *credibility* of the interpretations increases (Denzin 1978:295; Lincoln & Guba 1985:307).

As all of us were attending the focus groups, this will enable a more thorough analysis on behalf of these as we have all experience (Goldman & McDonald 1987:162). In this regard, it is important to note, that the focus group will be the primary interviews used in the analysis as these are the ones giving us the point of view of the informants' attitudes. But the explorative interviews with the US end-consumers and the individual interviews with the Danish GPs, will also be implemented in order to support, give another insight or perspective on the knowledge constructed in the focus groups and in order to help us reach an understanding of the topic and field studied.

In this initial interpretation process we wish to have a look at the shared and common themes, which can be derived from the statements or comments of the informants (Edmunds 1999:94; Krueger 1988:109). This is thus a sort of indexing where the purpose is to index the knowledge constructed in the focus groups into themes and elements relevant for the analytical framework (Bloor et al. 2001:63; Krueger 1988:114/116; Goldman & McDonald 1987:163; Halkier 2009:73). Hence, reading the transcription we will be aware of aspects relating to themes and thus find the overall lines of the focus group. For example, in wishing to explore end-consumers' attitudes, a theme might be the GP, as this might be an aspect of the formation of attitudes. However, we will also be aware of everything that is not encompassed in these overall lines (Frankland & Bloor 1999:147), which is linked to the exploratory purpose (Fern 2001:93). Thus the disadvantage of indexing is to lose overview of the context as the focus is on smaller parts (Lofland & Lofland 1995:192). As the knowledge constructed during the focus group is situated in a context, this must also be taken into consideration when analyzing the informants' statements (Krueger 1988:46).

Morgan argues that, "*The analysis of focus groups involves a more subjective process of listening to and making sense of what was said in the groups.*" (Morgan 1998a:30) and thus, we wish to make use of what Kvale defines as *meaning interpretation* (Kvale 1997:191). Important to remember here is that interpretation means presentation of meaning providing understanding rather than a summary (Krueger 1988:110). By doing this we wish to reconceptualise the informants' statements in relation to a broader context (Kvale 1997:191), which can be e.g. the focus group as interaction or in relation to our theories concerning attitude formation. In this way, our theories will be implemented in relation to the themes found (Halkier 2009:76) in order to understand the informants' attitudes and the underlying constructions. Here we will also try to see our findings in relation to other studies conducted (Halkier 2009:77), with a similar topic as seen in paragraph 5. Moreover we wish to interpret the informants' statements by going beyond what has been said in order to gain a deeper understanding of their constructions of meaning and knowledge and thus reach an understanding of their attitudes (Kvale 1997:191/199). In this way, we will try to understand what is being actually meant, rather than just what is being said (Goldman & McDonald 1987:166). Hence it

could be possible to create more sophisticated constructions as mentioned in paragraph 3.1. In this way, interpretation is as shown on the continuum a step further than the initial knowledge constructed in the focus group, as it goes beyond the words being said (Krueger 1988:111). As a part of doing this we will include quotations from the focus groups in order to support our interpretations, which can be ideally shortened to bring out the relevant meaning (Kvale 1997:190; Edmunds 1999:94). Thus, as mentioned earlier, if any general themes are found, we wish to include these in the analysis (Edmunds 1999:94; Krueger 1988:108-109). Hence in the analysis, the transcripts will be "divided" into subdivisions on the basis of patterns in meaning and knowledge constructed in the focus groups (Seidel & Clark 1984:110/112-113/123). Finally, we will be critical and reflexive in relation to our own interpretations and findings in which we are aware that our interpretations will be based on the way we analyse and question the constructed knowledge (Halkier 2009:77-78).

4.8. Overview of Interviews

As seen during the paragraphs above, a variety of interviews have been conducted in order to obtain the knowledge wished for. An overview of these can be seen in the figure below:

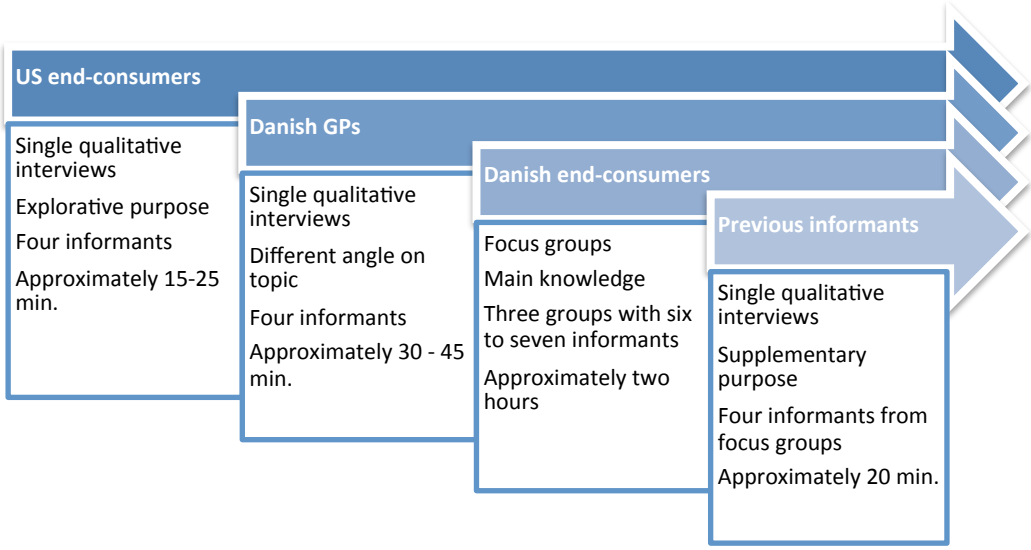


Figure 7: Overview of interviews (Own construction)

Hence it is seen, that the explorative interviews with US end-consumers were firstly conducted in order to gain insight into topics to include in the interview guide as well as which theoretical aspects to look into. Next, single interviews with Danish GPs were conducted alongside with focus groups with Danish end-consumers. Most weight is on the focus groups with the Danish end-consumers, functioning as our main knowledge. Hereto the knowledge obtained through the interviews with Danish GPs has the function of providing a different angle and understand-

ing to the topic and hereby sensitise us in relation to the topic. Lastly, supplementary interviews were conducted with informants from the focus groups in order to obtain more refined knowledge on specific aspects for achieving a more refined and deeper understanding of the informants' attitudes.

In this way, the process from conducting the interviews, to the transformation of speech to text and to the beginning of analysis has been tried clarified in order to create transparency. Next we will focus on the theoretical aspects that should hopefully help us in obtaining an understanding of the constructed knowledge from the interviews, concerning the informants', as end-consumers, attitudes and the constructions hereof toward marketing of prescription medicine.

5

Theory: *The Prescription*

With the wish of obtaining a wide and deep understanding of the informants' diverse attitudes toward the topic, we will make use of a range of theoretical aspects (Banik 1993:48/50; Fielding & Fielding 1986:33; Hammersley & Atkinson 1995:214). Hence we will be making use of the possibility of theoretical triangulation (Denzin 1978:297:301; Thurmond 2001:254/257). The choice of these is based on a review of literature on the topic, where findings from previous research conducted in other cultural contexts will be included. Moreover, these have been chosen in close connection with the explorative interviews with US end-consumers. Thus multiple perspectives will be used to interpret the constructed knowledge of the interviews conducted, as a way of trying to enhance the *credibility* of this thesis (Banik 1993:48/50; Fielding & Fielding 1986:33; Hammersley & Atkinson 1995:214), as these different theoretical perspectives could provide insight into the multiple realities and attitudes of the informants in regard to the field of interest. Hence these theoretical aspects are included as they might represent features enabling us to answer our problem formulation and thus create valuable results. In this way, these different theoretical aspects will together constitute a collected insight into the formation of attitudes. As they are highly connected, they will each refer back and forth to the other paragraphs. Thus the hope is that this collected insight will help us answer our problem formulation more thoroughly. These theoretical aspects thus function as means of trying to get a more comprehensive understanding of the end-consumers' attitudes. The choice of these will naturally mean a de-selection of others and hereby perhaps also a de-selection of other perspectives. In this way, the theoretical aspects chosen will yield construction of specific knowledge and in this way, one must be aware that these will not necessarily be exhaustive in the sense that these will affect the obtained knowledge. Even though we have chosen some specific theoretical aspects, we are open to the possibility of these not being adequate in achieving the wished understanding in the analysis and thus the need to revise and include other theoretical concepts. This is part of the emergent process of constructing knowledge as we adhere to the constructivist epistemology.

This paragraph will thus consist of a range of theoretical aspects concerning the complex field of attitudes. A considerable part of these focus on the attitude formation process, as the topic of our study, is one that the end-consumers have not yet been exposed to in a Danish context. This focus is based on the notion that the informants we wish to study, will most likely not have an attitude formed toward this, and will thus perhaps have to form this during the focus group. Moreover, as a review of literate showed that this topic had mainly been studied quantitatively, the wish is thus to try to understand and get insight into, what underlies the informants' attitudes, rather than merely finding out what their attitudes are. As it will be argued below, the attitude formation process will be influenced by a range of aspects and hereby the complexity is further increased. Thus this paragraph will be composed on a range of theories with the focus on aspects that can affect the process of attitude formation.

Illustrated in the figure below, are the chosen theoretical concepts, which are all connected, due to the notion that the aspects contained in these will all affect the attitude formation process:

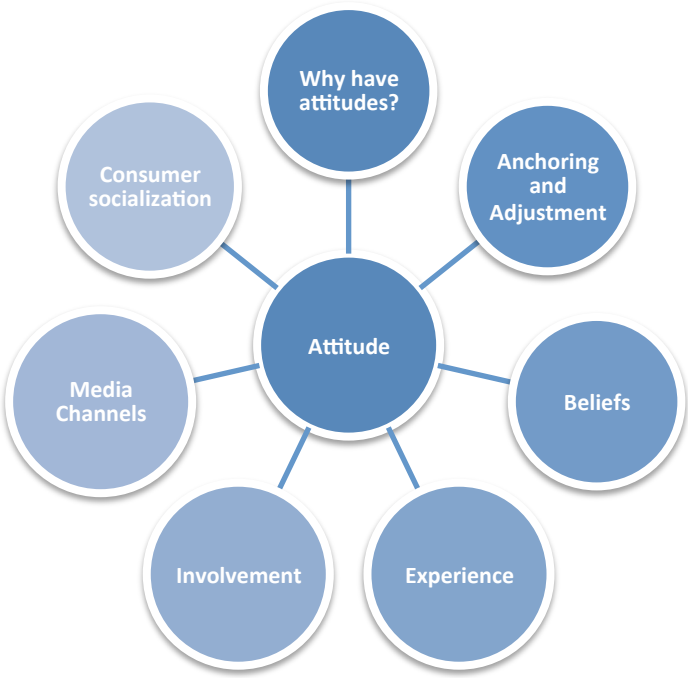


Figure 8: Structure of Theory (Own construction)

In this paragraph we will start out in the middle by clarifying the concept of attitudes and hereafter move through the different aspects, which influence the attitude formation process and thus ending with the notion of consumer socialization. Each of these will throughout their

respective paragraphs be related to the topic of the thesis in terms of how they can be helpful in answering the problem formulation. However, we will first have a look at some of the previous findings about attitudes toward DTCA of prescription medicine being one part of our problem formulation. Additionally, aspects hereof will also be included continuously in the paragraphs below.

5.1. Empirical Findings on Attitudes toward DTCA

In the following, empirical findings on attitudes toward DTCA of prescription medicine are presented. This is done in order to get insight into what has been written about the topic of DTCA of prescription medicine earlier, as it is necessary to become familiarized with existing knowledge in order to contribute with new knowledge to this field through this thesis. Moreover, as no theory has been found that concerns our topic in specificity this will provide us with a more focused perspective of attitudes in relation to marketing of prescription medicine, which might also help us understand these in regard to our topic. Before going into these findings it should be mentioned that if nothing else is delineated the studies are founded on some form of quantitative data.

As seen in a study including US and New Zealand respondents, the attitudes toward DTCA seem to differ depending on the aspect of DTCA, which the consumers are asked to assess. In some aspects the respondents seemed predominantly positive e.g. in claiming that DTCA create awareness of new medicines, whereas scepticism was expressed in regard to the possibility of DTCA confusing people (Hoek et al. 2004:216-217). In regard to the latter finding more than half of the respondents in a US study believed that they did not have the competence to evaluate the stated claims in DTCA and furthermore most respondents did not think that they were better informed by DTCA. In relation hereto almost half of the respondents were opposed to DTCA. Yet, some consumers still felt empowered by the DTCA in making their own health decisions (Singh & Smith 2005:374). Similarly, mixed results were found among US consumers, where over half thought DTCA was helpful and a fourth found it confusing and frightening (Brown 2010:17-18). This is in accordance with findings by Herzenstein et al. as they found that US consumers overall attitude including all aspects in the study, were of moderate extremity (Herzenstein et al. 2004:209/203). In supporting this latter finding, it has been found that consumers' attitudes toward DTCA are decidedly neutral. However, variations across individuals exist (Bell et al 1999:655-656). In another study scepticism was more widespread, as the respondents in both New Zealand and Belgium were overall relatively negative toward DTCA of prescription medicine questioning the informativeness and reliability of DTCA. However, the patients in Belgium are more negative than patients in New Zealand, which might be due to their lack of exposure to DTCA (Dens et al. 2008:56-58; Vatjanapukka & Waryszak 2004:357). As DTCA practice is not legal in Belgium, it could indicate that Danish

end-consumers would be negative toward the practice, if the legislation context is a crucial factor in consumers' attitude.

The results illustrated above might be related to the different ways that the researchers measured the end-consumers' attitudes toward DTCA. The parameters used as well as the number of parameters included could have an effect on the results. In the figure below an excerpt of the parameters can be seen with the purpose of merely giving an overview of these: [13]

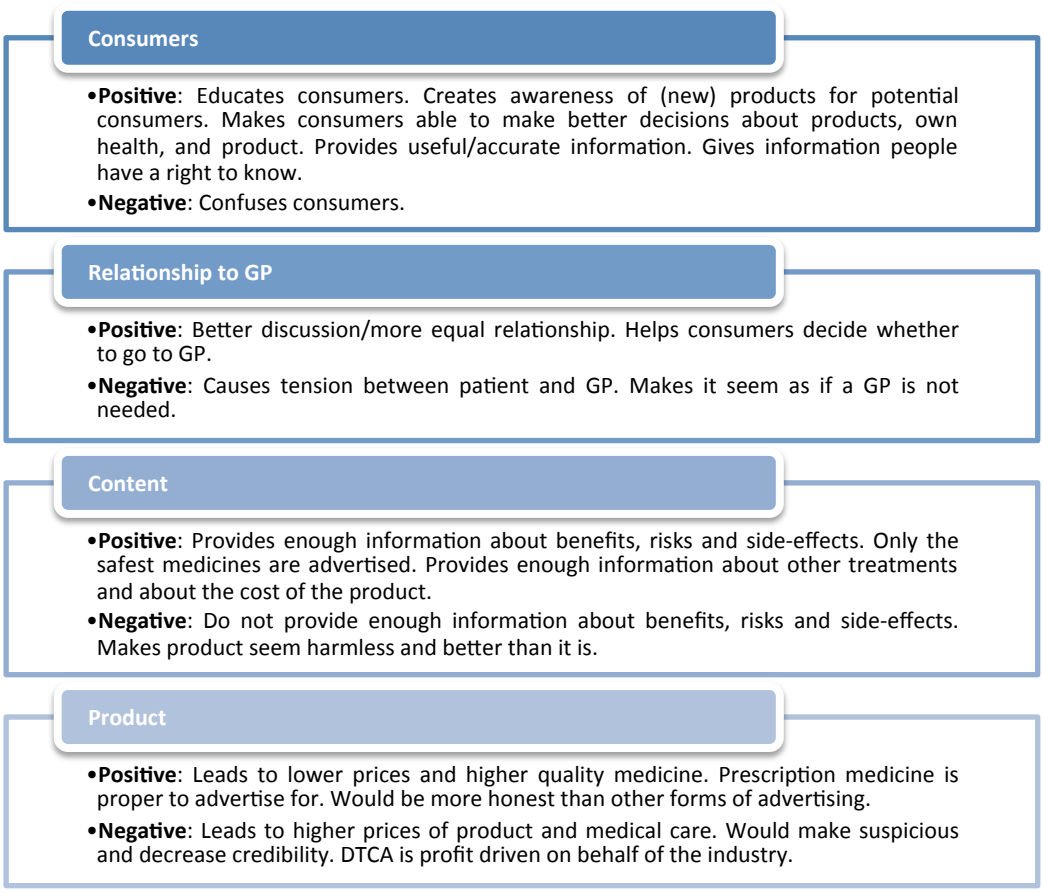


Figure 9: Own adaption (Aikin et al. 2004:45; Alerstein & Peyrot 1993:52; Hoek et al. 2004:217; Dens et al. 2008:53; Miller & Waller 2004:393; Joseph et al. 2008:126; Robinson et al. 2004:429; Herzenstein et al. 2004:207; Spake & Joseph 2007:287; Bell et al. 1999:652; Sumpradit et al. 2002:71)

[13] The specific parameters used in these individual studies, can be seen in appendix L.

As seen above the parameters are highly diverse, suggesting that this diversity is likely to be influential in measuring attitudes. Furthermore, this could indicate the value of a qualitative study, where one could get insight to the factors that the end-consumers' focus on, thus moving away from parameters formed by the researchers.

In a Danish context, only one empirical study regarding consumers' attitudes toward the DTCA was found. Generally, it was concluded that Danish consumers were positive toward medicine-related advertising. This tendency could be related to the finding that about 60% of the respondents found it acceptable to advertise for OTC medicine. However, only about a fifth of the respondents found advertising of prescription medicine acceptable (Rehne & Møldrup 2007:34). Furthermore, the findings showed that Danes were generally negative toward the role of the pharmaceutical industry in campaigns concerning health and diseases (Rehne & Møldrup 2007:37). Thus some of these tendencies might also be expected among our informants.

Among other things, the review of above studies showcases that end-consumers can have different attitudes toward different aspects of DTCA. This could indicate that it is a highly complex field, which might be valuable to study qualitatively in order to get a more nuanced understand of the attitudes and insight into the underlying reasons for these attitudes. Additionally, this literature review reveals that the research found has not taken a similar approach to the one we attempt. As a consequence our study attempts to narrow the knowledge gap of the end-consumers' attitudes by studying the topic from a new and different perspective that have not been done before. As a result, this thesis will contribute with new knowledge of this field.

5.2. Attitudes

Many definitions of attitudes have been proposed, but in current years, the definition of attitudes has been largely agreed to mainly possess an evaluative aspect (Schwarz & Bohner 2002:1; O'Keefe 2002:6; Albarracín et al. 2005:4). Attitudes can be argued to consist of two components; namely *direction* e.g. good/bad (Kardes 2001:85; Katz & Stotland 1959:428; Petty et al. 1997:611; Ajzen & Fishbein 2000:3) and *extremity* e.g. slightly good/extremely good (Kardes 2001:85). Moreover, the object that the attitude concerns can be *general* or *specific*, e.g. prescription medicine or anti depressants, and *physical* or *abstract* e.g. a print advertisement for a specific medicinal product or marketing for prescription medicine in general (Kardes 2001:85; McGuire 1985:239). Attitudes are generally defined as learned dispositions (Doob 1947:135; Allport 1935:811; Fishbein & Ajzen 1975:8-9/217; Sherif & Sherif 1967:115). In this way, attitudes can be anchored in *external information* where a third party's view, such as hearing about it through the media, is argued to effect attitude formation (Reed et al. 2002:375/386), which we will have a closer look at in paragraph 5.10. Moreover attitudes are

seen as a kind of readiness to respond to an object (Allport 1935:799/805; Rosenberg & Hovland 1960:1; Smith et al. 1956:33; Triandis 1971:6; Osgood et al. 1957:189) in a favourable or unfavourable manner (Fishbein & Ajzen 1975:6; Antonides & van Raaij 1998:197).

Theorists argue that attitudes can be memory-based (Albarracín et al. 2005:6) associations spontaneously evoked stemming from a cognitive process (Argyriou & Melewar 2011:1-6; Shavitt 1990:124; Katz 1960:167). In this sense, people are exposed to a stimulus, about which they form an attitude, which is then stored in memory. When exposed to this stimulus again, the attitude is evoked from memory (Argyriou & Melewar 2011:4) hereby being a heuristic process ensuring minimal effort (Ajzen & Fishbein 2000:12-13; Ajzen & Sexton 1999:122). In this way attitudes can be more stable. At the same time, attitudes are also argued as being able to be automatic, on the spot (Albarracín et al. 2005:6) evaluations formed via associations based on emotions and feelings (Argyriou & Melewar 2011:1/2; Feldman & Lynch 1988:422; Reed et al. 2002:375; Schwarz & Bohner 2001:5) and thus be more temporary. Consequently, attitudes can be both stable and temporary (Albarracín et al. 2005:5-6/746-747). An example could be an end-consumer having a negative attitude toward marketing of prescription medicine, as she believes that it will lead to unnecessary medicating. After several years she is exposed to an advertisement, which tells about alternatives to the hay fever medicine she has been taking for years, where after she gets a prescription for another medicinal product for this, which works better than the medicine she took before. Hereafter her attitude toward marketing of prescription medicine turns into being more positive. In this way, her attitude has been rather stable in the sense that it has been the same for several years, but at the same time temporary as it changed after having experience the practice herself. In relation to our informants' attitudes toward marketing of prescription medicine, it could be imagined that these might be more temporary as they are likely to be made on the spot, as they might not be aware of have experience with this practice. Hence the attitudes formed could be less stable and deep due to lack of cognitive processing beforehand.

As mentioned, due to the topic of interest our informants might not have an attitude toward the topic before we introduce it to them as they have not been exposed to the practice and might not even be aware of it. Thus it can be discussed what happens when people do not have an attitude toward an object and therefore must form one. In this case a person might put the object into a pre-existing attitude category and anchor it herein (Triandis 1971:3). For example a person might have an attitude toward marketing of OTC medicine, but not toward marketing of prescription medicine and thus, when being exposed to marketing of prescription medicine he might ascribe the same attitude toward this, as he has toward marketing of OTC medicine. Moreover, the construction of the new attitude might also be based on a combination of other attitudes (Arnould et al. 2005:634). Thus a person, who has no attitude toward marketing of prescription medicine, can thus combine his attitude toward marketing in gen-

eral and his attitude toward prescription medicine and hereby construct a new attitude – in this way, the new attitude is anchored in pre-existing ones. In this way, when exploring Danish end-consumers' attitudes toward this topic, their attitudes toward several other aspects might be useful in trying to understand these e.g. toward marketing in general and toward prescription medicine as a product, as these might have an impact on their attitude toward marketing of prescription medicine. Hereafter, when additional information is achieved, the attitude might be adjusted into being a more "suitable" attitude (Arnould et al. 2005:648). Moreover, as argued by Allport, "*An attitude is retained so long as it satisfies the individual, but is likely to be modified under the provocation of serious affective disorganization"* (Allport 1935:814), meaning that when attitudes no longer seem to fit, new information will be searched for and the attitude will be revised. In this way we argue that attitude formation is continuously developing as new information can always be added (Als & Heiselberg 2010:181), which can e.g. also be in the course of a focus group. Hence, the attitude expressed during the focus groups might not be the same as one expressed later on as attitudes can always be changed and refined. Thus attitudes will most likely never be exactly the same from time to time, as new information continuously will revise these in either small or greater ways (Allport 1935:822).

5.3. Expression of Attitudes

Attitudes can be expressed non-verbally and verbally. When they are verbally expressed they can be termed as *opinions* (Katz 1960:168), which can be seen as indications of a person's attitude (Fishbein 1967:477). Thus attitudes are not necessarily easy to gain insight into as they cannot be directly observed (Sherif & Sherif 1967:112; Schwarz & Bohner 2002:2; O'Keefe 2002:6; Doob 1947:36; Ajzen 2005:3; Allport 1935:839). In this way, we wish to gain an understanding of the informants' attitudes through the interpretation of their expressed opinions. In this regard, in order to have a chance at obtaining this understanding, the use of qualitative interviews can be argued to be beneficial. As mentioned earlier, we have conducted focus group interviews with the Danish end-consumers. In this way, we were able to explore their verbally expressed attitudes, as it is an interview. Moreover, as the practice is non-existing in Denmark and therefore most likely not to be discussed among the end-consumers, we will through our focus groups articulate a topic, which the informants might not have verbally expressed beforehand. Therefore, through the verbalization of this topic, meaning and their attitudes are likely to be constructed during the focus group. Yet, due to the interaction between the informants in the focus groups and the focusing exercises, which can be seen in paragraph 4.5.6.2., this might enable us to get an insight into their attitudes through non-verbal expressions.

In relation hereto Rosenberg & Hovland argue, that attitudes consist of the following three main components (Rosenberg & Hovland 1960:1-3; Schiffman & Kanuk 2004:256; Ajzen 2005:20) in their *Tricomponent Model* (Schiffman & Kanuk 2004:256; Ajzen 2004:20):

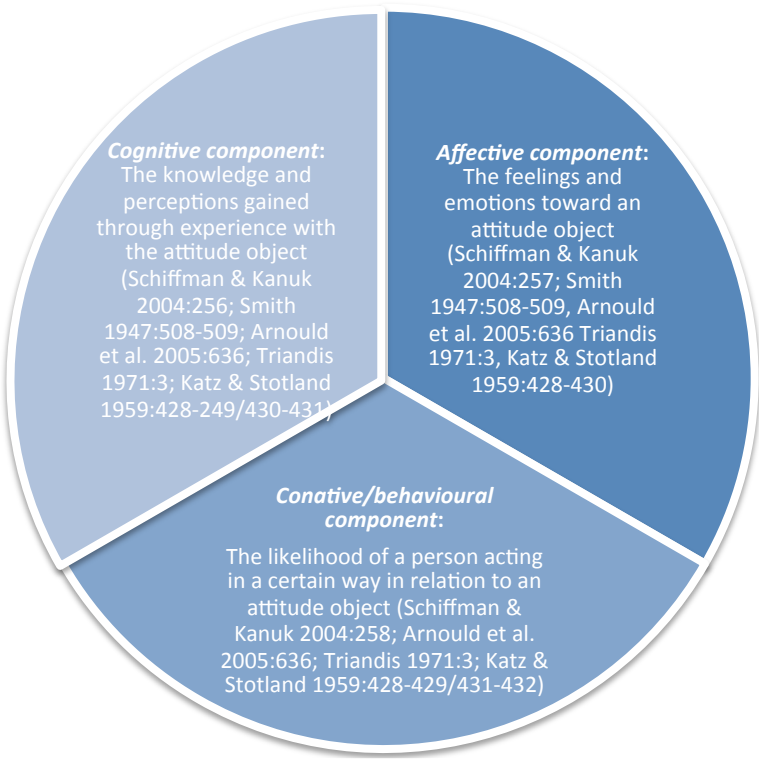


Figure 10: Rosenberg & Hovland's *Tricomponent Model* (Own adaption)

In relation to our topic, it might be argued that the *affective component* is of highest interest. This is based on the fact that the Danish end-consumers have not yet been exposed to marketing of prescription medicine directed at them from the pharmaceutical companies and therefore have experienced the practice in a Danish context and therefore the *cognitive component* is not directly relevant. Nonetheless, as briefly mentioned in the beginning of this paragraph, as they most likely have no attitude toward the practice and topic yet, they might base the formation of this new attitude in pre-existing ones. Hereby experience can have an impact as they might base the new attitude in e.g. their attitude toward marketing of OTC medicine, which they have experience with. Finally, we have the *conative/behavioural component*, addressing the likelihood of a person acting in a certain way, which could also be relevant as the informants might indicate their attitude in expressing their behavioural intentions. Behavioural intentions are claimed to indicate a person's readiness or intention to perform a specific be-

haviour (Ajzen 2002:667) and in this way, these behavioural intentions can be connected to the end-consumers' attitudes (Fishbein 1967:481-482). The relation between attitudes, behavioural intentions and behaviour has been a topic highly written about (see e.g. Schwarz & Bohner 2002:2; O'Keefe 2002:6; Doob 1947:136/143; Ajzen 2005:3/6; Allport 1935:805; Fishbein 1967:481-482; Sherman 1980:217; Triandis 1971:6; Petty & Cacioppo 1996:8; Antonides & Raaij 1998:202; Fishbein & Ajzen 1975:8). However, these relations are beyond the scope of this thesis as attitudes in itself are a highly complex matter and thus aiming at obtaining a rich understanding of these and the constructions hereof, these relations are excluded.

As mentioned, Rosenberg & Hovland argue that attitudes have three different components and that each of these components has a response (Ajzen 2005:3; Rosenberg & Hovland 1960:1/3; McGuire 1985:242). These can be verbal or nonverbal responses, in the sense that people can express these attitudes verbally or non-verbally. This results in the figure below with examples drawn from the medical field:

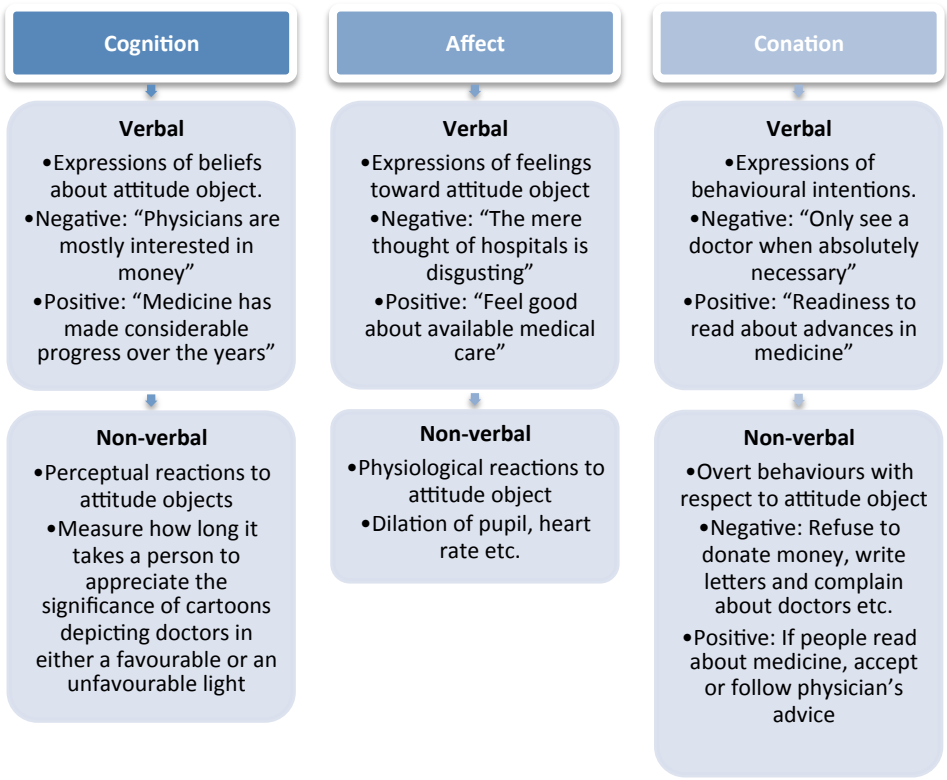


Figure 11: Responses used to infer attitudes from behaviour and examples (Ajzen 2005:3-5). Own construction.

Connected to the above figure we will focus mostly on the verbal expressions, which are stated in the interviews as mentioned in paragraph 4.2.1., due to the topic of interest as the Danish end-consumers have not been exposed to the practice of marketing of prescription medicine and thus we are not able to observe behaviour. However, interpretations of non-verbal responses might be included in order to increase our understanding of their attitudes, as mentioned earlier. In interpreting the constructed knowledge in trying to understand the informants' attitudes through their expressions, the elements of the *Tricomponent Model* seems useful as it creates awareness of the different components, which could comprise an attitude.

5.4. Why have Attitudes?

Attitudes have been argued to be either short-term or more long-term motivations (Argyriou & Melewar 2011:6-7/9; Wright 1975:61; Payne 1982:382) in order to fulfil a need, a function or a goal (Triandis 1971:4-5; Smith et al. 1956:41; Katz 1960:167; Argyriou & Melewar 2011:3-4/6-7/9; Shavitt 1990:125-126; Triandis 1971:5; Wright 1975:61; Payne 1982:382). In this way, attitudes can be said to be a motivation for people, where different aspects has been discussed (Eagly & Chaiken 2005:754). As we are interested in the underlying constructions of the Danish end-consumers' attitudes toward marketing of prescription medicine, this notion of different reasons why individuals have certain attitudes can be helpful in order to make sense of and interpret the end-consumers' opinions in order to get insight into their attitudes. Thus, these can be vital in order to understand attitudes, as they might enable explanations of why people have a given attitude in terms of their motivation to form it.

In relation to more temporary motivations, it has been argued that attitudes have the goal of minimizing cognitive effort, increasing accurate decisions and minimizing negative emotions (Argyriou & Melewar 2011:6/7/9; Wright 1975:61; Payne 1982:382). Thus people might rely on heuristic processes, in order to avoid cognitive effort (Argyriou & Melewar 2011:7; Tversky & Kahneman 1974:1124), which we will have a closer look at in paragraph 5.8. Hence, it might be argued, that people unconsciously choose not to use resources on an attitude formation process toward a given attitude object. In this way, a person who believes that he is not influenced by advertisements might think that it is alright to advertise, as he might subconsciously want to avoid cognitive effort. This might also be connected to how often the person encounters this attitude object, as objects encountered on a daily basis might be subject to an attitude anchored in habit. This might be a way of making one's day flow more easily and effortless, where Fazio argues that can structure surroundings and ease decision-making (Fazio 1989a:153).

Turning to more long-term motivations (Argyriou & Melewar 2011:6), attitudes have among other things been argued to have an *object appraisal function* (Smith et al. 1956:41), *instrumental, adjustment or utilitarian function* (Katz 1960: 170) or a so-called *knowledge function*

(Argyriou & Melewar 2011:3; Katz 1960:170/173; Triandis 1971:5). This focuses on attitudes as a help for people in summarizing actions and experiences related to a given attitude object (Smith et al. 1956:41), in relation to the positive and negative elements associated with it in order to minimize punishments and maximize rewards (Argyriou & Melewar 2011:3; Katz 1960:170; Triandis 1971:5). This might be of interest as our informants might thus form their attitudes toward marketing of prescription medicine on the basis of whether they believe it can benefit them or not e.g. that it could inform them or make them unnecessarily nervous. Moreover, attitudes are formed in order for people to structure and organize their surrounding world (Argyriou & Melewar 2011:3; Katz 1960:170/173; Triandis 1971:5).

Moreover, attitudes have been argued to have a *social adjustment* (Smith et al. 1956:41) or *value-expressive function* (Argyriou & Melewar 2011:3; Katz 1960:170/173; Triandis 1971:5), which focuses on attitudes as a tool, which makes it easier for us to associate with other people (Smith et al. 1956:41) – especially the ones close to us, which we often tend to share attitudes toward specific objects with (Triandis 1971:5) and thus attitudes can play a vital part in relation to reference groups and identification (Smith et al. 1956:42-43), which we will have a closer look at in paragraph 5.10. In this way, attitudes express a person's values, meaning the way that he perceives himself, thus allowing communication with and between others (Argyriou & Melewar 2011:3; Katz 1960:170/173; Triandis 1971:5). For example a person might be negative towards taking pills, as it would influence his self-image of being healthy in terms of not supplying his body with anything unnatural. This might thus form a foundation for dialogue and discussion. In this way, this might be interesting to look out for when analysing the focus groups, as this might be found in some of the informants' statements.

Additionally, attitudes have been said to have an *externalization* (Smith et al. 1956:43) or *ego-defensive function* (Katz 1960:170/173; Triandis 1971:5) emphasizing that attitudes can *externalize* inner problems in the sense that the attitude constructed is a transformed result of the attitude helping in solving inner problems (Smith et al. 1956:43) and in this way a person who is afraid of hospitals, leading to anxiety, might develop a negative attitude toward the medical science in order to protect himself from the anxiety. Thus, attitudes protect the individual from his own true nature and the realities of the external world (Katz 1960:170/173; Triandis 1971:5). Alike the function mentioned before this, this might be helpful in trying to understand the informants' constructions of attitudes toward marketing of prescription medicine.

5.5. Anchoring and Adjustment

As mentioned in the beginning attitudes can be anchored in pre-existing ones. This aspect is further explored in Feldman & Lynch's *Accessibility-Diagnosticity Model* (Argyriou & Melewar 2011:2), which is thus relevant for us due to the field of research being a practice the informants have not yet been exposed to in a Danish context. They argue that pre-existing beliefs,

attitudes, intentions, and behaviour will be used in the attitude formation process, if they are accessible and relevant (diagnostic) for the formation of the new attitude (Feldman & Lynch 1988:421; Kardes 2001:116). More specifically, this theory concerns, which information from the above-mentioned that will be used in order to form attitudes (Kardes 2001:116). The determinants of which information (input) that will be used are:

Firstly, *accessibility of an input,* hereby meaning recency and frequency of an input in terms of how often consumers think about an input and when they did it the last time (Kardes 2001:116; Reyes et al. 1980:11). In relation to our specific topic, an informant might anchor his attitude toward marketing of prescription medicine, in his attitude toward prescription medicine, if he recently had a bad experience with a given product. The more accessible an input is, the more likely it is that alternative inputs will be retrieved, bringing us to the next determinant. Secondly, *accessibility of alternative inputs,* concerning whether the person has accessibility to alternative inputs (Kardes 2001:116). Inputs that seem more relevant (diagnostic) will be retrieved over ones that seem less relevant (diagnostic). Moreover, personal characteristics, such as expertise, life interests or involvement, will influence the capability of developing alternative inputs (Feldman & Lynch 1988:428). In relation to our topic an alternative input might be their attitude toward marketing of OTC medicine, which in this case would be more relevant than their attitude toward marketing of cars. Additionally, an informant taking prescription medicine, is more likely to find this input accessible and relevant than an earlier attitude of being against taking medicine in general, which could be influential when forming an attitude about a new object. This can be connected to involvement, which we will have a closer look at later in paragraph 5.8. Thirdly, *diagnosticity (perceived relevance) of the alternative inputs*, meaning that what a person perceives as relevant is depended upon what he knows. Thus a given input is assessed for its use in the attitude formation in relation to whether it is relevant in regard to what is known about the attitude object (Kardes 2001:116; Feldman & Lynch 1988:424-426; Bargh 1984:22). Thus if a person is to form an attitude about a specific prescription medicine he might assess the relevance of what he knows about the prescription medicine e.g. that it can cure a serious disease and that it has a slight side-effect of dry skin. Hence the attitude is formed on what is perceived to be most important. In this way, an informant taking anti-depressants might assess an input of marketing of these differently than would an informant not taking anti-depressants as their knowledge on the product. Consequently, the formation of attitudes will be anchored in an existing input if this is accessible and if it is seen as more relevant than alternative inputs (Feldman & Lynch 1988:431). In this way, already existing beliefs, attitudes, intentions or behaviours will be assessed in relation to the three determinants above, before using this to form the attitude (Feldman & Lynch 1988:431). Thus it is interesting to be aware of what the informants base the formation of the new attitude on. However, we are aware that we as researchers and the other informants influence

the constructions of knowledge. Consequently, e.g. the accessibility and relevance of an input could be influenced by the immediate situation of the focus group. Hence, as always meaning is constructed in context – in this case, attitudes.

Cohen & Reed unify these thoughts, in their model *A Multiple Pathway Anchoring and Adjustment Model of Attitude Generation and Recruitment* by arguing that there are several ways to attitude formation and therefore that several attitudes can occur toward the same object at different times (Cohen & Reed 2006:1/7), which can be connected to seeing attitudes as able to be both stable or temporary. These attitudes can be formed through different mechanisms such as personal experiences and transmitted information (Cohen & Reed 2006:7) thus context can affect the attitude formation process and therefore, when analysing we must be aware of that the context of the focus group can affect their attitudes e.g. the other informants' statements, as mentioned earlier. In this way, as there are different opportunities to form an attitude, a single integrated attitude does not necessarily occur (Cohen & Reed 2006:7) and thus when an attitude is modified, this does not mean that it will also replace the initial attitude (Wilson et al. 2000:101/121). Additionally, much alike Feldman & Lynch, Cohen & Reed argue that attitude formation can be anchored in pre-existing attitude and thus constructed if an attitude does not exist or is accessible, to the object (Lynch 2006:25). Such pre-existing attitudes are thus predominant over other inputs in accessibility (Lynch 2006:25). However, two assessments are likely to lie between encountering a new attitude object and the formation of an attitude toward the object (Cohen & Reed 2006:10-11). Firstly, the pre-existing attitude needs to have *representational sufficiency* (Lynch 2006:25), meaning the clarity or the ambiguity of the pre-existing attitude in relation to the new attitude object (Cohen & Reed 2006:11). Hence our informants will probably be most likely to use a pre-existing attitude of marketing of OTC medicine rather than a pre-existing attitude of marketing of cars, as the former is more in line with the topic of interest. If it does not, additional information will be implemented in order to make up for this (Lynch 2006:25). However, if the attitude is representationally sufficient, the attitude will secondly be assessed for *functional sufficiency* in the sense that the person will evaluate whether he has enough information to act. If the answer is positive, the attitude will guide to behaviour and if the answer is negative further information will be added in order to modify the attitude (Cohen & Reed 2006:11; Lynch 2006:25). In our case, it seems as if the first of these assessments will be of highest relevance, as we are interested in attitudes only.

In this way attitudes are shaped in close connection to the "*(…) salience and diagnosticity of any information available in a given context.*" (Argyriou & Melewar 2011:6). This means that the surrounding context will impact the formation of attitudes, using this as a source of information (Argyriou & Melewar 2011:2; Feldman & Lynch 1988:422; Reed et al. 2002:375; Schwarz & Bohner 2001:3/5; Arnould et al. 2005:630). Thus it is important to be aware of the

fact that attitudes occur within situations, such as a focus group, which is therefore vital in trying to understand the attitude (Schiffman & Kanuk 2004:254-255). The attitude is hence highly affected by the accessibility of information at the moment in which the attitude is needed (Reed et al. 2002:375). This is greatly connected to our ontological stance in terms of people being affected by both their societal and immediate context and the notion of people's continuous constructions, as seen in paragraph 3.1. In relation hereto such a contextual aspect might be a country's legislation on the area, which could affect their attitudes. Consequently, attitudes are continuously formed in relation to the context that the individual finds himself in when encountering a given attitude object (Als & Heiselberg 2010:181).

Generally, these models of anchoring are useful as they point to the notion of anchoring an attitude in a prior experiences, transmitted information, beliefs, attitudes, intentions, and behaviour, which is particularly relevant as the Danish end-consumers' attitude formation is likely to be founded in prior subjective constructions, as they not exposed and therefore not likely to be aware of the practice of marketing prescription medicine to the end-consumers.

5.6. Beliefs and Attitudes

A study from Australia, showed that when consumers' knowledge of legislation and DTCA was increased, the support of this practice drops (Vatjanapukka & Waryszak 2004:350/356). Additionally a study in California found that consumers' positive attitudes toward DTCA might be based in beliefs about high regulatory control of DTCA, which might not always be the case (Bell et al. 1999:654-655). A US study similarly found that consumers might not be aware of the actual regulatory control (Singh & Smith 2005:373). In this way, it has been found that consumer knowledge and beliefs could influence attitudes toward DTCA of prescription medicine, which was also indicated in the explorative interviews. Thus it could be imagined that it also might be of importance in studying the Danish end-consumers' attitudes. Hence the following model of Fishbein & Ajzen is included.

In their *Expectancy-Value Model*, Fishbein & Ajzen argue that attitudes are based on the many beliefs (Fishbein 1967:479-480; Ajzen & Fishbein 2000:1; Fishbein 1963:233) people have about an attitude object before having an attitude toward the object (Ajzen & Fishbein 2000:1/12-13; Fishbein 1963:233). Beliefs can be seen as all the information a person has about a given object (Fishbein & Ajzen 1975:12), which are non-evaluative judgments (Kardes 2001:85). Therefore beliefs can be seen as a part of knowledge e.g. "The GP prescribes medicine" where attitudes rather are whether the statement is evaluative e.g. "The GP is the right person to prescribe medicine" (Wyer & Albarracín 2005:274/276). These beliefs are learned through experience with attitude objects, where a given attribute is assigned such as good/bad, which a person hereby associates the object with, leading to the formation of an attitude (Fishbein & Ajzen 1975:217). The attributes that a person values as important are

evaluated more positively than attributes that are less important to the person. Fishbein & Ajzen argue that people tend to have more information about more important than less important aspects, and hereby tend to have stronger beliefs about these (Fishbein & Ajzen 1975:228). In relation to our topic, this might mean that an informant who takes medicine for hay fever will have more information and thus stronger beliefs about such medicinal products, than for example anti-depressants, which is likely to affect the attitude constructed in relation to marketing of this. Each of these beliefs is associated with an attribute, and together these two aspects form the person's attitude toward a given object (Ajzen 2001:30, Fishbein 1963:233; Fishbein & Ajzen 1975:216). Thus this theory concerns how beliefs are combined to an evaluation of an object, i.e. an attitude (Fishbein & Ajzen 1975:223). Linked hereto attitudes can be seen as emergent in the sense that they are affected by changes in beliefs and formation of new beliefs, which is included in the evaluation (Ajzen & Sexton 1999:119). Consequently, the way FIshbein & Ajzen is illustrated below,

Figure 12: Attitude formation as argued in *Expectancy-Value Model* (Own construction)

In this way, the experience a person has with an object, forms beliefs and information about it, which is thus basis of the attitude formed. Hence, the attitude formation process is founded in already existing beliefs about a given attitude object. In relation to our topic, this process should be seen in relation to anchoring and adjustment as the informants do not have experience with the practice of marketing of prescription medicine in a Danish context, but most likely have experience with related attitudes objects, in which they might anchor their attitude toward the former. Related to our topic, a person whose parents have all his life been hypochondriacs, might thus believe that marketing of OTC medicine leads to unnecessary concern about one's health, whereby he anchors an attitude toward marketing of prescription medicine herein and therefore have a negative attitude toward this. In this way, beliefs about the topic, or fragments of the topic, can have a vital influence on our informants' attitudes. Related hereto one could consider the factual aspect of beliefs, meaning that what a person believes might not be "true" or factual. However, as we are interested in the subjective constructions of reality, then this distinction is not of concern, for what matters is what the individual believes to be true. Thus it is the subjective beliefs, which affect the attitude formation. After the attitude formation, the attitude object will prompt the attitude, which is available without conscious effort (Fishbein 1963:233; Ajzen & Fishbein 2000:16). Importantly however is, that if people may have several beliefs about a given object, only the beliefs that are accessible at the

time of the attitude formation process and the ones that are most salient, will influence the attitude outcome (Ajzen 2001:30; Fishbein & Ajzen 1975:218; Ajzen & Sexton 1999:119). Thus a person's belief about marketing of prescription medicine leading to hypochondria might be more accessible at a given time, as he just experienced a person responding to advertisements of prescription medicine, by believing that he had all the symptoms. Hereby we need to be aware that our informants' attitudes toward the topic will be influenced in relation to which beliefs are accessible and most salient at the time of study.

5.7. Experience and Attitudes

In his theory, *The Response-Latency Approach*, Fazio argues that attitudes will be highly affected by direct experience with an attitude object, related to the *Expectancy-Value Model*, making it easier for the person to form an meaningful attitude toward an object due to more direct information at hand (Fazio et al. 1978:48). In this way, *experience* with an attitude object has great effect on attitude formation (Allport 1935:810/819; Argyriou & Melewar 2011:6; Fazio et al. 1978:49/51; Reed et al. 2002:386; Schiffman & Kanuk 2004:267; Bagozzi et al. 1991; McGuire 1985:240) resulting in stronger attitudes as e.g. an experience with an attitude object will overrule something that the person has read about the attitude-object (Argyriou & Melewar 2011:6; Fazio et al. 1978:49/51; Reed et al. 2002:386; Schiffman & Kanuk 2004:267; Bagozzi et al. 1991; Fazio & Zanna 1981:195) than would indirect experience (Fazio et al. 1982:354). Such strong attitudes will be immediately retrieved from memory (Fazio 1989b:284; Fazio 1989a:155), when a person encounters a given attitude-object, where weaker attitudes will lead to the attitude formation process being influenced to a higher degree by "*(…) momentarily salient thoughts or features of the object"* (Fazio 1989b:284). Hence, weaker attitudes will to a higher degree be influenced by the surrounding context at the given moment of the attitude formation process, than will stronger attitudes, which the person have spend a longer time thinking about (Fazio 1989b:284). Thus, the longer timer people spend on thinking about an attitude-object, the stronger the attitude will be and vice versa (Kardes 2001:101-102). This should again be understood in relation to anchoring, as the informations due to lack of experience might not have strong attitudes toward marketing of prescription medicine, but they might have experience with related attitude objects and thus have strong attitudes toward these, which might then influence their attitude toward marketing of prescription medicine. Moreover Fazio argues that people generally respond quicker to objects, which they have stronger attitudes toward (Fazio 1989a:155-157; Powell & Fazio 1984:145-146; Kardes 2001:101; Fazio et al. 1982:352). Hereby, if our informants hesitate, stumble or have a hard time explaining what they mean, this might indicate that the informants' attitudes are non-existing or weak.

5.8. Involvement and Attitudes

There are several different motivational factors, which have implications for how people respond to an attitude object and in the end, form an attitude. One of them is how personally relevant the topic or parts of it is to people, which we found through our review of the literature and through the explorative interviews with US end-consumers, where the latter can be found in appendix B, indicating that this is an aspect to look further into. In the following we will shortly clarify on the findings from previous studies and afterwards these findings will be integrated with attitude literature.

5.8.1. Empirical Findings – the Role of Personal Relevance

US studies have found that product involvement is a significant predictor of people's attitudinal response toward DTCA of prescription medicine (Limbu & Torres 2009:51). Thus high involvement consumers, understood as consumers with a large extent of interest in and concern with the product e.g. because they feel ill or are ill (Limbu & Torres 2009:55; Deshpande et al. 2004:508-512) had a higher level of awareness (Alperstein & Peyrot 1999:54), had more favourable attitudes toward DTCA and a higher intention to ask a doctor about the advertised drug than low involvement consumers (Limbu & Torres 2009:51/68/71-72; Hausman 2003:231; Deshpande et al. 2004:508-512). In this regard, a US study found that people in poorer health perceive DTCA as more useful in making decisions about health than those healthier (Deshpande et al. 2004:511). Yet, an US study found that chronic ill patients valued DTCA highly. However, it was also shown that people, who have been ill recently, hold a more negative attitude, which according to the researchers could be due to their trust and recent contact with their doctor (Gönül et al. 2000:219). Oppositely, people who believe that they are in "excellent health" have little interest in health information from any source and are less likely to be influenced by commercial messages about medicine (White et al. 2004:61-65). Moreover, it was found that that consumers who are healthy or feel healthy had a tendency not to pay attention to DTCA aimed at ill people (White et al. 2004:64/66). Similar results were found in an older study from the US (Perri & Dickson 1988:69). On the basis of this, these empirical findings generally suggest that consumers, who are involved with health issues and therefore find DTCA of prescription medicine personal relevant, might have a more positive attitude toward it. Even though these results are found in another cultural context, it is likely that personal relevance also affects the Danish informants' attitudes toward marketing of prescription medicine, e.g. they might be interested in advertisement for medicinal products if they feel they need knowledge of alternatives to medicine they currently take and consequently have an positive attitude toward DTCA of prescription medicine. Also it can be argued that personal relevance is present across cultures, and therefore also will be a relevant element to study in the Danish context.

5.8.2. Theoretical Emphasis on Involvement

Researchers are in agreement, about the central role of involvement in persuasive processes and attitude change and formation (Chaiken 1987:3-4; Grunig 1989:5; Krugman 1965:352; Petty et al. 1983:143-144; Sherif & Sherif 1967:116/120/130-131; Sherif & Hovland 1961:129-131; Burnkrant & Sawyer 1983:43). In the literature, level of involvement is defined and studied in terms of consumers' level of involvement with a product, issue, message, situation or action. These are considered *high involvement* if they have great personal relevance, interest, concern, importance or consequence for people or elicit a high number of "connections" in the individual between the object and the "content of their life" during exposure to a message (Petty et Al. 1983:136; Petty & Cacioppo 1979:1916; Petty & Cacioppo 1981:107; Mittal 1989:148; Mitchell 1979:194; Day 1970:80; Zaichkowsky 1985:342-343; Celsi & Olson 1988:211; Krugman 1965:255; Grunig 1989:5). Furthermore involvement has been defined as being links between information presented and central values (Sherif & Hovland 1961:74-79; Mitchell 1979:194; Chen & Chaiken 1999:77) or the motivation to process information (Burnkrant & Sawyer 1983:46/48). Drawing parallels to our study, involvement can in accordance with the many types of involvement just noted, possibly take many forms. For example, the informants' involvement can be with a specific product, e.g. a certain prescription medicinal product, which the person takes herself, or with an issue, which can e.g. be the abstract problem of marketing of prescription medicine. The issue can be of personal concern and interest to the informants if they themselves are or feel ill, as found in the empirical studies above. In connection hereto it can be considered that the informants in this thesis are among the demographic group which are not likely to be ill, both in severity and frequency, as these are relatively young (Burak & Damico 1999:21). However, personal relevance does not need to be only in relation to one's own health but likely also be at stake if a close relation e.g. family is ill, as this is still of concern to most individuals.

In relation to the above, it can be argued that might be too simplistic to divide people into two categories of being either low-involved or high-involved. Thus, in accordance with Petty & Cacioppo we advocate for seeing level of involvement as a continuum, rather than two exclusive categories (Petty & Cacioppo 1986a:7-10; Petty & Wegener 1999:42/44; Chen & Chaiken 1999:75), which will be returned to.

The fundamental proposition of involvement is that the nature of the processing of a message and its resulting impact on attitudes depends on the recipient's involvement with a message. If the message is personally relevant to the person and he is able to, the message will be processed with much more attention to the arguments presented, than if the message had no personal relevance (Krugman1965:354-355; Sherif & Sherif 1967:119-128/130-133; Sherif & Hovland:1-10;Petty & Cacioppo 1986a:3/5; Chen & Chaiken 1999:81; Burnkrant & Sawyer 1983:44). This view is in line with *Selective Attention Theory*, which emphasizes that people

are consistently bombarded with stimuli, but have a limit to the number of information that can be processed at one time. Therefore people point their attention to subconsciously selected matters (Deutsch & Deutsch 1963:1; Cohen 2011:1). They will tend to selectively process information, which is personally relevant and relates to a current need or current knowledge (Wyer 2008:40-42; Schiffman & Kanuk 2004:172; Williams & Hensel 1995:40).

5.8.3. Dual-Process Theories

In the following we will focus on two dual-process theories; the *Heuristic-Systematic Model (HSM)* by Chaiken and the *Elaboration Likelihood Model of persuasion (ELM)* by Petty & Cacioppo. They establish a fairly comprehensive framework for understanding how people evaluate persuasive messages, where the concepts of high and low involvement take a central role.

As these models focus on people's processing of persuasive messages, they might not provide full explanation in relation to our context, as the informants are not exposed to persuasive messages concerning the topic in their everyday lives nor during the entire focus group. Furthermore, prescription medicine is a unique product, as it is only accessible to the end-consumers via the GPs. Thus the persuasion process is more complicated in regard to this product and thereby traditional conceptual frameworks of persuasion do not necessarily provide a full understanding (Dens et al. 2008:47-48; Slater 2002:176). Furthermore, our focus in this thesis is not the Danish end-consumers' attitudes in relation to a specific overtly persuasive message, but instead their general attitudes toward the practice of marketing as a whole. Thus we look at involvement and attitude formation in relation to a non-overtly persuasive message (Slater 2002:176) and a more *abstract* form of persuasive messages. In this regard Petty & Cacioppo argue that their findings and thereby the basic principles of the *ELM* may be applied to other attitude change and formation situations (Petty & Cacioppo 1986a:3), thereby also our context. Thus, we argue that this model might be applicable to understand our informants' information processing and attitude formation during the focus group interview.

The *ELM* and *HSM* share the idea that people's attitudes toward a specific issue or product, is formed through two general avenues, varying in the amount of careful thinking involved, also referred to as the level of elaboration (O'Keefe 2002:137-138; Chen & Chaiken 1999:80-81; Petty & Cacioppo 1986b:125-127; Petty & Cacioppo 1986a:7). They furthermore attempt to specify the cognitive and motivational factors, which determine when attitudes are likely to be mediated by each of these processing "routes" (Chen & Chaiken 1999:81). In some situations people are likely to engage in considerable elaborative effort, whereas they in other situations will engage in much less effort, depending on the ability to process information and the level of motivation, e.g. personal relevance (Petty & Cacioppo 1986a:7; Chen & Chaiken 1999:81).

5.8.4. Two Routes to Persuasion

The *ELM* and *HSM* differentiate between two general avenues, through which people process information and form an attitude. In *central route* or *systematic processing*, the receiver engages in comprehensive, thoughtful and analytical consideration (elaboration) of the issue-relevant information (arguments) and carefully thinks about this (Chen & Chaiken 1999:74/80-81; Petty & Cacioppo 1986b:125-126; Petty & Wegener 1999:42). The term "elaboration" is used to suggest that people add something by themselves, related to the issue-relevant information provided in the communication (Petty & Wegener 1999:46; Petty & Cacioppo 1986a:7). Attitude changes induced via the *central route* are argued to be relatively enduring and predictive of future behaviour and also more resistant to counter persuasion (Petty & Cacioppo 1986b:125-126; Petty et al. 1985:93/94; Petty et al. 1983:135; Petty & Wegener 1999:61).

Processing through the *peripheral route* or through *heuristic processing* is associated with less thoughtful and rational processing (Chen & Chaiken 1999:74; Petty & Wegener 1999:42). This type of processing entails activation and application of judgemental rules or "heuristics", which are, like other knowledge structures assumed to be learned and stored in memory, e.g. "Experts' statements can be trusted", "The more advantages listed, the better the product" (Chen & Chaiken 1999:74). These heuristics can also include stereotyping (Chen & Chaiken 1999:81). Attitudes founded through this route can also rely on simple positive or negative cues, for instance visual cues and sounds, or heuristics that are unrelated to the actual merits of the message, for instance the message being associated with an attractive source (Petty et al. 1983:135; Petty & Cacioppo 1986a:3; Petty & Wegener 1999:42-43). The information processing through the *peripheral route* is thus quantitatively and qualitatively different from that processing occurring through the *central route* (Petty & Wegener 1999:46-47). Attitudes formed through the *peripheral route* are not as strong and should specifically not be as resistant to counter attempts at persuasion. They are furthermore stated to be relatively temporary and less predictive of behaviour (Petty et al. 1983:136; Petty & Cacioppo 1986a:5; Petty & Wegener 1999:61). In relation to the discussion in paragraph 5.2. about *affective* and *cognitive components* of attitudes, this division of these elements can be compared to the above noted distinction of the two ways to form an attitude by either the *central route*, relying more on arguments and thereby cognitive processing or the *peripheral route*, relying more on cues or heuristics and thereby more affective formation of an attitude. Thus by these theoretical notions, the informants in our research might form an attitude toward marketing of prescription medicine by using careful, objective scrutiny and evaluation of the message arguments and/or using more irrational cues and heuristics. In our research context, it can be questioned whether the informants can rely their attitudes on careful elaboration and scrutiny of the arguments, since they have no experience with the practice before the focus group and since the focus group is limited to two hours interview. Thus it could be imagined that they will rely more on

cues or *affective attitude component*. On the contrary it can be argued that they will try to elaborate and scrutinize all the arguments, which come up during the focus group, thus also relying on *central route* processing. Furthermore, as we note below, the attitudes might not be formed solely upon either the *peripheral* or the *central route*, but the attitudes can be formed on basis of different variables from both routes.

5.8.5. The Elaboration Continuum

The degree to which recipients engage in issue relevant thinking forms a continuum, from cases of extremely high elaboration to cases of little or no elaboration (Petty & Cacioppo 1986a:7-10; Petty & Wegener 1999:42/44; Petty & Cacioppo 1984:669; Chen & Chaiken 1999:75). The distinction between the *central route* and the *peripheral route* and the *systematic* and *heuristic* mode of information processing, should not obscure this underlying elaboration continuum (Petty & Wegener 1999:45; Chen & Chaiken 1999:75). Despite the distinction, the two routes are not exhaustive and mutually exclusive categories, rather the two routes should be understood as prototypical extremes on the high-to-low elaboration continuum (Chen & Chaiken 1999:75; Petty & Wegener 1999:45; O'Keefe 2002:140). In continuation of the above, the two models differ in the degree to which they find the routes exclusive of each other (Chen & Chaiken 1999:81). While the *HSM* explicitly assumes that both modes of processing can co-occur and have an impact on attitude when motivation and ability for argument scrutiny are high, the *ELM* assumes that as motivation or/and ability for argument scrutiny increases, peripheral factors become less determinant for the final attitude (Chen & Chaiken 1999:81). Additionally, Petty & Cacioppo note that as people approach the high end of the elaboration continuum, they are more likely to "(…) *scrutinize all available information in the immediate persuasion context (...)"* in an attempt to evaluate the true merits of the arguments and position advocated (Petty & Cacioppo 1984:671). This means that peripheral cues can be a part of the *central route* processing. Thus the message variables can serve multiple roles in the information processing (Petty & Wegener 1999:48; Petty & Cacioppo 1984:671). Thus a given variable may serve as a peripheral cue, an argument or an elaboration moderator, or it can produce bias in elaboration, depending on the specific circumstance in which the variable is encountered (Petty & Wegener 1999:48-49; Petty & Cacioppo 1984:668-671; Petty & Cacioppo 1986:5).

5.8.6. Factors Affecting Elaboration likelihood

The *ELM* and *HSM* suggest that motivation and ability/capacity are factors, which affect elaboration likelihood and thus attitude. These factors can be situational conditional or they can be internal to the individual (Petty & Cacioppo 1986a:7-8; Petty & Wegener 1999:42/44; Chen & Chaiken 1999:79). According to these theories we can expect a variability in the attitudes toward marketing among end-consumers because the issue is of higher importance for some people than for others due to their individual context and life worlds, also noted in paragraph

3.1. This is also a good argument for conducting qualitative research in relation to the focus of this thesis, ensuring that many nuances and perspectives on this issue can be explored.

The motivational factor influencing elaboration likelihood can be features of the persuasive message itself e.g. whether or not the topic or product is personally relevant. Thus subjectively important issues and personal relevant issues are likely to elicit higher elaboration likelihood (Petty & Wegener 1999:45; Petty et al. 1981:853). In accordance with the theoretical notion of personal relevance, it is interesting to study if something in the persons' background and life world makes the issue of marketing of prescription medicine of personal relevance to the informants, and thereby affects their attitude toward this practice. For the same reason we have asked the informants to provide us with background information on them before the interview and consequently we will have a look at this in beginning at the analysis. Involvement can also be seen as a result of people's personal values, which might be the case with our informants (Slater 2002:179). This is a reason why we supplemented the *ELM* with the *HSM* as it has a higher emphasis on evaluating according to personal values, affective and social influence in the evaluation process more than the *ELM*, which is argued to focus on people being primary rational processors (O'Shaugnessy & O'Shaugnessy 2004:127-129).

Motivational factors can also be features of the persuasion context and features of the message interpreter, e.g. high or low in "need for cognition", which means that some people to a larger degree enjoy thinking and exerting cognitive effort (Cacioppo & Petty 1982:116; Petty & Wegener 1999:44-45; Cacioppo et al. 1996:230-231). In relation to this thesis, our informants are primarily university students or people with a higher education, which can be seen in appendix G. Thus it is possible that the informants are likely to have a high need for cognition, which might increase the elaboration likelihood for their evaluation during the focus group. However, this element will be especially difficult to identify, as it will be very difficult for us to identify the amount of processing the informants undertake, therefore this is not something that we will treat in the analysis. However it is an aspect, which might have influence on our findings.

As a basic *motivational factor*, the *ELM* and the *HSM* assume that people are motivated to hold objective accurate and correct attitudes and beliefs (Petty & Wegener 1999:44; Chen & Chaiken 1999:76-77; Chaiken 1980:752). However, people are not always able or willing to carefully elaborate on the arguments presented in an objective and critical manner (Petty & Wegener 1999:44; Petty & Cacioppo 1979:1915; Petty et al. 1981:853). For example people can be motivated to give a certain impression in interaction in a specific social context, thus answering in a social acceptable way (Chen & Chaiken 1999:78) and desire to hold and defend one's own attitude and beliefs, thus the interpreter process information selectively (Chen & Chaiken 1999:77-78; Petty & Wegener 1999:44; Chen & Chaiken 1999:76/81). In accordance

with our ontological stance, it can be discussed if people's elaboration will not always be selective, thus they interpret subjectively and therefore people will elaborate and focus on certain perspectives, which is meaningfully relevant to the individual and thereby not necessarily include all elements in their elaboration.

HSM, more than the *ELM* accentuate the possibility, that multiple motives might be relevant in a given situation and perceivers might be multiple motivated and therefore engage in hybrid forms of motivated processing in their effort to satisfy multiple goals (Chen & Chaiken 1999:79). As a critique to this part of the theory, the assumption that people are always motivated to hold objective and correct attitudes is debateable as it can be asserted in continuation of our ontological stance, that an objective or correct attitude does not exist, as the social reality will always be subjective, based on individual interpretations of the world. Furthermore, subjective constructions will be dependent on social norms, conventions and affective considerations (O'Shaughnessy & O'Shaughnessy 2004:127).

Ability factors on elaboration likelihood can be cognitive abilities and capacities, e.g. prior knowledge and intelligence (Petty & Wegener 1999:45; Chen & Chaiken 1999:74/79). *Situational ability factors* on elaboration likelihood can be distractions, such as noise or other distracting stimulus or task accompanying a persuasive message (Petty & Wegener 1999:45, Chen & Chaiken 1999:74/79).

5.9. Advertising, Media Channels and Attitudes

As we are interested in the marketing of prescription medicine we have included notions about attitudes toward media channels and advertising as these are related to the field of interest, the latter specifically in regard to DTCA. Additionally, these attitudes could be some of the pre-existing attitudes on which the Danish end-consumers base their attitude toward marketing of prescription medicine. Furthermore, the interpretations of explorative interviews indicated that media channel used could be of importance, as seen in paragraph B.

In relation to advertising, one could distinguish between attitudes toward *advertising* and attitudes toward a specific *advertisement* (Lutz 1985:46) as it has been found that attitudes toward advertising in general, can affect the attitude toward a specific advertisement (Mehta & Purvis 1995:1-5; Mehta 2000:67/71; Bauer & Greyser 1968:339; Lutz 1985:53-54). Linked hereto Bauer & Greyser found that people's overall attitude toward advertising have a tendency to affect their attitude toward advertisements in the same direction (Bauer & Greyser 1968:258/266). In this way people who generally are more negative toward advertising, report being exposed to more annoying and offensive advertisements, than those who are generally positive toward advertising, who report being exposed to more enjoyable and informative advertisements (Bauer & Greyser 1968:266-267). In our case it could thus be interesting to see

whether the informants are generally negative toward advertising, as it might affect their attitude toward advertising of prescription medicine, which could be a vital element for our understanding of their attitudes and the constructions hereof. Additionally, advertising's effect on social and economic environments, might also impact the attitude formation toward such (Muehling 1987:39; Bauer & Greyser 1968:332-334). Therefore an end-consumer might think negatively about advertising for prescription medicine, but feel that advertisements concerning birth-control might have a social informative aspect, which makes it legitimate to advertise, as indicated by one of the informants in the explorative interviews (App. A, Grace:39).

Furthermore, it has been suggested that an attitude toward an advertisement is formed on the basis of two aspects; firstly, on the basis of an overall attitude toward advertising in general – thus toward what can be termed the *institution* (Muehling 1987:36/39) as also mentioned above, which might then affect attitude toward an advertisements (Friman 2010:12; Mehta & Purvis 1995:1-5; Mehta 2000:67/71; Bauer & Greyser 1968:339; Lutz 1985:47-48). Secondly, formation of attitudes toward advertisement can also be on the basis of the media channel used – toward what can be termed the *instrument* (Muehling 1987:36/39), and thus media channels have an impact on this attitude formation process (Friman 2010:13; James & Kover 1992:81; Mehta & Purvis 1995:5; Mehta 2000:67/71; Mittal 2004:40). In this way, there might be a difference in the end-consumers' attitudes toward the topic, as they might find some media channels more legitimate or suited to use for the purpose than others, which might be especially relevant in relation to the proposal as the media channel is one of the main features of the proposal's characteristics.

In continuation hereof, Alwitt & Prabhaker found that people are generally negative toward TV advertisements as they see them as offensive, untrustworthy and as having low relevance to their needs, interests and personality (Alwitt & Prabhaker 1992:41; Alwitt & Prabhaker 1994:22-23/26; Mittal 1994:42). Thus it has been found that TV advertisements are seen as non-informative and low in *credibility* (Mittal 1994:49; Larkin 1979:7-8). In this way, one could argue that this might be, as TV advertisements are something that people are involuntarily exposed to and not something that they themselves choose to spend time on, as they can with for example a magazine (Mittal 1994:47). This thought can be extended in relation to the Internet, as people here have a greater deal of self-decision and can thus take action themselves (Wang et al. 2002:1146). However, it has also been found that consumers generally have negative attitudes toward Internet advertising, but that they are not as negative when compared to the general attitude toward advertising (Schlosser et al. 1999:48), but at the same time, consumers have also found Internet advertising to be highly informative and relative trustworthy (Schlosser et al. 1999:50). This might be connected to the "pull", rather than "push" nature of the Internet advertisements as consumers themselves, decide, whether they wish to spend time on such (Schlosser et al. 1999:51; Ducoffe 1996:21-22). Hence one might argue that peo-

ple might thus not rate Internet as negatively as TV, as the advertisements here are pushed more unwillingly unto people, whereas people can click away from them, when on the Internet.

Overall, in wanting insight into the research purpose concerning attitudes toward marketing of prescription medicine, attitudes toward and beliefs about advertising and media channels could be important to keep in mind in interpreting the opinion statements in order to get insight into the informants' attitudes, as they might be affected by the abovementioned aspects.

5.10. Consumer Socialization

In the debate revolving around marketing of prescription medicine, the debaters often assume that this practice has an influence on the attitudes and behaviours of end-consumers, as also seen in paragraph 1. Nonetheless, as pointed out by Lee et al., DTCA of prescription medicine is not the only source of information that is accessible to the end-consumers (Lee et al. 2007:107-108). Instead it is possible for the end-consumers to obtain information concerning prescription medicine from a range of sources (Chen & Carroll 2007:287), which can affect their attitudes in relation to this topic. Thus a possible assumption in a Danish context might also be that the attitude toward the marketing of prescription medicine directly at the end-consumers could also be affected by other sources of information besides the marketing from the pharmaceutical companies. This might be very likely in the Danish context, as the end-consumers have not directly experienced this type of marketing in relation to prescription medicine but only in relation to OTC medicine. Thus the attitudes can be constructed from other information sources and anchored in existing attitudes toward related topics as mentioned in paragraphs 5.2. and 5.5. The notion of the influence of different contextual elements in relation to marketing of prescription medicine could be a practical example of our ontological stance as the end-consumers' social constructions are made from a social standpoint. Thus, attitudes are not formed in a vacuum but are also founded in relation to the social environment.

By accepting the influence of the social environment, the conceptual framework of consumer socialization can be included. Different understandings of socialization exist, but in general socialization refers to the learning processes, where individuals in interactions with other people learn to partake in their social setting in an effective manner including acquiring knowledge, attitudes, values and skills as well as learning social roles with the appertaining behaviours (Ward 1974:2; Zigler & Child 1969:474; Brim 1966:3/5; Mortimer & Simmons 1978:422; Sewell 1963:163; Inkeles 1969:615-616: Clausen 1968:139-140; Gerson 1966:42; Rosow 1965:35). However, even though a person is influenced by the surrounding society, the individual should not be understood as passive, since the individual can mediate and actively

process these external influences (Zigler & Child 1969:469/473; Brown 1965:153-154). As an example, the individual might also engage in self-initiated socialization e.g. a person could go to the gym to improve his performance in relation to the role of being a healthy person. However, it should not be understood as without influence of other persons, but the influence is more of a distant and symbolic kind than direct (Brim 1968:189-190). Thus socialization can occur regardless of the intent of the socialization agent (McLeod & O'Keefe 1972:131; Sarbin 1959:226-227). This notion of active processing fits with the view of the individual in the communication process described in paragraph 3.1.

More specifically, Ward has defined consumer socialization as *"(…) processes by which young people acquire skills, knowledge, and attitudes relevant to their functioning as consumers in the marketplace."* (Ward 1974:2). As indicated, this means that the focus here is a particular part of socialization; namely consumption (Moschis & Smith 1985:275). A distinction between direct and indirect skills, knowledge and attitudes in consumption can be made. The former refers to the relevant skills, knowledge and attitudes in the physical act of purchasing or making the purchase decision (Ward 1974:2-3). This is not particularly relevant in our case due to the nature of the product, as prescription medicine is unattainable without the involvement of a GP and his knowledge (Lee et al. 2007:110) as explained in paragraph 1.2.2. On the other hand, the indirect relevant skills, knowledge and attitudes are related to what motivates consumption. In this case consumption or the decision to consume is a response to the perceived norms and requirements in relation to a given role. Thus social expectations exist, which can influence consumption (Ward 1974:3). An example could be norms and expectations related to the roles of being an information seeker, e.g. due to the influence of DTCA of prescription medicine (Liu et al. 2005:254/262), a healthy citizen or a good patient. Thus the individuals perceive themselves to perform a specific societal role (Armitage & Conner 2001:1434). A further example, which is portrayed by the US end-consumer Grace, concerns taking birth-control pills to avoid the particular societal role of being e.g. a teen mom (App. A, Grace:39-40). Hence the norms of the preference for avoiding teen pregnancies could motivate the consumption of birth-control pills, thus being socially acceptable. As we are interested in the end-consumers' attitudes and the reasons underlying these, it is interesting to get insight into what could affect their attitudes toward the field of interest, thus the focus will more likely be on the indirect approach. One aspect that might need some clarification in regard to this definition is the use of the term "young people". Studies have often focused on socialization of children and adolescents (Ward 1974:2/10; Churchill & Moschis 1979:23; Brim 1966:21; Clausen 1968:149; Mangleburg et al. 1997:258/262), nevertheless this childhood socialization is claimed not to be sufficient for living up to the demands required of adults. Hence the processes of acquiring relevant skills, knowledge and attitudes are continued throughout adulthood (Ward 1974:4; Moschis & Churchill 1978:600; Churchill & Moschis 1979:25; Brim 1966:3;

Brim 1968:184; Zigler & Child 1969:468; Mortimer & Simmons 1978:421; Sewell 1963:173). Brim and Mortimer & Simmons argue that these skills are often founded on existing skills and attitudes, and the objective of adult socialization is usually to combine and refine the known elements into new varieties instead of acquiring completely new responses (Brim 1966:19/28; Mortimer & Simmons 1978:423). Adult socialization could be particularly relevant when it comes to consumer socialization about marketing of prescription medicine in a Danish context as the end-consumers have not been exposed to this before, and thus they could be in need of obtaining the relevant skills, knowledge and attitude in order to handle the new consumer role. Additionally, following the thoughts of Brim and Mortimer & Simmons could mean that in answering the problem formulation the informants' attitudes toward marketing of prescription medicine could be connected to existing attitudes toward other attitude objects, which could be combined and refined in the construction of the attitudes toward the main attitude object of marketing of prescription medicine.

Lee et al. have adapted a model of Moschis & Churchill (Lee et al. 2007:111; Moschis & Churchill 1978:600) to the specific area of consumer socialization concerning DTCA, which will be adopted in this thesis, besides the last element in the model concerning the behavioural outcome of DTCA of prescription medicine, which will be disregarded due to the focus on attitudes. The model is presented below:

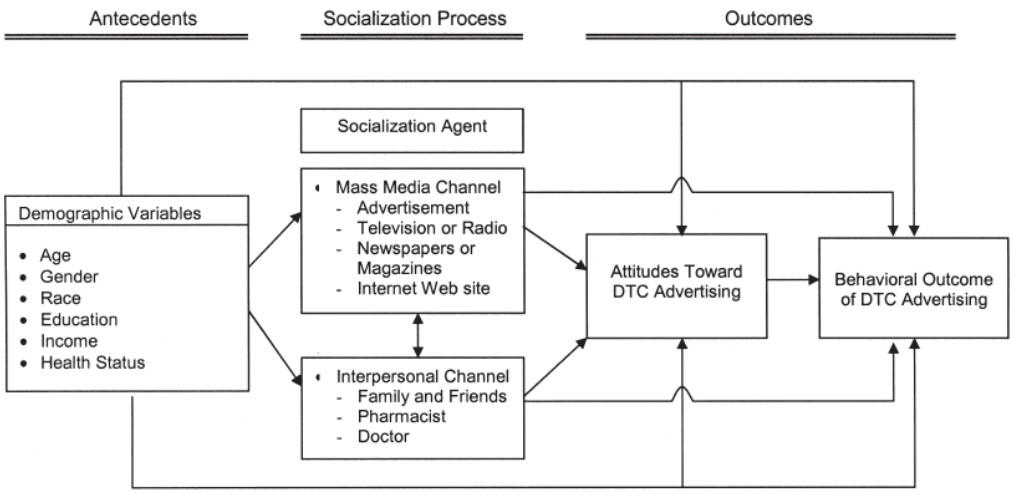


Figure 13: "A Conceptual Model of Consumer Socialization and Attitudes Toward Direct-to-Consumer (DTC) Advertising and Behavioural Outcome" (Lee et al. 2007:111).

This model will be adopted in this thesis as a way of trying to obtain an understanding of the end-consumers' attitudes toward marketing of prescription medicine and the possible aspects, which can affect these constructions. More specifically, insights into the different sources of

socialization from which the individuals learn to feel about health issues and medicine could be influential in understanding their attitudes toward marketing of prescription medicine.

Like the model of Moschis & Churchill, Lee et al.'s model explain the acquisition of cognitive and behavioural patterns in relation to consumer socialization through two models of human learning: the *cognitive development model* and *social learning model* (Lee et al. 2007:108; Moschis & Churchill 1978:599; Churchill & Moschis 1979:25-26; Zigler & Child 1969:467-468). However, as *the cognitive development model* concerns that the process of socialization occurs due to changes in the cognitive structure (Ward 1974:6; Zigler & Child 1969:456; Kohlberg 1969:349/352-353; Ginsburg & Opper 1979:23/25; Moschis & Smith 1985:277; Piaget 1969:11/13), this model will not be focused on, as the insight into complete distinct cognitive structures seem impossible, when using a focus group method, even though it is a qualitative approach, since we spend a limited time with the informants and several reality constructions are voiced simultaneously. This lesser focus on the cognitive development approach is also present in the model of Lee et al. as the approach is included only as a part of the antecedents, which can affect both the socialization processes and the attitudes (Lee et al. 2007:111). In this way we will also have a look at some of these antecedents as studies from our review of the literature shows that some of these antecedents could affect the attitudes toward DTCA of prescription medicine.

An Australian study found that age could have an influence on the end-consumers' attitudes toward DTCA. Generally the young group (aged 29 or less) held less strong opinions compared to the older groups e.g. being negative toward the *credibility* of the product and being suspicious of the advertised medicine. The researchers' explanation was that the young group might not have as much interest, experience or knowledge about medicine (Miller & Waller 2004:397/399). The scepticism, which seemed to be more widespread among the older age group, was supported by another Australian study of older adults' attitudes (Jones & Mullan 2006:6/11). Gönül et al. found in relation to age, that young US consumers were more likely to welcome DTCA (Gönül et al. 2000:219). On the contrary, Baca et al. found that older US consumers had more positive attitude toward DTCA, which the researchers linked to the likelihood for the presence of a medical condition in this group (Baca et al. 2005:382/384/385). These results above seem somewhat conflicting making it difficult to anticipate what should be expected in relation to the Danish informants' attitudes toward DTCA of prescription medicine as to the influence of their age. Hence the *direction* of the attitudes of the young informants included in the construction of knowledge could go both ways when taking these results into consideration. Additionally, the comparison of age groups is not a possibility in this thesis as we have only managed to get informants, which could be said to belong to a young age group. Furthermore, both Miller & Waller and Baca et al. connect age to the possibility of the presence of a medical condition, which is tied to the extremity and direction of the attitude. If

believing in the results and explanation of Miller & Waller, this would indicate in relation to the problem formulation that the informants' attitudes will be rather vague, as the young group might not have that much experience with, interest in and knowledge about medicine, which as mentioned in prior paragraphs could influence attitudes and the constructions underlying these.

Another factor, which also seemed to affect attitude toward DTCA of prescription medicine, were socioeconomic status and education. Consumers having less education and socioeconomic status were more likely to welcome DTCA and seek care after exposure (Gönül et al. 2000:219; Robinson et al. 2004:431). The findings of Gönül et al. and Robinson et al. could in regard to our problem formulation and the included informants mean, that it could be expected that the informants will be prone to be less welcoming toward the idea of DTCA of prescription medicine, as the informants are as mentioned either in the process of obtaining or have finished a university education.

In this thesis we will follow the focus on the other included theoretical approach of *social learning* in the model of Lee et al. (Lee et al. 2007:111) i.e. the centre of attention is primarily on the socialization agents and how these can influence the end-consumers' attitudes toward DTCA of prescription medicine. Nevertheless, before moving on to explaining the *social learning* approach, we would like to point out that the sources of influence of *mass media* and *interpersonal communication*, which Lee et al. set forth in the structural model, are predictors of attitude and behaviour (Lee et al. 2007:110). In this regard, we view the mentioned socializations agents as sources, which possibly can influence the end-consumers' attitudes, but should not be understood as determining the attitude and behaviour (Thornton & Nardi 1975:871/883; Bandura 1986:18), as also mentioned earlier. Furthermore other factors such as experience, personal relevance and media channels, as mentioned in paragraphs 5.7., 5.8. and 5.9. can also be of importance in this regard.

The *model of social learning* tries to explain the development of cognitions and behaviours from sources of influence in the environment. These sources of influences have been termed *socialization agents*, which convey expectations about attitudes, norms, value, motivations and behaviours to the learner. Accordingly, learning happens when the individual interacts with the socialization agents in diverse social settings (Churchill & Moschis 1979:26; Moschis & Churchill 1978:600: McLeod & O'Keefe 1972:131; Zigler & Child 1969:466-467; Brim 1966:8; Bandura 1986:18/47; Thornton & Nardi 1975:872; Moschis & Smith 1985:277). Hence, the socialization agents teach a person how to feel and behave in relation to a certain object in a specific setting (Lee et al. 2007:109), e.g. which attitude to have toward a given object as mentioned in paragraph 5.2. Socialization agents can be a person or an organization, who are involved in the process of socialization due to the frequency of interaction with the learner,

have precedence over the learner, and/or have the power to control rewards and punishments given to the learner (Brim 1966:8/33; Bush et al. 1999:16). This understanding of the different ways in which the socialization agents can be a part of the socialization process put forward by Brim and Bush et al. can e.g. be connected to one of the specific characteristics of informants in the focus groups, which has also been mentioned as a part of the antecedents, the aspect that they all have or is a process of obtaining an university education. This means in terms of frequency that the informants will spend between three and five years in this educational institution, which is an authority having precedence over the informants among others by giving the rewards or punishments of marks. Hence, what is learned in the university could influence the way that the informants approach and think about marketing of prescription medicine affecting the attitudes and the constructions hereof. Consequently, this common characteristic could influence in the findings of this thesis. Of course interactions with other socialization agents could also be influential, which we will return to later on. Linked hereto several authors in regard to *social learning* point out that impact of various socialization agents might also vary depending on the individual's life cycle level (Churchill & Moschis 1979:25; Kagan & Moss 1983:3/279; Brim 1966:33/35; Baldwin 1969:335/342; Riley et al. 1969:951/956/962-963).

Moreover, the learning process through the socialization agents can occur by modelling, reinforcement and social interaction (Churchill & Moschis 1979:25). The former concerns an imitation or rule learning of the socialization agents' behaviour, whereas reinforcement can be both positive and negative in the form of reward and punishment (Moschis & Churchill 1978:600: McLeod & O'Keefe 1972:132-133; Rosenstock et al. 1988:177-178; Chaffee et al. 1971:325; Bandura 1986:47-48; Crandall et al. 1958:440-441; Kagan & Moss 1983:3; Bandura 1969:213-214/255; Moschis 1985:900; Schramm et al. 1961:182). The learning process of social interaction does not propose a specific type of learning, but could incorporate the former mentioned types of learning. Furthermore the social interaction mechanism emphasizes that the focal social norms involved in the interaction form attitudes, values and behaviour. Hence social norms are learned in relation to a given social role and this social role's relations to the socialization agent such as power and communication structures (Churchill & Moschis 1979:25; Moschis & Churchill 1978:600: McLeod & O'Keefe 1972:132-133/159; Thornton & Nardi 1975:872; Chaffee et al. 1971:331-332; Moschis 1985:900-901). In connection hereto the learned power and communication structures surrounding the patient-doctor relationship including the social role of being a "patient", which might be portrayed by the GP and other socialization agents, could be influencing the informants' attitudes. These communication and power structures could e.g. be as team where the illness is managed in unison or the GP could have the role of authority (Gönül et al. 2000:216). Hence the informants' attitudes toward this relationship

could perhaps also influence the informants' attitudes toward marketing of prescription medicine.

It is furthermore mentioned that adults might have to learn and adapt to different roles (Dion 185:124; Brim 1984:184; Brim 1966:8; Brown 1965:156). Additionally, the adult individual is also more likely to be in more complicated situations as various persons can have different demands and expectations and thus compete for influence (Brim 1966:12; Brim 1968:187/192). In our case the informants might also feel as though they are in a complicated situation when considering their attitudes toward the marketing of prescription medicine directly to the end-consumers, as diverse sources can have different expectations and advocate different attitudes in relation to the specific consumer role such as the family, GP, marketer and employer. Linking these notions of Brim to the problem formulation could mean that the construction underlying the informants' attitudes toward marketing of prescription medicine could be connected to the attitudes, norms and expectations of several socialization agents, which the informants take into consideration.

5.10.1. Socialization Agents

Different socialization agents could be parents, mass media, school, colleagues, and peers (Moschis & Churchill 1978:601; Thornton & Nardi 1975:872/874/878; McLeod & O'Keefe 1972:131; Kagan & Moss 1983:3), which are somewhat similar to the ones, put forward in the model of Lee et al. (Lee et al. 2007:2009). However, some differences exist as the model additionally due to the specific focus of DTCA of prescription medicine includes doctors and pharmacists in the interpersonal channels. Furthermore school as a socialization agent is disregarded, but on the other hand is a part of the antecedents, which, as argued earlier, could be of relevance because of the current or prior relation to university education. Hence we will focus on the socialization agents put forward in the model, which are the sources of influence of mass media channels and interpersonal channels (Lee et al. 2007:109).

Besides Lee et al. others have also suggested *mass media* to be a socialization agent including advertisements, TV or radio, newspaper or magazines, and Internet websites (Bandura 1986:20; Thornton & Nardi 1975:874; Lee et al. 2007:109/112; Gerson 1966:41/44/49-50; Bush et al. 1999:19-22; Ward & Wackman 1971:424-425; Backer et al. 1992:170-172). Mass media as a socialization agent can function both as reinforcement of existing values and attitudes and as mentioned teaching norms and values to the individual (Gerson 1966:41/43). The other source of influence is the *interpersonal channels* including family, peers, pharmacist and doctor, which have by different researchers also been shown to have influence (Bush et al. 1999:19/21-22; Lee et al. 2007:109; Aikin et al. 2004:2; Moshcis & Churchill 1978:603; Ward & Wackman 1971:423; Moschis 1985:902-903/910; Smith & Moschis 1985:89; Ward et al. 1977:172; Mangleburg et al. 1997:272).

The two posed socialization agents have also been found in a FDA study concerning among others patients' attitudes in relation to DTCA of prescription medicine. It was shown that people seek information on health in general, conditions and medicine primarily at the doctor and pharmacy but also from reference books, friends, family, and the Internet (Aikin et al. 2004:2). Doucette & Schommer have also found that individuals have a preference for obtaining information on prescription medicine from doctors and pharmacists (Doucette & Schommer 1998:1081-1082/1084-1085). Correspondingly, the result of White et al.'s study showed that the doctor was the most valued source of healthcare information followed by friends/relatives and pharmacists with 20% less (White et al. 2004:58/66). These results are also indicated by Chen & Carroll (Chen & Carroll 2007:278). Linked hereto Gönül et al. have concluded in their study that trust in one's physician reduces the valuation of DTCA of prescription medicine in particular for people who are older, have been sick recently and are more educated (Gönül et al. 2000:215/224).

As suggested by Gönül et al. the influence of the interpersonal socialization agents can be connected to the likelihood that individuals trust their family, friends, pharmacist and doctor and thus find their statements credible (Murray 1991:13; Rogers & Storey 1987:837 Lazarsfeld 1968:155). Linked hereto, interpersonal channels have been perceived to be more influential than communication from companies (Buttle 1998:241-242) and more likely to affect the end-consumers, whereas communication through the mass media to a higher degree creates awareness (Dowling 1986:115; Lee et al. 2007:107/115; Saba & Valente 1998:99; Rogers & Storey 1987:829/836-837; Lazarsfeld et al. 1968:151-152) e.g. in relation to public health (Cassell et al. 1998:71; Backer et al. 1992:31). The studies above seem to indicate a preference for obtaining health information from pharmacists and especially doctors. This can be linked to what Giddens call *expert systems* meaning that certain systems in our society have *credibility* independently of the individual practitioner in this case the individual doctor. Thus people are likely to trust the expert system of the medical profession (Giddens 1996:30-31; Bordum & Uldal 2001:51). From the above empirical results there seems to be a preference for the GP being the main provider of health information and as socialization, as mentioned, can also occur without the intent of the socialization agent, the GP could be an important socialization agent. Thus this attitude of the GP being an important provider of health information and related hereto the doctor-patient relationship might be an anchor point for the attitude toward marketing of prescription medicine, which in relation to the problem formulation means that how the view the GPs as an information source could be another attitude object, which could affect the attitudes toward marketing of prescription medicine. Hence it seems that the GP could have a significant role in relation to prescription medicine and DTCA hereof, which is also one of the reasons why we have interviewed Danish GPs, as they might provide us with insight into the end-consumers in relation to prescription medicine and thus be valuable in

trying to reach the understandings wished for in this thesis. Related to the attitude toward the EU-proposal it has been found that websites recommended by GPs or hospitals were seen as most credible, whereas the least credible where the sites sponsored by the company behind the products (Sundar 2011:195). This could indicate that the informants might not find the information provided by the pharmaceutical companies credible, which might affect their attitudes toward the EU-proposal.

Additionally, mass media and interpersonal sources can also work as socialization agents in combination (Gerson 1966:48; Ward & Wackman 1971:418; Moschis 1985:902/907). In this regard a topic relevant example could be health-related forums and virtual communities, where information is disseminated, interpreted and reproduced (Dahl 2006:268-270). Thus this is a combination between mass media and interpersonal sources, and the Internet could be placed in either category depending on its use (Galarce et al. 2011:168-169). Thus these different channels separately or in combination could provide the end-consumers with information on health issues and prescription medicine, which could influence the informants' attitudes toward marketing of prescription medicine aimed directly at the end-consumers. It will furthermore be interesting to find out, how important these different socialization agents and information sources are, whether they are connected and whether the role of the GP is as central as indicated by the literature. As a practical consequence this means that these different sources of influence was included in the interview guide for the focus group interviews in aiming at constructing knowledge, which can be seen in paragraph 9.1.2., meanwhile still being open toward other sources of influences being brought up by the informants in order to understand their point of view in-depth.

5.10.2. Socialization of Related Attitude-Objects

Throughout the paragraphs of the theory it has so far become clear that the influences on an attitude can be complex. This complexity is furthered as the Danish end-consumers' attitudes toward the topic of interest is as mentioned likely to be anchored in existing subjective constructions e.g. attitudes toward areas related to marketing of prescription medicine directly to the end-consumers, which can also be influenced by the abovementioned socialization agents. Thus it is not just the specific attitude of interest, but also the related constructions that can be affected by various sources of influence. Hence, these socialization agents could convey e.g. certain norms, knowledge, values, and attitudes, which could affect the end-consumers' subjective constructions e.g. attitude. One could imagine that such areas could be individuals' perceptions and attitudes toward e.g. marketing of OTC medicine, the medicinal industry, a specific medicinal company, or a particular medicinal product and disease. Thus in answering the problem formulation the purpose is not just to establish the attitudes toward marketing of prescription medicine directly to the end-consumers. Instead it is the wish to try to obtain an understanding of these attitudes and the related attitude objects, which the main attitude

object of marketing of prescription medicine might be anchored in. Hence the aim is to get insights into these different attitude objects and how they are associated to obtain an understanding of the main attitude object. For example it could be envisaged that the current commotion regarding Lundbeck's medicine being used to execute prisoners sentenced for life (Skovmand 2011; Ullerup 2011; Lambek & Simonsen 2011) could affect the attitudes we are interested in. Besides communication from the general news media the end-consumers might also be affected by monitoring agencies and constituents' organization such as IRF, Lif and the Danish *Consumer Council* (Rindova 1997:192). Thus, the mass media could be influential.

Additionally, cultural constructions about certain illnesses could also exist (Thorbjørnsrud 2009:233/245; Eriksen & Sørheim 2005:235). For example diabetes type 2 and depression could be surrounded by cultural constructions including norms and values, which could be portrayed by the socialization agents (Bech 2009; Elliott 2008; Schimelpfening 2008; Diabetestinget 2008:27). Linked hereto assumptions about a stereotyped or typical user can thus be present. Hence a consumer can be defined through a certain product acquired, used, or the meanings and attitudes toward the product (Levy 1959:118-119; Grubb & Grathwohl 1967:23/26-27; Ward & Wackman 1971:417-418; Sirgy 1982:287-288; Grubb & Hupp 1968:59-61; Schewe & Dillon 1978:69-70). These stereotyped users could be founded in societal norms, which could be communicated through different socialization agents. Hence, these could influence the attitudes toward marketing of prescription medicine directly to the end-consumers, as individuals' attitudes toward an issue can be affected by the construction of that issue (Kotler 2000:553). Thus some products, in our case prescription medicine, can be associated with a stereotyped user, which the end-consumers might not want to be linked to and as a consequence have a certain attitude toward, as attitudes can function as an expression of values, as seen in paragraph 5.4. Lastly, perhaps the norm and values about be healthy in general could also be influential on the end-consumers' attitudes (Featherstone 1982:182-183; Thorbjørnsrud 2009:242).

5.11. Sum up

As seen in the above, the focus has been on the attitude formation process in terms of, which elements might influence this, as we argue that our informants would most likely not have pre-existing attitudes toward the topic. In this way, it has been argued that several aspects will influence their attitude formation process and thus we have a variety of attitude objects to be aware of when analysing the knowledge constructed during the focus groups. Hence, out main topic cannot said to be *one* attitude object, but rather a topic where the appertaining attitude, will be formed and affected by a variety of other attitude objects, that will in turn interplay and influence each other. Hence, the topic of choice is loaded with grey areas that are interesting to explore. As this thesis is explorative in nature, and no specific theories have been

found in relation to how the informants' attitudes toward marketing of prescription medicine are constructed, can make it hard to clearly to specify the attitude objects, which are important to the informants. It could be imagined that the attitude object of *prescription medicine* as a product, in itself can be an anchor point for the informants in constructing their attitudes toward the topic of this thesis. Additionally, as indicated above, the attitude object of *advertising* and *media channels* might also influence these attitude constructions. Due to only having experience with *marketing of OTC medicine*, this is also likely to be an anchor point, as this might be the closest the informants come to the notion of marketing of prescription medicine in a Danish context. Moreover, another possible influential attitude object could be the *role of the GP* as he, as mentioned above, can function as a valued source to health information. Furthermore, as these attitude objects can all in turn be affected by beliefs, knowledge, experience, involvement, and socialization agents the informants will most likely talk about these in different levels in the sense that some may e.g. have a lot of knowledge but little experience and some be highly involvement but not been affected greatly by socialization agents. Thus these aspects influence the constructions of attitudes, and hereby the theoretical notions about these are included as a way of trying to reach an understanding of the informants' constructions of attitudes toward marketing of prescription medicine. Hence it will be interesting, in the following analysis, to get insights into the attitude objects and beliefs at play and possibly the connections between these in order to understand the informants' attitudes.

6

Analysis: *The Surgery*

As shown in the introductory paragraph of this thesis, marketing of prescription medicine is surrounded by great complexity when it comes to the legislative context, the industry's nature and its relations to stakeholders. Marketing of prescription medicine and specifically DTCA has been debated and researched upon in other contexts such as the US, and the debate has been evolving around different aspects, advantages and disadvantages, showing a complexity in the discussion of the practice. In a Danish context, the end-consumers have so far only been given a voice on this matter through one quantitative research. In accordance with the purpose of this thesis, the forthcoming paragraphs will be an attempt of trying to obtain an in-depth understanding of Danish end-consumers' attitudes toward such a practice and expose the complexities and aspects, which underlie these constructions. For constructing this knowledge, we will draw on knowledge and aspects collected so far, which mean that the theoretical foundations, the explorative interviews, the interviews with the Danish GPs and the supplementary interviews will be included as they might be helpful in trying to obtain the wished understanding.

Through the analysis, readers will get to know our informants. Beginning this familiarity we will start out giving a glimpse of these informants and their lives specifically in relation to medicine in terms of whether they are using prescription medicine, has used prescription medicine or know someone who is using prescription medicine, as these can have significance for their attitudes, which can be seen in the following tables:

Name	Occupation	Age	Know-ledge (0-5)	Is using	Has used	Know someone who is using
Katrine	Employed[14]	25	2	Yes	No	Yes
Allan	Student	26	2	No	Yes	Yes
Helle	Student	25	2	Yes	Yes	Yes
Joakim	Student	25	2	Yes	Yes	Yes
Jette	Student	21	2	Yes	Yes	Yes
Cecilie	Student	27	1	Yes	Yes	Yes
Anne	Student	33	1	Yes	Yes	Do not know
Lau	Student	22	2	No	No	Yes
Carina	Student	24	1	Yes	Yes	Yes
Michael	Student	26	1	No	No	Yes
Lise	Student	29	2	Yes	-	Yes
Pernille	Student	36	3	Yes	Yes	Yes
Naja	Student	25	3	No	Yes	Yes
Alex	Student	21	2	No	Yes	Yes
Simon	Student	23	2	No	Yes	Yes
Catja	Student	25	4	Yes	Yes	No
Mie	Student	22	2	Yes	No	Yes
Line	Employed[15]	31	2	Yes	Yes	Yes
Sara	Student	21	1	Yes	Yes	Yes
Mike	Student	29	1	No	No	Yes

Table 1: Overview over Informants (Own construction)

As seen in the table above most of the informants rate their own knowledge about marketing of prescription medicine fairly limited, besides Catja. This might not be that surprising since the informants, as mentioned, have not been exposed to the practice as it is currently illegal in a Danish context. In this aspect it is however also interesting why the informants have thus not rated their knowledge even lower, which might be related to their experience with prescription medicine as most of the informants use or have used such or know somebody who has. In the following table, an overview is presented over the types of prescription medicine that the informants have experience with:

Name	Is on prescription medicine for	Has been on prescription medicine for
Katrine	Birth-control – 9-10 years	Earwax (?)
Allan	No	Hay fever
Helle	Pain killers – couple of years	Infection in pancreas – 1 year Pain killers – 3 months
Joakim	Asthma inhaler	Pain killers – shortly (operation)

[14] Former student at the university. Communication- and project employee.
[15] Former student at the university. Consultant in Region Nordjylland.

Jette	Yes	Spray for allergies Lotion for eczema
Cecilie	Asthma – 3 years Antidepressants – 2 years	Birth-control – 5 years Antibiotics for fungal infection – 2 years
Anne	Allergies – 2 months	Birth-control
Lau	No	No
Carina	Birth-control – 10 years	Hay fever – couple of years Asthma inhaler – couple of years
Michael	No	No
Lise	Birth-control – 9 years	-
Pernille	Birth-control – 20 years For sleeplessness – 1 year	Penicillin
Naja	No	Acne – 6-8 months
Alex	No	Acne – 6 months
Simon	No	Yes
Catja	Allergies – 1 year Birth-control	Yes
Mie	Birth-control – 4 years Cholesterol reducing – 1 year	No
Line	Lotion for skin disease – 25 years	Different kinds of antibiotics Allergies
Sara	Birth-control	Antibiotics – shorts periods (weeks)
Mike	No	No

Table 2: Overview over Informants and medicinal history (Own construction)

As seen in the above, several of the informants take or have taken either birth-control pills or medicine for allergies/asthma, which are medicinal products fairly common used (Malmgren 2008; Lif 2011c). Moreover a smaller amount take or have taken penicillin, some kind of pain-killers or antibiotics. Lastly three informants take or have taken medicine for sleeplessness, antidepressants and cholesterol reducing. In this way, their experiences with each of these medicinal products could be the point of departure for their discussion of this topic.

We have chosen to let the informants' expressions guide the aspects touched upon as we are as mentioned interested in their attitudes and constructions hereof. In this regard it should be pointed out, that not all informants have touched upon all aspects, which might be due to the method of focus group and the time frame but also because they are likely to emphasize different aspects. In trying to answer the problem formulation, this analysis will firstly start out exploring the informants' attitudes toward DTCA and secondly, the informants' attitudes toward the proposal of allowing the pharmaceutical companies to inform directly to the end-consumers.

6.1. Attitudes toward DTCA of Prescription Medicine

In accordance with our problem formulation we wish to obtain an understanding of the informants' attitudes toward DTCA of prescription medicine[16], which will be elaborated on in terms of the underlying aspects of the construction of these attitudes. In this way we will have a look at the informant's attitudes in terms of their *direction* (Kardes 2001:85; Katz & Stotland 1959:428; Petty et al. 1997:611; Ajzen & Fishbein 2000:3) that is how the informants through their attitudes can seem to be for or against DTCA. However many nuances in these attitudes also resulted in differences in these (Kardes 2001:85). In this regard, attitudes are an integration of knowledge about various information and arguments of known or presented attributes, which are subjectively weighed and valued (Sanbonmatsu et al. 2003:289). Thus it might be expected that most informants, weigh the arguments for and against the issue in question, which can make their attitude very complex to characterise. Below we will briefly start out introducing the overall *directions* of the informants' attitudes, which might seem as a simplistic representation, but it is in order not to be overwhelmed by the complexity that this topic brings. However the following paragraphs of analysis will elaborate on the attitudes toward DTCA, in trying to understand the complexities in their construction, thus one will first be able to have a rich insight into the attitudes toward DTCA at the end of the analysis.

Now we will shortly indicate the *direction* of the informants' attitudes toward DTCA in order to give an indication of the overall tendencies of the *direction* of the attitudes, from the knowledge constructed during the interviews. Having a look at this, only two of the informants express an overall positive attitude toward DTCA. Connected hereto Mike says in relation to differentiation of medicinal products in relation to whether these should be advertised for,

> *"Yes, it's probably again that I have a very, very positive attitude toward marketing of prescription medicine. Whether it's going to be directly to me or I get it from my doctor that doesn't matter to me. In the end it's a decision between me and my doctor (…)"* (App. F:201)[17]

In summing up his overall view of DTCA Michael states that,

> "*Well, I think uhm on the personal level (…) then I don't think that there's a problem in giving them permission (…) to advertise for it (…) Uhm.. and as already said, given that you have to go to the doctor (…) then I think this takes the worst of if, if you can say that."* (App. F:153-154)

[16] From now on, when using *DTCA* it should be understood as DTCA of prescription medicine.

[17] As all other quotes, this quote has been translated from Danish to English by the authors and original quotes can be seen the respective appendixes.

In the quotes these informants express positive attitudes toward DTCA. Related to these expressions of positivity toward DTCA, they mention the role of the GP. Hence this is an aspect, which seems as being connected to the construction of their attitudes, which we will have a closer look at in paragraph 6.1.6.

As will be seen the following paragraphs, most informants seemed to express an attitude toward DTCA in a negative *direction* (Kardes 2001:85; Katz & Stotland 1959:428; Petty et al. 1997:611; Ajzen & Fishbein 2000:3), even though several of these informants were able to recognize positive *elements* of the practice. In this way, both pros and cons are weighed and considered in relation to DTCA, whereby some of the informants seem to have attitudes of *moderate extremity*, as an integration of both favourable and unfavourable aspects of the attitude object were included in the informants' evaluations (Herzenstein et al. 2004:203; Sanbonmatsu et al. 2003:289). Consequently, this might also be the reason why it for some of the informants is difficult to interpret the *direction* of their attitudes, as will be shown in the following analysis. Thus is seems as if the informants' attitudes toward DTCA are complex, which will be elaborated on in the paragraphs below. Furthermore the informants, as will also be seen, anchor their attitudes toward the practice of DTCA, in different related aspects. In the following it is attempted to make this complexity of the informants' attitudes and the aspects on which they construct them, visible. Due to this complexity it should be expected that references will be made back and forth between the different paragraphs.

6.1.1. Relating Oneself to Becoming Ill

Firstly, we will have a look at the informants' view on being and becoming ill, which might originate from their experience with illness. This is included, as it was seen in paragraph 5.8.1., that studies have shown that whether people feel ill or are ill, could influence their attitudes toward DTCA (Limbu & Torres 2009:51/68/71-72; Hausman 2003:231; Deshpande et al. 2004:508-512; Gönül et al. 2000:219).

Interpreting the constructed knowledge it seems that some of the informants are involved with illness when it has personal consequences in the sense that they become ill themselves (Petty et al. 1983:136; Petty & Cacioppo 1979:1916; Petty & Cacioppo 1981:107; Mittal 1989:148; Mitchell 1979:194; Day 1970:80; Zaichkowsky 1985:342-343; Celsi & Olson 1988:211; Krugman 1965:255; Grunig 1989:5). In this way, illness first seems to become of their concern, when they get ill themselves. In this regard Lau and Michael says that,

> **Lau**: "*Well, I don't know, I don't care unless it becomes a problem.*"
> **Michael**: "*That's how I feel too.*"
> **Lau**: *"You can't (…) plan your way out of it (…) so you need to take it as it comes."*

> **Michael**: "*That's also the approach I have (…) It's not something I give much thought, I try to live in a way that makes me feel good and then we'll take it from there.. If something occurs, then we need to do something about it."* (App. F:83).

In this way, Lau says that he does not worry about illnesses unless he gets ill, which Michael agrees to. Lau further says that it is not something that he can plan and therefore it is not an aspect, which is of his daily concern to him. Moreover Michael thinks about living in a way which makes him feel good and if he gets ill, then it is something he will need to take care of. Connected hereto Mike mentions that,

> "*Well, as long as I feel good, then I'm actually, then I don't think about whether.. odds and ends.."* (App. F:159).

In this way, Mike says that he does not think about illness as long as he feels good. Alike Lau and Michael, Mike does thus not think about illnesses in his daily life, but differing from Michael, Mike focuses on whether he feels good or not, where Michael perhaps more actively thinks about living in a way, in which he feels good. Overall one might say that these informants only express interest in illness when it becomes relevant for their own health, which might be connected to a form of *personal relevance* in the sense that it can have personal consequences (Petty et al. 1983:136; Petty & Cacioppo 1979:1916; Petty & Cacioppo 1981:107; Mittal 1989:148; Mitchell 1979:194; Day 1970:80; Zaichkowsky 1985:342-343; Celsi & Olson 1988:211; Krugman 1965:255; Grunig 1989:5). Connected hereto are the notions of *Selective Attention Theory*, where people as argued by theorists are subconsciously attentive to information that relates to a current need (Wyer 2008:40-42; Schiffman & Kanuk 2004:172; Williams & Hensel 1995:40).

Moreover, Mie brings in a slightly different aspect of this,

> "*(…) it's not that I fear that I'll get I'll tomorrow, because I don't eat healthy or exercise (…)"* (App. F:159-160).

Here Mie says that she does not fear getting ill on a daily basis, by not living in a specific way. This is connected to Michael's notion about living in a way that makes one feel good instead of focusing on what or what not to do in order not to get ill (App. F, Michael:83). Mie's lack of fear could be connected to that she moreover mentions that she is spared for being ill (App. F, Mie:159). In relation hereto, Lise mentions that she does not really have a relation to it, as she has rarely been ill (App. F, Lise:89).

Thus, illness is among the above-mentioned informants connected to *personal relevance* in the sense that they focus on whether they themselves are ill. A differing notion can be found with Carina in relating *personal relevance* of illnesses beyond herself and onto family members,

> "*(…) naturally I have someone in my family, most people probably have that, so I would of course like to avoid cardiovascular diseases and stuff like that (…) but it's definitely something I think about. Treating my joints properly, not getting rheumatoid arthritis and stuff like that, a lot of fat, so that they're getting greased and stuff like that (…)"* (App. F:83)

In this way, Carina mentions that she is aware of illnesses in the sense that some of her family members are ill, which might be hereditary. Hence, illness is personally relevant to her in the sense that it concerns her family and as the illnesses might also have personal consequences for her in the future (Petty et al. 1983:136; Petty & Cacioppo 1979:1916; Petty & Cacioppo 1981:107; Mittal 1989:148; Mitchell 1979:194; Day 1970:80; Zaichkowsky 1985:342-343; Celsi & Olson 1988:211; Krugman 1965:255; Grunig 1989:5). In this way, she actively thinks about illnesses and tries to prevent what she thinks might become of *personal relevance* in relation to her own health. In this way, her attitude toward becoming ill might be partly shaped on experience with having family members diagnosed with specific illnesses, which some theorists argue have a great impact on attitude formation (Allport 1935:810/819; Argyriou & Melewar 2011:6; Fazio et al. 1978:49/51; Reed et al. 2002:386; Schiffman & Kanuk 2004:267; Bagozzi et al. 1991; McGuire 1985:240). Carina is the only informant directly addressing concerns about becoming ill. The lack of focus on illness among the other informants could be connected to the age of the informants, as it was hypothesized in an Australian study that medicine is not an aspect that young people are interested in, have experience with or knowledge about (Miller & Waller 2004:397/399). Closely connected hereto, another study noted the presence of a medical condition in older age groups (Baca et al. 2005:382/384/385) and thus the informants not focusing much on illness, might be connected to the notion that younger people are generally rather healthy (Burak & Damico 1999:21). This tendency of being healthy might influence some the informants' attitudes toward DTCA, which will be returned to in paragraph 6.1.6.

6.1.2. Advertising

As indicated in paragraph 5.9. the informants' attitudes toward DTCA could be influenced by their attitudes toward advertising in general i.e. the *institution* (Muehling 1987:36/39). Hence this could be an aspect, which some informants anchor their attitude toward DTCA in. This seems to be an important aspect for Lau,

> *"Well, uhm, I don't know, but generally I'm not much for advertisements, but it's almost that I'd rather that they advertise for (…) prescription medicine than for candy and all other kinds of things (…) that's unhealthy (…) it's somewhat easier to stuff oneself with. That is, in this there's at least an obstacle in the fact that you have to go to the doctor (…) I don't think that it's a good idea, generally I would very much like to have the amount of advertisements reduced, but I can't see why the pharmaceutical industry should suffer*

more under that than, uhm… than the food industry and especially perhaps the cosmetics-industry (…)" (App. F:154-155).

When summing up his attitude toward DTCA, Lau seems to emphasize the *institution* of advertising as an important aspect in constructing his attitude as he states that he does not think it is a good idea, hereby having a negative attitude toward DTCA, as he would generally like to have the amount of advertisements reduced. In relation hereto, Lau furthermore says that advertisements was what made him throw out his TV (App. F, Lau:152), which can be seen as underlining his negative attitude toward the practice of advertising in general, thus this attitude seems to concern an *abstract* object (Kardes 2001:85; McGuire 1985:239). As argued by theorists, the construction of an attitude can be anchored in a pre-existing attitude (Triandis 1971:3; Feldman & Lynch 1988:421; Kardes 2001:116; Lynch 2006:25), which it appears as if Lau does in his construction of the attitude toward DTCA by focusing on advertising. This could also be an expression of a judgmental rule, concerning advertisements being bad, being a part of *heuristic processing* (Chen & Chaiken 1999:74). Thus it seems, from the *available inputs* in relation to his knowledge about this practice, that this attitude toward advertising is perceived as being relevant (Kardes 2001:16; Feldman & Lynch 1988:424-426; Bargh 1984:22). However, Lau does not view advertising for prescription medicine as worse than advertising for e.g. candy, which is unhealthy and much easier to get access to. In this regard, he indirectly notes that the GP is there as hindrance in obtaining prescription medicine. The GPs' role in this regard will be returned to in paragraph 6.1.6.

Another informant having a negative attitude toward advertising is Alex,

Alex: *"(…) I have like a personal hatred toward advertisements, for some reason.."*
Interviewer: "*You have?"*
Alex: "*(…) well, basically advertisements are a company's attempt to sell a product (…) and whatever we want it or not, then we're affected in the sense that, when we're standing in a shop and we see the product, and another product we don't know, then there's a huge chance that we choose the one we've seen before (…)"* (App. F:175).

In this way, Alex says that he does not like advertisements, as they are an attempt to sell a product to people, which he believes no one can ensure not to be affected by. Further he says that most people probably know that advertisements are trying to sell a product, but that it will still affect them (App. F, Alex:208). As Alex further mentions that he is negative toward DTCA (App. F, Alex:207), in trying to understand his attitude toward DTCA, the aspect of advertising's influence might be a part of the construction of this.

Another informant, who also emphasizes the aspect of advertising being an attempt to sell a product is Mike (App. F, Mike:202). Besides focusing on the GP, which we will have a closer

look at in paragraph 6.1.6., in relation to his attitude toward DTCA having a positive *direction* (App. F, Mike:177/180/192-193/201), Mike also brings up another aspect of advertising, which could influence this attitude,

> **Mike**: *"Yes, it is probably again that I have a very, very positive attitude toward marketing of prescription medicine (…) so I can generally not see any problem in them starting to advertise (…)*
> **Simon**: *"(…)"*
> **Mike**: "*And myself I think, that with the advertisements I've been bombarded with over the years, which are actually quite a few, hereby I'm used to knowing that advertisements are something that want to sell me something. So when all comes to all it's a decision that's up to me, whether I want to buy the product or not."* (App. F:201-202).

Here Mike expresses a positive attitude toward DTCA, which seems to be of high *extremity* as he says that he is "very very positive" (Kardes 2001:85), which also seems to be connected to his experience with advertisements, as he notes that he is bombarded with advertisements daily and hereby indicating that it has become a part of his daily life where he mentions that he knows that they have a purpose of selling. In saying that it is his decision as to whether he will buy the product, he indicates that advertisements do not necessarily affect him. This interpretation can be further underpinned as Mike additionally says that he does not think that he would be affected anymore by DTCA than he does by advertisements for OTC medicine (App. F, Mike:177) and that he thinks that the latter are like any other advertisements; he notices them when he sees them but forgets them when he has passed them (App. F, Mike:173). Here the concept of *self-efficacy* might be relevant, which can be understood as person's conviction that he can successfully carry out the behaviour needed to reach a specific outcome, as Mike might thus see himself as being able to distance himself from advertisements (Janz et al. 2002:50; Maddux & Rogers 1983:470). In this way, Mike's belief about the effect of advertising on his behaviour, could be an aspect, which is part of the construction of his positive attitude toward DTCA in the sense that he does not think it would affect him. Even though the aspect of *self-efficacy* has not been included in theory, through the analysis it was found to be beneficial in trying to understand the informants' attitudes.

Closely connected hereto, Michael also mentions the notion of being able to sort out advertisements, which might be an aspects influencing his attitude toward DTCA, as he says the following in summing up this attitude,

> "*Well, I think uhm on the personal level (…) then I don't think that there's a problem in giving them permission (…) to advertise for it, but I think, I would prefer advertising rather than information, because it's more, easier to see through for those who might then not be, who are more susceptible."* (App. F:153-154)

From the quote above, Michael says that he personally does not see any problems in allowing DTCA, which he prefers to information if either of these two should be legalized (App. F, Michael:154), as he believes advertising is easier to see through than information, which is a distinction that will be further elaborated on in paragraph 6.2.2.1.1. The view of being able to sort out advertising is somewhat similar to the view of Mike. In this way, Michael's attitude toward DTCA might include a *cognitive component* as, suggested by *Tricomponent Model*, in the sense that Michael appears to have knowledge about advertising through his experience with this attitude object (Schiffman & Kanuk 2004:256; Smith 1947:508-509; Arnould et al. 2005:636; Triandis 1971:3; Katz & Stotland 1959:428-249/430-431). Moreover, from the above quote, it seems as if Michael is somewhat positive toward DTCA as he says that he does not have a problem with it. However, he does not talk about whether or not he thinks it should be legalized, but rather takes the point of departure in a situation where either DTCA or information as suggested in the proposal will be legalized. Thus, it might be difficult to interpret if he is actually positive toward the notion of DTCA. This uncertainty concerning the precise attitude, is further underpinned as Michael himself notes that there are pros and cons for it, which makes him say that he has no opinion about it, when being presented with the task of differentiating between different illnesses in his attitude toward DTCA (App. F, Michael:119), which we will have a closer look at in paragraph 6.1.7. Connected hereto, as seen in table 2, Michael assesses his knowledge about the topic to be limited, and furthermore notes in the evaluation schema, that he found it hard to differentiate between the different illnesses, due to lack of knowledge (App. J, Michael). Thus from the constructed knowledge it is difficult to interpret his attitude toward the notion of DTCA, which might also be due to that he is himself not fully clarified. If we are trying to understand his attitude in relation to Cohen & Reed, his pre-existing attitudes might not have *representational sufficiency* in the sense that he might not feel that they are adequate for constructing his attitude toward DTCA (Lynch 2006:25; Cohen & Reed 2008:11).

Like Michael, we interpret that Naja's construction of her attitude toward DTCA, might include similar notions, including focusing on distancing oneself from advertising,

> **Naja**: *"(…) I think that uhm.. that it's very easy to (…) distance oneself in relation to advertisements (…)"*
> **Interviewer**: *"So you also think that would happen, if it became prescription (..)*
> **Naja**: *"(…) One can keep a distance to it, yes, I think"*
> **Interviewer**: *"So then it would be okay? Or?"*
> **Naja**: *"**I** could handle it (…) thus not said that everyone (…) consumers in society uhm.. is able to do the same, but uhm.. yes, well so therefore I'm not necessarily a proponent of the practice (…) it's a little difficult (…)"* (App. F:153).

In this regard, Naja says that she can easily distance herself from advertisements, but as she thinks that it is not everybody who can, she is not necessarily for DTCA. In this way, Naja's attitude might have a *value-expressive function* as argued by theorists (Argyriou & Melewar 2011:3; Katz 1960:170/173; Triandis 1971:5) as she expresses that she sees herself as an individual capable of withstanding the affect of advertisements but at the same time recognizes that not all people can. Moreover, in trying to understand Naja's attitude, the notion of *self-efficacy* can again be mentioned as she believes that she is capable of distancing herself from advertisements (Janz et al. 2002:50; Maddux & Rogers 1983:470). Even though she also mentions her ability to filter out advertisements like Michael, a difference seems to exist, as Naja also focused on the possibility that not all people have this ability, which might be an aspects influencing that she might not necessarily be a proponent for DTCA. This could be interpreted as if Michael and Naja associate advertisements with something negative, as they say it should be avoided. Another similarity between Michael and Naja appears to be the notion about their lack of knowledge concerning the topic. Here Naja notes in the evaluation schema that she is not comfortable commenting on issues that she does not has enough knowledge about (App. J, Naja), which she moreover notes several times during differentiating between the illnesses (App. F, Naja:127/132/137/141). This might be connected to her own statement about that she think it is difficult to construct her attitude toward DTCA, as seen in the quote above. This might indicate, as considered in paragraph 5.2., that Naja's attitude is constructed on the spot, hereby possibly not being stable and deep due to lack of cognitive processing beforehand. Additionally, Naja mentions an advantage of that DTCA could inform end-consumers about medicinal products, in trying to construct her attitude toward it (App. F, Naja:121-122), thus she sees both positive and negative aspects. Such an attitude might be termed as being of *moderate extremity*, which according to Herzenstein et al. is people's evaluation and integration of both favourable and unfavourable aspects of the attitude object (Herzenstein et al. 2004:203). Thus as there is evaluated upon multiple pieces of information, attitudes tend to be less extreme and thereby more moderate (Sanbonmatsu et al. 2003:289). Moreover, attitudes that are of *moderate extremity*, is by Sanbonmatsu et al. argued to possibly result from people acknowledging that they do not have sufficient knowledge or information, and hereby they are aware of the absence of important aspects and information (Sanbonmatsu et al. 2003:290/298). This could be a way of understanding Naja's attitude toward DTCA and in relation to the latter point this might also be helpful in trying to interpret Michael's attitude toward DTCA.

As mentioned earlier by Alex, other informants also mention the aspect of getting influenced by advertising, somewhat opposite of Mike and Michael's notion about this aspect. The following informants' beliefs about this influence could affect the *direction* (Kardes 2001:85; Katz & Stotland 1959:428; Petty et al. 1997:611; Ajzen & Fishbein 2000:3) of their attitudes toward

DTCA, which appear to be negative (App. F, Helle:24-25/27/74; Pernille:96/106/115/117/153; App. K, Helle:02.20; Pernille:08.40/09.21; App. G, Helle; Pernille; App. I, Helle). Helle notes that,

> "*(…) I don't think that consumers can do much, actually. We see a lot of things today and it's kind of hard to make a filter for, you're affected by advertisements no matter where they are (…) So I don't just think that you as a consumer can say "No, I don't want to see that" (…)"* (App. K:17.26).

In the quote Helle hereby says that she does not think that consumers can filter out advertisements, thus believing that people are influenced by these, which she mentions various times (App. F, Helle:15/17/32/58-59; App. K, Helle:10.37). This notion is supported by Pernille's statement below,

> "*I don't think we can escape advertisements' influence. No matter what, that is, it's not a coincidence that people are advertising (…)"* (App. K:04.11)

In this way, Pernille also notes, as Alex and Helle that she thinks that people will be affected by advertisements. Moreover, Pernille implies that she does not think that it is a coincidence that products are advertised for. This aspect is also noted by Helle as she says that advertisements works with the purpose of selling, as the companies would not advertise if it did not work (App. F, Helle:15/59). This belief about the influence of advertisements, might affect their attitudes toward DTCA, as they would perhaps think, that this would also be hard to escape and not be influenced by, hereby perhaps having an unwanted effect as end-consumers might be inclined to want medicine even if they do not need it. We will have a further look at this in paragraph 6.1.4.

In the supplementary interview, Allan also mentions the aspect of advertising's influence in saying that,

> **Allan**: *"Well, I just think that it's a bit strange, that you're advertising for something like that, that you're trying to sell something to someone who's ill, but.. I do hope.. or there would definitely be some who would fall for it , and think "Oh, I'll try a pill like that" (…)"*
> **Interviewer**: *"So that you would be against?"*
> **Allan**: "*Yes, a little bit."*
> **Interviewer**: "*Yes. Why not 100% against it then?"*
> **Allan**: "*Well, I just also think that.. when they are allowed to advertise for all other kinds of things, then I can't understand why they're not allowed (…)"* (App. K:06.55).

Thus he mentions that people could be influenced by such advertisements and furthermore states that he thinks it is strange to sell a product to people who are ill. This aspect could af-

fect his attitude toward DTCA in a negative *direction*, which does however not seem to be of severe extremity as seen in the quote. His explanation of not being completely against DTCA could be linked to his indicated notion about equal possibilities for advertising among different products. However, in the focus group, Allan seems to express a more positive attitude, in saying that he does not have anything against it, as he cannot see why medicine should be a product, much worse than other products to advertise for as he believes that all advertisements have some responsibility (App. F, Allan:45). This seems to be somewhat divergent from Allan's notion from the supplementary interview as seen above, where he states that it is strange to sell a product to people who are ill. Adding to the complexity of Allan's attitude toward DTCA, he moreover notes during the focus group that he as a consumer would rather not have such advertisements, as he would prefer himself to be investigative (App. F, Allan:47), which we will have a closer look at in paragraph 6.2.2.3. From the constructed knowledge, Allan hereby seems to include different aspects in considering the practice of DTCA, about which he seems to have differing attitudes. This might be connected to Cohen & Reed's notion that a single integrated attitude might not necessarily occur (Cohen & Reed 2006:7) as in modifying the initial attitude it might not be replaced (Wilson et al. 2000:101/121). Thus, we cannot clearly interpret the *direction* of his attitude, whereby his attitude can be seen as being of *moderate extremity* (Herzenstein et al. 2004:203; Sanbonmatsu et al. 2003:289).

6.1.3. Medicine

As part of trying to understand the informants' attitudes toward DTCA, an important aspect is how medicine is being characterized as a product, as this understanding could influence this attitude.

6.1.3.1. Medicine works Individually – Possible Side-Effects

In this regard, some of the informants mention the aspect of medicine being a product, which works differently from person to person in the sense that it will have different effects in terms of whether it will help people with a given illness (App. F, Katrine:21; Michael:121; Lau:126; Simon:180; Line:192; Sara:195; Catja:200). Connected hereto four of these informants mention that DTCA should not influence people to take a specific medicinal product, as it functions with different effects depending on the individual (App. F, Lau:126; Simon:180; Line:192; Sara:195). Thus these informants also seem to believe that DTCA could influence individuals, as seen in the above paragraph 6.1.2. Hence, this belief could influence their attitudes toward DTCA in a negative *direction*. Connected hereto, Catja further elaborates that it might be dangerous just to take some medicine, due to that it is individual what suits one's body (App. F, Catja:200). In this regard, Allan mentions that,

> *"(…) they [the pharmaceutical companies] sell something that's not just a harmless product, but which can actually be harmful for some, if you don't use it correctly, then it's not good for you. Then they might have a higher ethical responsibility than other companies have."* (App. F:10.10)

Here Allan says that, if used incorrectly, medicine can be harmful, which he connects to the pharmaceutical companies having a higher responsibility than other companies. Herein could lie a belief of medicine being different from other products in the sense that, if used incorrectly it can be harmful. This might also be connected to his earlier expressed view of it being strange to advertise to ill people (App. I, Allan:06.55). Further, in relation to the pharmaceutical companies' ethical responsibility, he also mentions that it is not just a pair of pants the pharmaceutical companies are selling (App. K, Allan:02.38) hereby comparing medicinal products to an everyday product, which can pose no harm to consumers if used incorrectly. As seen in the above paragraph, Allan's attitude toward DTCA seems complex and unclear, but this understanding of the product could point this attitude in a negative *direction*. Comparing medicinal products to other products, can also be seen in Helle's statement below,

> **Interviewer**: "*But (…) you say that it's a different product than other products?"*
> **Helle**: "*Yes, I think that it kind of is. Uhm, it's also hard to explain why it is. One can say, that another product, a car, right, you can say to everyone that, "You need this car". Medicine, it's not everyone that needs that, or* ***needs****, what can you say, not needs.. There's no reason for everyone to buy this medicine. Nothing happens if people buy a car, or something like that, something happens if people get the wrong medicine (…). It's got something to do with, that people that aren't ill, don't need it, uhm, compared to other products, which wouldn't actually matter if they bought. So it probably has something to do with that"*
> **Interviewer**: *"So it can have some other consequences, you think?*
> **Helle**: *"Yes, exactly."* (App. K:14.10).

Hence a comparison between medicinal products and other products is again seen, which is, as also seen in Allan's statement connected to the consequences medicine can have if used incorrectly. Comparing to other products might be a way for Helle and Allan to more easily explain why they see medicinal products as something else but a regular product, where Helle also mentions that she thinks it is difficult to explain why. In the above quote Helle additionally mentions that not everybody needs medicine, which is an aspect connected to her attitude toward DTCA, which will be further elaborated on in paragraph 6.1.4. Like Allan and Helle, Lise also compares medicine to other products in her effort to explain her attitude toward DTCA,

> **Interviewer 1**: *"So medicine is kind of a different product or what, than..?"*
> **Lise**: *"Yes, I truly see it that as, that is, I don't think that it can be compared to, uhm, a packet of cold meat or a piece of clothes or something like that, because.."*

> **Interviewer 1**: *"What makes the difference?"*
> **Lise**: "*Well, it's definitely because, well medicine is not always something that's not dangerous, that is, there are for example many side-effects and, yeah, it's not just something you can take without reservations (…)"*
> **Interviewer 2**: *"So that's (…) what you think is inappropriate about it? (…)"*
> **Lise**: "*Yes, if you just took medicine as it suited you, then I think it would be bad."* (App. K:12.20).

Like Helle, Lise thus says that medicine is not always something that is not dangerous. Moreover Lise notes that medicine is something one should be careful about taking. This understanding of medicine could be connected to her attitude toward DTCA, which together with her beliefs about that end-consumers should not be exposed to it all the time as a normal product, as she thinks it would then become normal to take all kinds of medicine, seems to give it a negative *direction* (App. K, Lise:11.57). Lise's attitude will be further elaborated in paragraph 6.1.6. Connected to Helle and Lise's beliefs about that medicine could be potentially dangerous, we find Katrine,

> *"Well, one can say, now that it has been banned to advertise for cigarettes (…) because you should not advertise for something, which is **bad** for people. And this, this is also people's health one (…) is advertising for some products that have an influence on, for the health of society. (…) of course one must assume, that it's products they want to increase our health, but it can also risk **not** to do it, if people (…) think they're actually sick and they aren't (…) So (…) is it for society's best, to advertise for these products. Maybe it isn't."* (App. F:26-27)

Katrine says that, it has been banned to advertise for cigarettes, as it is bad for people, which she links to medicine, and says that medicine can also be at risk of being bad for people's health. In this way, she relates the notion of medicine possibly having a bad influence on people's health as people might think that they suffer from an illness, which they might not. This is an aspect we will have a closer look at in the paragraphs below. The beliefs about medicine's possible harmful consequences and the risk that people might think they are ill, seems to make her question whether DTCA is for society's best. This is closely related to Katrine's attitude about it being morally wrong to make a profit on people's health, thus it seems as if she does not think that these two elements should be intermixed (App. F, Katrine:25). Thus these views could indicate a negative attitude toward DTCA.

Hence for the abovementioned informants' beliefs about medicine, its effect on the individual and possible consequences as well as their apprehensions about advertising for it might together be combined in constructing their attitude toward DTCA, as Fishbein & Ajzen argue that people's beliefs about an attitude object are combined in evaluating this object i.e. construct-

ing an attitude (Fishbein & Ajzen 1975:223; Fishbein 1967:477; Ajzen & Fishbein 2000:1/12-13; Fishbein 1963:233). Thus medicine seems to be different than other products and this belief could be a part of constructing their attitude toward DTCA.

6.1.4. Advantages and Disadvantages

As argued by proponents, DTCA has a number of advantages (Holmer 1999:380-81; Dubois 2003:99/101; Cunningham & Iyer 2005:412-413) as seen in paragraph 1.

Some of these advantages are also mentioned by some of the informants, as seen in the following noted by Cecilie,

> **Cecilie**: "*Well, the **good** thing about it might be that it could put **focus** on some illnesses (…)"*
> **Interviewer 1**: "*There's perhaps a difference in (…) which product that should be advertised for?"*
> **Katrine**: "*Yes.*"
> **Interviewer 2**: "*What kinds could that be (…)?"*
> **Cecilie**: "*Oh, that's bloody hard (…)"*
> **Interviewer 1**: "*Perhaps you think one some rare illnesses, or?"*
> **Cecilie**: "*Yes, or illnesses where there's perhaps a need for showing consideration. Perhaps some hidden illnesses that you'll not offhand see on people, but where there's people who need, that consideration is being showed for them (…) Some illnesses that need attention in some way (…)"* (App. F:26).

In this way, even though previously having said that she would never buy such a product after an advertisement (App. F, Cecilie:12) and that she generally does not like medicine (App. F, Cecilie:14), she finds that DTCA might be beneficial in giving attention to illnesses, where people might be in need of other people showing them consideration in everyday life, which can be connected to the advantage of educating consumers about health conditions, mentioned by proponents for DTCA (Holmer 1999:380; Dubois 2003:99/101). In this way, this aspect might point Cecilie's attitude toward DTCA in a positive *direction*, but as we will see in paragraph 6.1.5.2., Cecilie appears to have a negative attitude toward DTCA, and thus other aspects seem to be of *higher perceived relevance* for her to anchor her attitude in, as argued by Feldman & Lynch (Kardes 2001:116; Feldman & Lynch 1988:424-426; Bargh 1984:22).

Catja and Mike also mention possible advantages of DTCA in the following sequence,

> **Catja**: *"I'll say, I'm not for making it legal to advertise for prescription medicine, but I can see that it will benefit the consumers, if you have a chronic illness and you're very ill, then you might only have the medical preparation that the doctor says (…) You don't know which alternatives there are. And that you could be told about if it became possible to advertise for it."*

Interviewer: "*Okay, so you also see some possible good things?"*
Catja: "*Yes, but I can also see, that it can create an unnecessary need (…)"*
Line: *"That's actually true, I haven't thought about that, that I've been using the same crème for 25 years and I have no idea whether something else has come since then (…)*
Catja: "*(…) if you're very ill, then it's important that you have some choices. But again, that depends on which type of illness."*
Line: "*Definitely."*
Simon: *"(…) I still don't think that you as a patient know which alternatives you have, through advertisements, as a rule, I don't trust advertisements. If you see, how many of you have read some of those small texts? (…)" [points to disclaimers on OTC advertisements]*
Mie: "*(…) whether you actually get **knowledge** from those advertisements, or whether it's just going to be like "This is good, you will be happy"-like. Whether it gives an actual possibility for that decision, because I don't think that it's often, that advertisements generally do that. They want to sell products, they try to make it better than it actually is, I'm not saying that they're lying, but they're trying to.. well.."*
Sara: "*That's also what I think, that if you're ill, then you can go on the Internet and read (…). Which might be more reliable in some way (…) than if you see three different advertisements."*
Mike: "*(…) I can go seek on the symptoms, but it might be that I only get one or two alternatives, but then a third or fourth alternative comes on advertisements, that I would be happy for, as an ill person. So I generally see it as an advantage, that there would be a possibility for advertising for prescription medicine."* (App. F:179-180).

In this regard, Catja starts out saying in the quote that she is not for DTCA as it could create unnecessary needs, but that it might also be a possibility for informing ill people about alternatives to the medicinal products they use. Hereby she seems to find it important to have a range of choices when being ill, which makes Line consider her own use of a prescription crème. Hence Catja mentions the possibility of DTCA informing and educating end-consumers about new products, as also mentioned by proponents of DTCA (Holmer 1999:380; Dubois 2003:99/101). Despite noting this positive aspect of DTCA, Catja simultaneously expresses a negative attitude toward DTCA. This might be connected to Gould & Friedman's findings that people who are negative toward DTCA, still might see a possible potential of DTCA as they welcome the information potential (Gould & Friedman 2007:103/105-106). The possible consequence of leading to unnecessary needs thus seems to be of higher *perceived relevance* for Catja (Kardes 2001:116; Feldman & Lynch 1988:424-426; Bargh 1984:22), than the possible advantages of DTCA informing end-consumers. Additionally, her attitude could also be pointed in a negative *direction*, as she as mentioned in paragraph 6.1.3.1, believes it might be dangerous just to take some medicine, due to that it is individual what suits one's body (App. F, Catja:200). Hence, the *direction* of the attitude is negative, but it can be difficult to precisely assess the *extremity* of this attitude as she evaluates the practice upon different aspects. Such

nuanced attitudes can be termed attitudes of *moderate extremity*, which according to Herzenstein et al. are people's evaluation and integration of both favourable and unfavourable aspects of the attitude object (Herzenstein et al. 2004:203), whereby attitudes tend to be less extreme and more moderate (Sanbonmatsu et al. 2003:289). Thus in weighing of several arguments could also indicate thorough elaboration of the topic. Hence it might seem as if Catja uses the *central route* of the *ELM* as posed by Petty & Cacioppo or *systematic processing* as argued by Chaiken (Chen & Chaiken 1999:74/80-81; Petty & Cacioppo 1986b:125-126; Petty & Wegener 1999:42), in constructing her attitude toward DTCA. Additionally, this might also be connected to the situation of the focus group as this is centred specifically about considering this topic (Petty & Cacioppo 1985:5-6; Chaiken 1987:4/6), which could enable her *ability* to elaborate on the topic (Petty & Wegener 1999:45; Chen & Chaiken 1999:74/79).

In this regard, Mike also notes that he would perhaps only find some of the alternatives on the Internet, whereby he would be happy for other alternatives told by advertisements if he was ill. This might be linked to empirical findings showing that if people are in poorer health or chronically ill, they are more likely to value DTCA and find it useful (Desphande et al. 2004:511; Gönül et al. 2000:219). Connected hereto, the aspect of *personal relevance* (Petty et al. 1983:136; Petty & Cacioppo 1979:1916; Petty & Cacioppo 1981:107; Mittal 1989:148; Mitchell 1979:194; Day 1970:80; Zaichkowsky 1985:342-343; Celsi & Olson 1988:211; Grunig 1989:5) might be useful in trying to understand this statement, as Mike says that he could see a potential in DTCA he himself was ill. Furthermore Mike says that DTCA would inform him about possible products that could help him when being ill, but also says that it would still not give him enough information to choose the product merely on the basis of the advertisement, but enough information to seek additional information about it (App. F, Mike:204). This view could be connected to the arguments of authors that mass media might create awareness, but be less likely to influence behaviour (Dowling 1986:115; Lee et al. 2007:115; Saba & Valente 1998:99; Rogers & Storey 1987:829/836-837; Lazarsfeld et al. 1968:151-152). The belief about DTCA's ability to inform end-consumers about a product as well as alternatives, as also mentioned by proponents (Holmer 1999:380; Dubois 2003:99/101), could be another aspect of his construction of a positive attitude toward DTCA (App. F, Mike:193), besides the aspect of being able to sort out advertising, as seen in paragraph 6.1.2.

In response to these advantages, Simon says in the sequence above, that he does not think, that consumers will be able to be told about alternatives through advertisements, as he does not trust such. This could be interpreted as if he thinks that they present the information in a specific way as he refers to the small texts of the disclaimers, which he does not seem to think call much attention to itself. Hereby his attitude toward DTCA, seems to point in a negative *direction*, which we will have a further look at later in this paragraph. Mie seems to agree in

saying that she thinks advertisements will rather try to make the product look at good as possible, whereby she indicates that advertisements' messages have an objective. Moreover she says that, she does not think that advertisements give consumers a real possibility of making a choice as they are trying to sell a product and hereby might make it look better (App. F, Mie:179-180). In this way, Mie points to a con for DTCA in making the product seem better than it is, which has also by authors been assumed to influence attitudes toward DTCA (Aikin et al. 2004:45; Hoek et al. 2004:217; Dens et al. 2008:53). Hereto Sara says that she thinks more reliable knowledge might be found on the Internet if one is ill. Hereby she differentiates between channels in the sense that she finds the Internet more reliable. Thus it might be connected to the "pull", rather than "push" nature of the Internet as consumers decide themselves whether they wish to spend time on it (Schlosser et al. 1999:51; Ducoffe 1996:21-22).

Connected to Mie's statements, Line says that she is not capable of making a choice on the basis of advertisements about a medicinal products trying to sell her something, due to limited knowledge about these (App. F, Line:198). One could thus imagine, that Line questions the information brought by DTCA, as it might be unilateral and therefore not objective. Connected to Line and Mie questioning the quality of knowledge in relation to objectivity, Anne mentions in relation to anti-depressants,

> "*(…) I think the information you get, should **both** inform, about the advantages of the medicine but also side-effects and that I can't imagine, that you in a TV-commercial will tell (…)"* (App. F:59).

Further she continues,

> *"(…) stuff like that, don't really belong to that genre, so therefore I think it's wrong, to make an advertisement, because it's **very unilateral** information."* (App. F:59).

And earlier she said,

> "*But surely that isn't a very good way, of choosing one's medicine? Because the happy lady in the advertisement, she has it?"* (App. F:49).

Hereby Anne notes that she does not see advertisements as telling about disadvantages of a given medicinal product and that she sees it as unilateral information, also mentioned by Herzenstein et al. as an aspect that could influence people's attitudes toward DTCA (Herzenstein et al. 2004:207). Hence it seems that Anne questions advertisements of medicine as a good way of choosing one's medicine. These beliefs could be a part of constructing her negative attitude toward DTCA, which she furthermore anchors in her belief about that advertising's main purpose, is to sell a product, which she does not think should be intermixed with medicine (App. K, Anne). Moreover, as argued by Fishbein & Ajzen, Anne's attitude might be an-

chored in her belief (Fishbein 1967:479-480; Ajzen & Fishbein 2000:1; Fishbein 1963:233) about advertisements being unilateral information, which she cannot imagine telling about both advantages and disadvantages concerning a specific medicinal product. In connection to this objective of advertising, Carina also mentions that she thinks it is another way of trying to make it seem harmless, even though it is still medicine (App. F, Carina:115), indirectly indicating that medicine might not be just that. Her beliefs about medicine and her attitude toward DTCA, will be further elaborated on in paragraph 6.1.5.2. The notion that DTCA might make medicine seem more harmless than it is, is also mentioned by Sumpradit et al. as an aspect that could influence people's attitudes toward DTCA (Sumpradit et al. 2002:71). In close connection hereto Pernille says that, she thinks that the aspect of side-effects would disappear in DTCA (App. F, Pernille:105) and thus like Anne indicating that she also does not think that DTCA would tell about disadvantages of the product, which could be an aspect influencing the negative *direction* of her attitude, which we will elaborate further on in paragraph 6.1.5.2. Thus these types of products and advertising can in the view of some informants be problematic, as the product might be harmful, as mentioned earlier in paragraph 6.1.3.1. Then in trying to understand their attitudes toward DTCA, the informants' beliefs about both medicine and advertising seem important.

6.1.4.1. Unnecessary Needs, Overconsumption and Hypochondria

Opponents have also argued for several other disadvantages of this practice, as seen in paragraph 1, including that it might lead to consumers obtaining unnecessary medicine and lead to overconsumption of medicine (Cunningham & Iyer 2005:412-413; Mintzes 2001:27). This is an aspect which is also found in the constructed knowledge of this thesis, which could be connected to paragraph 6.1.2., where some of the informants mentioned the possible influence of advertising. Connected hereto, Mie and Sara say,

> **Mie**: *"Well, I also think generally I'm probably against it. (..) but you can say when they try to sell a product, then they try to sell it in a way so those who doesn't need it, also want it. And that's what I think is dangerous. So I think I'm against it."*
> **Interviewer**: *"Yes."*
> **Sara**: *"Uhm.. I think, especially if it has something.. that is, I'm generally against it, but I especially think that if it has something.. uhm.. which goes in an affects some persons who are already that weak in some aspects, that is if you have a depression, or probably also sleeplessness (…) then I'd think one would easier say, "Well, then I should probably also try this product" (…)"* (App. F:207).

In this sequence, Mie thus says that she thinks that she is against DTCA, which she elaborates in saying that the advertisement has the objective of making people want the product, even though they do not need it, which she thinks can be dangerous. Hereafter Sara agrees with the

direction of the attitude toward DTCA and elaborates that it could especially influence people who already suffer from an illness, which in her opinion might make them more susceptible. Hence the quote indicates that both Mie and Sara anchor their negative attitudes toward DTCA in a belief about it influencing people perhaps leading to unnecessary needs, which especially Mie mentions during the focus group (App. F, Mie:173/190/202/204-205), which in this ways seems to be an anchor point of *perceived relevance* for her in constructing her attitude (Kardes 2001:116; Feldman & Lynch 1988:424-426; Bargh 1984:22). These negative attitudes might also be connected to the former mentioned expressions where they question the possibility of actually obtaining knowledge from advertisements, as seen in paragraph 6.1.4.1. Carina also pinpoints the notion of DTCA creating unnecessary needs,

> *"(…) I feel that advertisements have a purpose, and that is to make money and if you start to advertise for prescription medicine, then I just think that it would create needs, that aren't necessarily there. (…) I don't think that all people can see that it's an advertisement and then you sort it out (…)"* (App. F:154).

Firstly, Carina mentions that advertisements have the purpose of making money, which was also a characteristic of advertisements mentioned by Alex (App. F, Alex:175), as seen in paragraph 6.1.2. Carina links this objective to a belief that it would create unnecessary needs, which could be a negative consequence as she does not think everybody can sort out DTCA, as earlier mentioned by other informants (App. F, Alex:175; Naja:153; App. K, Helle:17.26; Pernille:04.11). This could be one of the aspects in which Carina anchors her attitude toward DTCA, pointing it in a negative *direction* (App. F, Carina:128). Yet, other aspects also seem to influence Carina's attitude toward DTCA, which will be returned to in mainly paragraph 6.1.5. and 6.1.6.

Some of the other informants note a related disadvantage of DTCA. In this regard, Helle says the following,

> **Helle**: *"(…) I'm very much against that (laughs). I am.* ***Very much.****"*
> **Interviewer**: *"Can you try to elaborate on that?"*
> **Helle**: *"(…) I think that people often become hypochondriacs of it and stuff like that. I don't think that there's any reason to tell people, who do not suffer from the illness, about it and advertisement does that. There's absolutely no reason why to advertise for it, I think. I'm a huge opponent of that, yes."* (App. K:10.20).

In this way, Helle says that she believes that advertisements for medicine make people think they have the illness advertised for and therefore that she does not see any reason why, people should be told about illnesses they do not suffer from. In this way, she argues that more people would turn into hypochondriacs if DTCA became legal (App. F, Helle:17). Thus it ap-

pears that the *direction* of her attitude (Kardes 2001:85; Katz & Stotland 1959:428; Petty et al. 1997:611; Ajzen & Fishbein 2000:3) toward DTCA is negative and that it is of high *extremity* (Kardes 2001:85), as she expresses that she is "very much" against it. From the quote it seems that she uses this disadvantage to construct her attitude. Moreover, she also highlights this aspect at other times during the interviews, which she mentions when stating her opinion about the practice (App. F, Helle:17/24-25/32). If including, Feldman & Lynch's *Accessibility-Diagnosticity Model* it might be argued that Helle *perceives* this aspect as being *relevant*, on the basis on her knowledge about the topic (Kardes 2001:116; Feldman & Lynch 1988:424-426; Bargh 1984:22). Hence, the aspect of the risk of becoming hypochondriacs is an anchor point for Helle in relation to her negative attitude toward DTCA (Triandis 1971:3; Feldman & Lynch 1988:421; Kardes 2001:116). This interpretation could be supported by Helle's experience with advertisements for OTC medicine, where she says that she thinks that many people take medicine on the basis of advertisements, which they do not need (App. F, Helle:24-25). Through experience Helle thus appears to have created a belief about advertisements for OTC, which leads to her constructing a negative attitude toward this (Fishbein & Ajzen 1975:217/233). Hence, this seems to be an anchor point in constructing her negative attitude toward DTCA (Feldman & Lycnh 1988:421; Kardes 2001:116; Lynch 2006:25). If turning to the *Tricomponent Model*, this could mean that her attitude has a *cognitive component* (Schiffman & Kanuk 2004:256; Smith 1947:508-509; Arnould et al. 2005:636; Triandis 1971:3; Katz & Stotland 1959:428-249/430-431) in the sense, it is anchored in a pre-existing attitude that has this component.

The aspect of hypochondria is also emphasized by Simon,

> *"(…) it would remove some sources of irritation for me, at any rate, by just forbidding it. Or not even making it legal. It seems as (…) a hypochondriac catalyst."* (App. F:207).

In this way, Simon's belief about DTCA leading to hypochondria, seems to be an anchor point in constructing his seemingly negative attitude toward DTCA (Feldman & Lynch 1988:421; Kardes 2001:116), which he also mentions at another point of the focus group (App. F, Simon:177). In relation to the US advertisements, Simon further elaborates this in saying that he thinks that it is scandalous that DTCA is trying to normalize the illnesses advertised in order for people to start consuming medicine (App. F, Simon:207). The notion of DTCA normalizing taking medicine is also mentioned by Lise, as seen in paragraph 6.1.3. Thus like Helle, the disadvantage of the risk of hypochondria also seems to be of *perceived relevance* for Simon (Kardes 2001:116; Feldman & Lynch 1988:424-426; Bargh 1984:22). (App. F, Simon:177). Hence from the constructed knowledge, this seems to be a main aspect in his attitude formation process.

The aspect of hypochondria is also noted by Naja who says that you might be able to make yourself believe that you all of a sudden have different kinds of illnesses (App. F, Naja:114). As seen in paragraph 6.1.2., Naja finds it difficult to construct a clear attitude toward DTCA, but this aspect might influence it in a negative *direction*, which can be connected to her statement that she is not necessarily a proponent (App. F, Naja:153).

6.1.5. Body and Medicine

As seen in the above, Simon states that he finds it appalling that DTCA tries to normalize a given illness. As a response hereto, Alex says that he thinks it is a way of making it socially acceptable to sort problems with medicine (App. F, Alex:206). The above-mentioned focus on the disadvantages of creating an unnecessary need and hypochondria could be connected to a view of medicine as a quick solution.

6.1.5.1. Medicine as an Easy and Quick Way Out

The construction of medicine as being just that, is noted by some informants below,

> **Helle**: "*Well, it might also be the extent of medicine that one can get, and then you can get medicine for bloody, well restless legs and things like that, right, and I can easily feel like having that once in a while, well, then you'll need to go get something for that instead of going for a walk (…) It's* ***easy*** *today (…) people don't have the time to go for that walk, well then it's easier to take such a pill. So I can see why they're advertising, because I think it works."*
> **Interviewer**: *"Yes."*
> **Helle**: *"Yes."*
> **Cecilie**: *"Yes, and then just instead of, drinking some water or trying to take a nap or something like that, if you have a headache, or go for a walk, run, something, right, then you can just eat some pills. It's kind of sad."*
> **Joakim**: "*The easy way out."*
> **Cecilie**: *"Yes, the* ***quick*** *way out."*
> **Joakim**: *"Well (…) so if you come home from a meeting and you have a headache (…) then it's easier to pop pills than to just, go for a walk in the fresh weather (…)* (App. F:15).

Here Helle, Cecilie and Joakim mention that taking medicine has become the quick and easy solution for people today, meaning that people do not hesitate taking medicine if it can fix a problem. Cecilie sees this behaviour as unfavourable as she states that it is sad, which might be connected to that she generally does not like medicine nor like taking it (App. F, Cecilie:14), which we will have a closer look at later in this paragraph. As noted earlier, Helle believes that DTCA could create hypochondria (App. F, Helle:17; App. K:10.20), which could be connected to the above notion about people having a tendency to easily consume medicine and thus taking the easy way out. In this way, this belief could be a part of the construction of her negative

attitude toward DTCA. In the construction of medicine as an easy solution, Cecilie and Joakim also note that it could be due to it being easier than doing something about it oneself e.g. exercising, which is an aspect that is also illuminated by Katrine and Anne in the following,

> **Katrine**: "*Yeah, I also think that. Definitely. There is someone, like we talked about headache. You probably **know** that it would be better to exercise or drink some water (…) but if you can just take two pills and sit in front of the television instead. That's easier."*
> **Anne**: *"(…) there's **so** many advices (…) that you need to relate to (…), relate to what you eat (…) relate to exercise (…) and that **is** hard to manage during the couple of hours one has a day, so therefore I think that many, then it would be an easy solution."* (App. F:30-31).

Here Katrine says that even though one knows that there are other solutions, medicine is easier. In this way, one might argue that beliefs and actions are not necessarily connected, as Katrine argues that one might know that one can do something about it oneself but might take the easy way out. Hereafter Anne says that this might be due to all aspects people need to take a stand to, which she argues can be hard for people to manage during their everyday lives. Connected hereto she says,

> *"Well, I think that there are many will say "Well then I save two hours in the gym, by taking something against this illness, which I have seen the advertisement that you could have."* (App. F:31).

Thus from this quote it seems as if Anne believes that DTCA could further medicine as an easy solution to a given problem. This belief might be a part of constructing her attitude toward DTCA, which appears to have a negative *direction* (App. F, Anne:30-31/48-49). This notion about DTCA furthering medicine as an easy solution, can be further elaborated on by Mie's statement below,

> "*But that might also be a bit of that with, that the advertisement gives an impression of that you can get like a quick fix for it (…) well that the doctor feels that you should go through something longer.. I don't know, almost a course of therapy or something, and then you are told than some easy happy pill can take care of it. Well, and then you can sit and keep on pushing, well, then I naturally hope that the doctor would argument and keep saying "You are not getting that", but.. I'm just thinking.. if you have been through some long course of an illness, then you might just want something that can take care of it fast, and "I can see in the advertisement that.." I'm not saying that people are stupid (…) but you can get quite desperate."* (App. F:181).

In this way, Mie says that she thinks advertisements for prescription medicine might lead people who have been ill for a long time, to see an advertised medicinal product as an easy solu-

tion compared to other solutions. Here she emphasizes that she would naturally hope that the GP would be there as a guardian, but that she thinks people could get desperate, as being ill for a long time can be hard. In this way, Mie puts a different angle on medicine as being a quick and easy solution, as she says, that if being ill, medicine can make a long course of illness easier. Thus people would probably be easily persuaded by DTCA, where the GPs' role would be to decide whether or not the end-consumers should have the medicine, which we will have a closer look at in paragraph 6.1.6. This could thus be another disadvantage of DTCA, which together with Mie's abovementioned belief about the risk of DTCA leading to hypochondria, could be aspects that influence her construction of the attitude toward DTCA in a negative *direction*. Thus this could be connected to the notion of constructing an attitude put forward by Fishbein & Ajzen, who argue that beliefs are combined in the evaluation of an attitude object (Ajzen 2001:30; Fishbein 1963:233; Fishbein & Ajzen 1975:216/223).

Through this the informants construct an image of their surrounding societal context as being one where people will rather take medicine than do something themselves. In regard hereto, Alex says that people's intake of medicine is affected by a societal norm of having to be ready and healthy all the time in order to fulfil e.g. jobs on Monday morning, thus feeling pressured to stay healthy in some aspects (App. F, Alex:175). This is supported by GP Jan saying that people should preferably not be ill on work (App. C, Jan:65). In this way, it might seem that societal norms have an impact on consumers' intake of medicine, which can be connected to seeing society as a socialization agent as argued by theorists, in relation to societal expectations of e.g. being a good employee (Ward 1974:3; Liu et al. 2005:254/262).

In regard to seeing medicine as a quick solution, Simon mentions a related aspect in saying that,

> **Simon**: "*(…) and then those crèmes*[18] *that you can apply on places, well I think they're horrible, because something is hurting, well the solution is, to apply some kind of crème, which will just remove it.. noooo…"*
> **Alex**: *"Then you can't feel it, then it's not there, then I have a healthy body again."* [Said in an ironical tone of voice] (App. F:171)

Thus in relation to advertising for OTC medicine, Simon mentions that applying something that makes the pain go away does not mean that you are not ill anymore. In response hereto Alex indirectly says people may think they are healthy if they cannot feel the pain after taking medicine, which is said in an ironical tone of voice, in trying to make it clear that medicine is not always the solution. Hence these informants indirectly argue that medicine might not solve the real problem, which is an aspect we will look further into in paragraph 6.1.7. In this way,

[18] Said in relation to OTC crèmes for e.g. back-pain.

Simon and Alex indirectly note that advertisements might tell people about the solution of medicine, even though this might not solve the real problem. This aspect might be one aspect influencing Simon's negative attitude toward DTCA, as seen in paragraph 6.1.4.1., in relation believing that DTCA would lead to hypochondria. Moreover, this might also be an aspect, influencing Alex's negative attitude toward DTCA, which can be connected to his personal hatred toward advertisements, as seen earlier in paragraph 6.1.2. Further indicating Simon's negative attitude toward DTCA is his belief that it will never be natural to eat pills of any sort (App. F, Simon:207). However, in constructing his attitude toward DTCA he can also see a positive aspect, as he additionally says that a bit of competition might be needed, which might be in the form of advertisements, as he argue that this will make the pharmaceutical companies work for making better and cheaper alternatives (App. F, Simon:182), as also touched upon in connection to the nature of the pharmaceutical industry as seen in paragraph 1. Miller & Waller an also uses this as an aspect, which could influence people's attitudes toward DTCA (Miller & Waller 2004:393). In this way, Simon can see a positive aspect of DTCA, namely that the competition given from advertisements could perhaps lead to better medicine, which might make Simon's attitude less extreme in the negative *direction* (Kardes 2001:85; Katz & Stotland 1959:428; Petty et al. 1997:611; Ajzen & Fishbein 2000:3) thus being more moderate in his attitude (Herzenstein et al. 2004:203; Sanbonmatsu et al. 2003:289).

Hereto, Allan has an additional perspective on intake of medicine,

> *"But I also think that, there's a lot who's trying to limit it. Who **won't** take that much medicine."* (App. F:15)

In this way, Allan mentions that he believes that a lot of people are trying to limit the intake of medicine hereby he makes a construction about the surrounding societal context. This could be connected to that Allan also notes about prescription medicine that it is not something everyone should buy and therefore it is not something people should be incited to take through advertising, as it would be better if one could do without medicine (App. K, Allan:08.30). Hence his notion about some people trying to limit intake of medicine, might thus be connected to this attitude about that it should be avoided if possible, which might be an expression of his personal values, whereby his attitude might be said to have a *value-expressive function* (Argyriou & Melewar 2011:3; Katz 1960:170/173; Triandis 1971:5). Despite not being able to clearly interpret Allan's attitude toward DTCA as seen in paragraph 6.1.2., this aspect could lead his attitude toward DTCA into a negative *direction*.

6.1.5.2. Intake of Medicine and view on Body

From the constructed knowledge, an aspect that seems to be influential in understanding some of the informants' attitudes toward DTCA is the view of the body as being able to take care of many illnesses, which could also be connected to attitudes toward intake of medicine.

In this regard, we will have a closer look at Pernille's attitude toward DTCA, where she notes that she thinks it seems untrustworthy and frightening that prescription medicine is being advertised for as was it liver paste (App. F, Pernille:96) or ice-cream (App. F, Pernille:105). This fright might be connected to her expression about prescription medicine being potentially harmful (App. F, Pernille:84). Here she compares it to an everyday product and thus indirectly states that it is exactly not that – an everyday product. In this way, it does not seem as if she thinks medicine and marketing goes together indicating a negative attitude toward DTCA, which she further elaborates on below,

> **Pernille**: "*(…) I think I would be against it and I think that I would be sceptical toward it for a **long** time. Of course you get use to things, right, uhm, and that's what I think is the danger about it, that you get used to it*"
> **Interviewer**: "*Why would you be against it?"*
> **Pernille**: *"Because for me it's something with, that medicine is something you get in the extreme, it's obviously not something that one should ponder on, in one's everyday life, "I wonder whether I need some of that". (…) it's in a **completely** different direction compared to my personal view, that the body is something that should be allowed to fix it itself (…)"* (App. K:08.40).

Pernille says that she thinks medicine is something one should only get if really necessary. In this way, Pernille immediately links her negative attitude toward medicine to her belief that DTCA would lead to illness becoming a daily concern of people. She further elaborates on this by saying that she does not think that illness should be a focus in society as she already thinks that people are getting too much medicine (App. K, Pernille:15.00). This might also be connected to her notion about medicine being something one should only take when really needed. Additionally, this is linked to her attitude about that the body should be given the opportunity to fix as much as possible by itself. In this way, as argued by theorists, Pernille can be said to anchor her negative attitude toward DTCA (Triandis 1971:3; Feldman & Lynch 1988:421; Kardes 2001:116; Lynch 2006:25) in her view on the body in relation to illness, which is further elaborated in the following. Here especially Pernille and Carina seem to create consensus,

> **Pernille**: *"(…) just the other day I wrote with my friend about her daughter being ill, in relation to her maybe having penicillin and that was final, there (…) was no other thoughts in her mind, where I kind of wrote that the body should might be allowed to try to fix it itself (…)"*
> **Carina**: *"Well, it's designed for it, one could say.."*
> **Pernille**: "*Exactly. My mum, if I have a fever, then my mum will say "Take some Panodil's", well the fever is there to.."*
> **Carina**: "*To do something."*

> **Pernille**: "*..to do something about, what's making you ill, right.. there are different ways of thinking about that."* (App. F:84-85)

Hereby they agree that the body can handle many things itself (App. F, Pernille:83-84; Carina:88). In this way, Pernille and Carina's image of the body can be seen as a social construction (Entwistle 2000:27). Thus Pernille and Carina have a subjective construction of the body, its abilities and functions. These attitudes could thus be said to take the function of *value-expressive* and *social adjustment*, where the attitudes as argued by theorists, is a way for Pernille and Carina to express their identities and to create a background on which to associate, communicate and agree (Smith et al. 1956:41-43; Argyriou & Melewar 2011:3; Katz 1960:170/173; Triandis 1971:5). In this way, it might be an expression of their personal values, and in the setting of the focus group these values that they share, allow for communication, especially between these two. Hereby in the specific situation of the focus group, meaning is created around the view of the body, which seems to have an influence on their attitudes toward DTCA, as they through this view, also express an attitude toward medicine as something one should try to avoid. In this way, this belief could influence their attitudes toward DTCA in negative *direction* (Kardes 2001:85; Katz & Stotland 1959:428; Petty et al. 1997:611; Ajzen & Fishbein 2000:3). Pernille also mentions that there are different ways of thinking about it, which might indicate that she is aware of that people think differently about this and may not necessarily agree with her. Carina's view of the body as something that can heal itself could be founded in what she has learned in her upbringing, which can be seen in the following sequence

> **Naja**: "*(…) if I was in pain anywhere, I had a glass of water (laughs and several informants laugh), well, uhm, my mum kind of made us believe that she didn't have any painkillers, but I've found out much, much later that she actually has (several informants laugh), but we've never gotten any pills.. at all."*
> **Carina**: "*I think I come from a home like that also (…) fever and stuff like that, it was under the covers."*
> **Naja**: *"Yes."*
> **Carina**: *"Watch a good movie and relax."*
> **Naja**: *"Yes."*
> **Carina**: "*No pills or something like that."*
> **Naja**: "*No."*
> **Carina**: "*That's for sure."*
> **Naja**: "*You got some tea."*
> **Carina**: "*Exactly, a good cup or camomile tea with honey."* (App. F:92)

Here Carina says that she has never gotten any medication at home, like Naja. In this way, these informants argue that they might have been raised into having an attitude toward me-

dicinal products as something one should not take. Hereby they seem to anchor their attitudes in *external information* from others as argued by theorists (Schiffman & Kanuk 2004:253-267; Allport 1935:810-811; Fishbein & Ajzen 1975:217; Osgood et al. 1957:189; Ajzen & Fishbein 2000:1/12-13; Fishbein 1963:233) and implying, as also argued by theorists, that family as socialization agents have an impact on their attitudes (Bush et al. 1999:19/21-22; Moschis & Churchill 1978:603; Ward & Wackman 1971:423; Moschis 1985:902-903/910; Smith & Moschis 1985:89; Ward et al. 1977:172; Mangleburg et al. 1997:272). This could also be linked to Carina's statement about prescription medicine being "harsh stuff" and thus not being good for the body to take every time being ill (App. F, Carina:111). In this way, Carina might have learned her attitude (Doob 1947:135; Allport 1935:811; Fishbein & Ajzen 1975:8-9/217; Sherif & Sherif 1967:115) toward taking medicine, which can be an attitude she anchors, her negative attitude toward DTCA in. Connected to her belief that DTCA might lead to unnecessary needs (App. F:154), as seen in paragraph 6.1.4.1,, these two aspect could be part of constructing the negative *direction* of her attitude.

Connected to Carina and Naja's notions about their upbringing influencing their attitudes toward intake of medicine, Pernille's attitude toward this issue could also be connected to her upbringing. Yet, as seen in the following, the socialization agents of her family, might not necessarily transfer their attitudes directly, as it is argued that individuals can mediate and actively process these external influences (Zigler & Child 1969:469/473; Brown 1965:153-154), which Pernille can be an example of as seen in the following,

> *"(…) for example my mum, right, who has been chronically ill for many years and gotten all kinds of pills and is still ill, where you look and think (…) does it do anything good (…) perhaps not, maybe I should stay away from that (…)"* (App. F:94)

Here Pernille says that she has looked at her mother through the years and seen that medicine has not done any good. Thus, Pernille herself reasons that her attitude is formed as a counter reaction in regard to her mother's situation (App. F, Pernille:91). Hence, as argued by theorists, the socialization of attitudes might have been without the intent of Pernille's mother as a socialization agent (McLeod & O'Keefe 1972:131; Sarbin 1959:226-227). Consequently, Pernille's mother seems to have had an impact on Pernille's attitude toward medicinal intake, which could be connected to her attitude toward the body as being something that should take care of illnesses whenever possible (App. K, Pernille:08.40; App. F, Pernille:84-85). In this way, this socialization can thus have had an impact in relation to Pernille's negative attitude toward prescription medicine. Moreover, it could be argued that Pernille's attitude might also be formed through experience (Allport 1935:810/819; Argyriou & Melewar 2011:6; Fazio et al. 1978:49/51; Reed et al. 2002:386; Schiffman & Kanuk 2004:267; Bagozzi et al. 1991; McGuire 1985:240) as she has seen that all the medicine her mother has been taking, has not benefit-

ted her (App. F, Pernille:91). As we saw in the beginning of this paragraph, Pernille is negative toward DTCA (App. K, Pernille:08.40) and thus her attitudes toward the body and taking medicine, could be a part of understanding the negative *direction* of her attitude toward DTCA (Kardes 2001:85; Katz & Stotland 1959:428; Petty et al. 1997:611; Ajzen & Fishbein 2000:3).

The view on taking medicine also seems to have a great influence on Cecilie's attitude toward DTCA as she says the following about taking medicine,

> *"Well actually I don't really feel like taking medicine, and I actually have to feel really, really **bad**, also even if it's just before taking a pain killer. I actually don't like medicine. I don't trust it."* (App. F:14).

Followed by,

> *"(…) It's because you don't really know what's in it, so I'd rather drink some herbal tea or take some Echinacea, is really good for a cold (…)."* (App. F:15).

Cecilie thus notes that she would rather not take medicine before it is really, really necessary, in which Cecilie expresses her personal values through her attitude. In relation to arguments by theorists, her attitude might be said to have a *value-expressive* function (Argyriou & Melewar 2011:3; Katz 1960:170/173; Triandis 1971:5) in being against medicine and rather making use of more alternative products such as Echinacea. The focus on alternatives to medicine due to her being opposed to taking medicine, could be interpreted as having a *ego-defensive function* (Katz 1960:170/173; Triandis 1971:5), in the sense that Cecilie writes in the evaluation scheme, that she was concerned of revealing that she is taking antidepressants (App. J, Cecilie), which might be connected to the possible social constructions surrounding this disease (Thorbjørnsrud 2009:233/245; Eriksen & Sørheim 2005:235). These values and thus her attitude toward taking medicine, seems to be connected to Camilla's attitude toward DTCA as seen below,

> *"I just don't think that medicine is something you should advertise for. I come to think, why should they advertise for it. Is it because they cannot sell it in any other ways? That is, I'm also afraid that people (…) will become like one's own **treatment provider**, right, I don't want that either. So, there I think, there I trust the doctor too much and her authority for that. But I also think it's because I'm in opposition to medicine (...)".* (App. F:11).

In the above quote, Cecilie says that she does not think that medicine should be advertised for and that she thinks it could lead to people becoming their own treatment providers. Moreover, she mentions the importance of the GP in obtaining medicine, as she trusts her GP. The aspect of the GPs' role will be further elaborated on in paragraph 6.1.6. below. Moreover, Cecilie also says that she would not buy such a product after an advertisement

(App. F, Cecilie:12), which was also mentioned by Anne, as she questions whether it is a good idea to choose prescription medicine on the basis of DTCA (App. F, Anne:49). Her negative attitude toward DTCA, seems to be anchored in the aspect of her negative attitude toward taking medicine and her belief that it might lead to self-diagnosis as also mentioned as a disadvantage by authors (Singh & Smith 2005:371; Miller & Waller 2004:390). This could be connected to some of the other informants' beliefs about that DTCA might lead to unnecessary use of medicine (Singh & Smith 2005:371).

6.1.6. The GPs' Role (DTCA)

In relation to prescription medicine the GP is as mentioned, a necessary character in consuming this product. Related hereto studies have also found GPs to be an important source to health information (Aikin et al. 2004:2; Doucette & Schommer 1998:1081-1082/1084-1085; White et al. 2004:58/66; Chen & Carroll 2007:278), and Gönül et al. specifically found that trust in the GP reduces the valuation of DTCA (Gönül et al. 2000:215-224). The role of the GP also seems for some of the informants to be an aspect of *perceived relevance*. As argued by Feldman & Lynch, in anchoring one's attitude, people use the input that they perceive as relevant from what they know about the attitude object (Kardes 2001:116; Feldman & Lynch 1988:424-426; Bargh 1984:22), which in this case, is the GP as seen in the following paragraph. One aspect mentioned in relation hereto, can be seen in Joakim and Lise's statements below,

> **Joakim**: *"I see it as unnecessary. Since prescription medicine isn't something you can get without a note from your doctor, marketing is irrelevant."* (App. K, Joakim)
>
> **Lise**: *"I still don't think that it's necessary (laughs), that is… you go to your doctor, if you really have one of these, uhm.. bigger problems (…) so I can't see why they should market themselves.. when you have to go talk to your doctor anyway."* (App. F:153).

In this way, Joakim and Lise both cannot see the necessity of DTCA, as you either way have to go to your GP, thus making DTCA irrelevant in their view. Thus the role of the GP in consuming prescription medicine appears for Joakim and Lise to be of relevance in the sense that they both pose the question why DTCA should be necessary. In this regard, Joakim more specifically notes that one cannot get the prescription without the cooperation of the GP and Lise says that she thinks one goes to the GP when having a problem. Both of them being unable to see the necessity of DTCA, might influence their attitude toward DTCA in a negative *direction* (Kardes 2001:85; Katz & Stotland 1959:428; Petty et al. 1997:611; Ajzen & Fishbein 2000:3), yet without directly expressing this. In Lise's case this might also be connected to, that she has not been ill that often (App. F, Lise:89), which might influence her notion not being able to see the relevance of DTCA, as studies have found that people who are ill or feel ill, had more favourable attitudes toward DTCA (Limbu & Torres 2009:51/55/68/71-72; Hausman 2003:231; Desphande et al. 2004:508-512; Gönül et al. 2000:219). Another indication in regard to Lise of

this *direction* of her attitude toward DTCA, could be her notion about medicine being potentially dangerous as thus should not be taken without reservations (App. K:12.20), as seen in paragraph 6.1.3.1.

Closely connected hereto some informants note that the GP is an important part in deciding whether to have a given medicinal product, e.g. Jette as seen below,

> *"(…) It's fine that it's not legal (…) If you are ill it should not be because you have seen it in and advertisement, then it should be because the GP says that you're ill and therefore you should take you medication (…)"* (App. F:16)

In the quote, Jette accentuates the GPs' role as the one who should assess whether you are ill and therefore it should not be a decision made on the basis of DTCA, on the background of which she notes that she thinks it is fine that it is not legal, and hereby anchors her negative attitude toward DTCA. This might be influenced by that she has not had any bad experiences with going to the GP and therefore she trusts her GP (App. F, Jette:8). Hence, in following the thought of several theorists (Allport 1935:810/819; Argyriou & Melewar 2011:6; Fazio et al. 1978:49/51; Reed et al. 2002:386; Schiffman & Kanuk 2004:267; Bagozzi et al. 1991; McGuire 1985:240) Jette's experience with her GP might be important in her attitude formation toward DTCA, as experience with an attitude object has a great effect on the construction of an attitude. The GPs' role is also mentioned by Carina and Alex,

> **Carina**: "*The way I feel is, that there should not at all be advertise."*
> **Others**: "*(…)"*
> **Carina**: "*You should to talk to your doctor and then get it through him, I think."* (App. F:128).

Like Jette, Carina also mentions, that one should go to the GP instead of listening to DTCA when having a problem. This aspect together with Carina's abovementioned beliefs about that the body can heal itself and that one should not take medicine too often, as well as DTCA could make prescription medicine seem harmless and create unnecessary needs (App. F, Carina:88/111/115/154), could all affect her attitude toward DTCA negatively (App. F, Carina:128). Thus, Carina seems to construct an attitude toward DTCA on a variety of beliefs and attitudes, which then functions as anchor points (Triandis 1971:3; Feldman & Lynch 1988:421; Kardes 2001:116; Lynch 2006:25). Somewhat like the above quote, Alex says that,

> *"I'm so negative, so I turn my thumbs down. I think maybe you should instead talk to your doctor about whether you **have** a problem. Instead of advertisements."* (App. F:207).

Further he says that,

> *"I think it's good that you don't advertise for medicine, which I normally should go to the doctor to get (…) you get affected in direction of a certain product and instead of thinking about what… which is actually best, because it's incredible deep to start going into each product and start to scrutinizing those. So, there I would think that it's good that we do not in this country affect the consumers in that way."* (App. F:176-177)

Hence, Alex expresses his negative attitude toward DTCA, which he links with the belief that one should go to the GP when having a problem instead of listening to advertisements, as one might get affected in direction of a specific product instead of focusing on, which product might be the best for the given problem. This might be connected to his notion that DTCA might make it socially acceptable to solve problems with medicine, as they normalize intake of medicine, which is also mentioned by Simon (App. F, Simon:207). Further Alex says that medicine does not always solve the real problem (App. F, Alex:206), which could also influence his attitude toward DTCA. Additionally, he indicates that end-consumers might have a hard time acquainting themselves with a given product due to the complexity of medicine, which might again be connected to his belief about the importance of the GP. Likewise Line also mention that it could be difficult for end-consumers to assess the information from DTCA,

> "*But doesn't that render the (…) risk possible, that you yourself are not competent enough to make the distinction between what works best for you, from an advertisement (…)"* (App. F:180).

Hereby Line argues that people might not be competent enough to make decisions on the basis of DTCA, which can be connected to her belief about the GP being more competent than the end-consumer (App. F, Line:180-181) and moreover that she mentions that she has a faith in the GPs' authority (App. F, Line:169/192). The focus on the GP and his competences could be interpreted as aspects influencing her attitude toward DTCA in a negative *direction* (Kardes 2001:85; Katz & Stotland 1959:428; Petty et al. 1997:611; Ajzen & Fishbein 2000:3).

In continuation of this Anne put all of her trust in expert systems, not least because she feel they have the competencies to make the decision for her:

> "(…) *I count on the doctor and the pharmacy to be an expert-system, which solve these problems for me, so that I don't need to think about it. So that I can think of other things (…)"* (App. F: 19-20).

In the above quote Anne expresses that she trusts the GP and the pharmacy as an expert system, so that she can think of other things, indicating that she does then not need to put a lot of effort into scrutinizing information in order to make a decision. Furthermore Anne notes that the GP has a long education, whereby he should know more about prescription medicine

than end-consumers (App. F, Anne:21) similar to Line's notion above. Closely connected hereto, Katrine also mentions that she trust her GP (App. F, Katrine:21), which Cecilie also expresses (App. F, Cecilie:11) as seen earlier. Connected to theory, these informants thus seem to trust the expert system of the medical profession (Giddens 1996:30-31; Bordum & Uldal 2001:51). Thus these informants could seem to make use of *heuristic processing*, in the sense that they might apply a judgmental rule about that the statements of experts can be trusted (Chen & Chaiken 1999:74). This trust in the GP by Anne, as well as her earlier mentioned belief that one should not decide, which medicine to take on the basis of advertising and that these should not be intermixed (App. F, Anne:49; App. K, Anne), could in combination affect her attitude toward DTCA in a negative *direction* (App. K, Anne). Dissimilarly to Anne and Katrine, Allan mentions that people should not blindly trust doctors and pharmacists as he thinks that you are responsible for you own health (App. F, Allan:20). Related hereto Allan mentions in relation to DTCA, that he think it is people's own responsibility (App. F, Allan:45). These notions about being responsible could be a part of constructing his attitude toward DTCA and influencing this in a positive *direction*, which could add to the complexity and haziness as seen in paragraph 6.1.2.

Additionally, Mike also notes the role of the GP, as seen in paragraph 6.1., in saying that it does not matter whether the information about prescription medicine is given directly to him in the form of DTCA or to his GP, as it will either way still be a decision which he will make in cooperation with his GP, which he links to having a positive attitude toward DTCA (App. F, Mike:201). Thus, opposite of the abovementioned informants, Mike uses the role of the GP as an anchor point in constructing his positive attitude (Triandis 1971:3; Feldman & Lynch 1988:421; Kardes 2001:116; Lynch 2006:25) toward DTCA, which can be connected to that he says he is able to sort out advertisements (App. F:201-202), as seen in paragraph 6.1.2. Thus, the GPs' role of importance in consuming prescription medicine seems to be an aspect both used in constructing negative as well as positive attitudes toward DTCA among the informants.

Another perspective on the GP in relation to DTCA is his role as an intermediary in the consumption of prescription medicine. In relation hereto, when expressing that he would not have a problem with DTCA, Michael also notes that the fact that you have to go to the GP, will take the worst of it (App. F, Michael:153-154), as seen in paragraph 6.1.2. This might be interpreted as if Michael sees the GP as a sort of guardian in obtaining prescription medicine and minimizing unnecessary use, which might be an aspect influencing his attitude in a positive *direction*. Closely connected hereto, Lau can also see the aspect of the GP as a guardian, in saying that the GP would at least be an obstacle in obtaining prescription medicine, if DTCA was to be allowed (App. F, Lau:154-155) despite having a negative attitude toward DTCA, as seen in paragraph XX. A similar notion can be found with Allan as he says,

> **Allan**: *"But maybe it's also more **the doctor's** responsibility to actually restrict people (…)* th*ose hypochondriacs who (…) have seen a new advertisement for some new medicine*" (App. F:16).
>
> **Interviewer**: *"So you think that the doctor has an important role to play in relation to..?"*
> **Allan**: " *I think he will get an **even more** important role (…)* (App. F: 17)

In the first quote Allan expresses that the GP has an important role in restricting hypochondriacs from getting medicine, which they do not need, being a disadvantage of DTCA, as seen in paragraph 6.1.4.1. Furthermore he thinks that in the future the GP will have an even greater role to play if DTCA is made legal. As another perspective on DTCA's influence on the GPs' role, Katrine suggests, in saying that if DTCA becomes a reality, it could affect the doctor-patient relationship and interaction:

> *"Well if the consumer becomes convinced that it's the product that they have seen in the advertisement is the best (…) and the doctor then says "Ah, my professional assessment is that you should have this and this ", well then it could be that there will be a conflict there because the consumer then has no confidence in the doctor."* (App. F:18).

In the above quote, Katrine expresses a concern that DTCA might convince end-consumers that the specific products is best, which might create a conflict if the end-consumers demand this product from the GP and he assesses that the end-consumer needs something else. Thus she indicates that, if DTCA is made legal it might interfere with the doctor-patient relationship in a negative manner, which might also be an indication of that her attitude has a negative *direction* (Kardes 2001:85; Katz & Stotland 1959:428; Petty et al. 1997:611; Ajzen & Fishbein 2000:3), as seen in paragraph 6.1.3.1. This could be connected to Sumpradit et al.'s notion about that the belief about DTCA causing tension between the patients and GPs, could influence people's attitudes toward DTCA (Sumpradit et al. 2002:71). The concern that it could influence the doctor-patient relationship is also mentioned by GPs Nis and Jannik in terms of more questions being posed (App. C, Nis:88; Jannik:20), which Nis expects will give rise to extra examinations and discussions with patients (App. C, Nis:90). Moreover GP Bente notes that DTCA might lead to that she would have to explain why a patient should not have a given product that he mentions due to DTCA, thus leading to extra workload (App. C, Bente:44-45). This is also mentioned by Jan, as he thinks that end-consumers will consult him more often (App. C, Jan:70). Hence, both Katrine and the GPs mention this possible negative consequence of DTCA.

Hence, the role of the GP seems to be an important aspect for the informants in constructing their attitudes toward DTCA, however, not only one perspective on the GPs' role is included,

bur rather a variety, thus adding to the complexity of understanding the informants' attitudes toward DTCA.

6.1.7. Differentiation of Prescription Medicinal Products

In describing what prescription medicine is, as seen in paragraph 1.2.2., it became evident that prescription medicine can include a wide array of different types of medicine. This variety might also influence the end-consumers' attitudes toward DTCA depending on the specific prescription medicine. Such a difference was found in studies by Hausman and Miller & Waller (Hausman 2003:231; Miller & Waller 2004:399-400), where the latter found that some types of prescription medicine were perceived as inappropriate for advertising e.g. antidepressants, whereas for example antihistamines were perceived as appropriate (Miller & Waller 2004:399-400). Addressing this issue there also seems to be some aspects related to different types of prescription medicine, which could affect the informants' evaluations of the appropriateness of DTCA. In this way, the focus is now on the attitude toward a more *specific* attitude object (Kardes 2001:85; McGuire 1985:239). Thus in the following paragraph specific types of medicine will not be slavishly examined, but rather the aspects that could influence this appropriateness will be touched upon.

For some informants, the aspect influencing whether a specific type of prescription medicine was appropriate to advertise for, were their overall attitude toward DTCA Thus Mike who has a positive attitude toward DTCA, considered all types of prescription medicine presented to him during the focus group, as more appropriate to advertise for (App. H, Mike), than the other informants did (App. H). When Mike was asked by the interviewer to give reasons for his assessment of the appropriateness of advertising for antidepressants medicine, he argued in the following manner,

> *"Uhm.. it's actually a bit difficult to say, it's mostly because I'm generally positive toward advertising for prescription medicine. So, I will say that mine (…) are placed around three [middle of continuum] or higher, so…so therefore I can't say that there's anything wrong with that. (…) I can see that there could be some problems, as it's mentioned around this table (…), but.. in the end it's in cooperation with some professional that the decision is made [the decision about whether taking medicine or not, and which kind]"* (App. F:193).

In the quote Mike argues for his assessment in the reason that he is generally positive toward DTCA, and therefore he has placed all of the types of prescription medicine from the middle of the continuum and upwards, in relation to how appropriate these are to advertise for. Furthermore he recognizes and admits that he can see the other informants' arguments for problems in advertising for antidepressants, but he still believes that there are some professionals who is the guarantee for end-consumers' use of prescription medicine (App. F, Mike:201), as

also seen in paragraph 6.1.6. Thus Mike does not seem to differentiate much between different types of prescription medicine, but have assessed them all to be appropriate to advertise for due to his positive attitude toward DTCA. He also seems to consider the other informant's arguments for why it is not appropriate to advertise for, but it seems like he ends up putting most weight on his own argument that the health professionals are the guarantee for end-consumers use of prescription medicine, thus this aspect which generally seems to be important in Mike's evaluations as can be seen in paragraph 6.1.6., also become a influential aspect when it comes to evaluating different types of prescription medicine in relation to how appropriate they are to advertise for. Hence, the role of the GP, seems to be of *perceived relevance* (Kardes 2001:116; Feldman & Lynch 1988:424-426; Bargh 1984:22) for Mike in general and thus when differentiating between the appropriateness for DTCA for specific prescription medicinal products. Thus, as Mike does not seem to differentiate much between the different types of medicinal products, this might support the *extremity* of his attitude, as seen in paragraph 6.1.2.

In a similar way as Mike, Allan explains his placement of all the types of prescription medicine as generally high on the continuum, with his general attitude that it is okay for the pharmaceutical companies to advertise for prescription medicine (App. F:45/57). Thus this expression could be a part of constructing his attitude toward DTCA, despite of that he at other times indicates a negative one, whereby this adds to the haziness of his attitude, as also mentioned in paragraph 6.1.2.

Pernille, one of the informants with a more negative attitude toward DTCA, as seen in paragraph 6.1.5.2., considered all types of prescription medicine to be inappropriate to advertise for. As Pernille is asked to give reason for her assessments of antihistamines as being inappropriate to advertise for, she argues that she has placed all the different types of prescription medicine presented to her, very far down on the continuum, because of her general attitude that there should not be advertised for prescription medicine at all (App. F:51). Furthermore in the supplementary interview, she expressed the following in relation to differentiating,

> **Pernille***: "(…) I thought it was actually very difficult to do, because in reality then I am fundamentally against it, so I would actually have placed them all low (…), it* ***is*** *actually very difficult to differentiate on it, because I don't think that you should advertise for anything."*
> **Interviewer:** *"No, is that because you think that there are side-effects with everything or what is the reason then?"*
> **Pernille***: "Well, (…) it is the element of* ***illness*** *in it, well it's like I don't think that there should be so much focus on illness right (…) I don't think it should be something that like takes up place in society in that way (…) because I think that you already perhaps medicate way too much."* (App. K:14.15).

Thus in the quote Pernille expresses the view that it is difficult to differentiate between the different types of prescription medicine as she is fundamentally against advertising for any prescription medicine. Furthermore here she grounds her negative attitude toward DTCA in the illness element in the product and because she thinks advertising for such products will create more focus and awareness in society about illness and use of medicine. Furthermore it could be anchored in the attitude (Triandis 1971:3; Feldman & Lynch 1988:421; Kardes 2001:116; Lynch 2006:25) that there is being medicated too much in society. Thus Pernille again, as seen in paragraph 6.1.5.2., seems to anchor her attitude toward DTCA in the product as an attitude object and the attitude that medicine should not be used too much.

Some informants found it very difficult to differentiate between the products, because they felt that they lacked knowledge to make an assessment (App. F, Michael 119/121; Joakim:58; Simon:189-190). In the differentiation of these medicinal products, Michael seemed hesitant, which the assistant interviewer addressed (App. F, Michael:119). Thus by interpreting his non-verbal expression an insight was gained into the formation of his attitude toward DTCA of different prescription medicinal products (Katz 1960:168). Connected hereto, it could seem as if Michael's attitude might not be particularly strong, as people tend to respond quick to attitude objects, which they have strong attitudes toward, as argued by Fazio (Fazio 1989a:155-157; Powell & Fazio 1984:145-146; Kardes 2001:101; Fazio et al. 1982:352). In relation to the lack of knowledge, for Joakim this concerned the assessment of antidepressants and Simon the assessment of medicine for erectile dysfunction. For Joakim, the lack of knowledge resulted in a judgement of antidepressants of *moderate extremity* (App. F, Joakim:58), if using the notion of Sanbonmatsu et al., who suggest that when people are aware that there is missing knowledge upon which to form an attitude, they tend to moderate their final attitude (Sanbonmatsu et al. 2003:290).

6.1.7.1. Seriousness of the Condition and the Side-Effects of the Product

One of the aspects, which seem to be influential when the informants assess the appropriateness of DTCA for a specific medicinal product, is the seriousness of the disease, which the product is meant to treat. Talking about how it could be advantageous to advertise for some illnesses in order to put focus on illnesses, which are tabooed and afterwards asked which such illnesses this could be, Cecilie says,

> "*Well, uhm. That's damn difficult (…) now I have to be careful that I don't take some really, really* ***serious*** *illnesses (...)"* (App. F:26).

In this above quote, Cecilie expresses that it is difficult to say which illnesses it could be okay to advertise for, where she is concerned about mentioning examples of serious illnesses, which she does not want to mention. This indicates that Cecilie has an attitude that it is not

okay to advertise for really serious illnesses. This aspect also seems important in deciding whether a type of prescription medicine is appropriate to advertise for, was shared by Jette as seen below,

> **Jette***:"(…) when I place them here, then I also do it like a bit according to how* ***serious*** *I think the illnesses are. And that's also a subjective judgement, and I think it has a lot to do with that, that you then place them at "Completely disagree" because you think, that it's more serious to suffer from hypertension, than it is, to get birth-control pills."* (App. F:45).

Above Jette accounts for her way to assess the different types of prescription medicine presented to her, which she says depends on the seriousness of the illnesses. She acknowledge that the assessment of the seriousness is subjective and furthermore she seems to weigh the illnesses against the other illnesses presented to her in terms of how serious they seem to be in relation to each other, were she assesses suffering from hypertension as more serious than the use of birth-control pills. Hence, the notion of Fishbein & Ajzen can be included, as they suggest that beliefs are used in the evaluation of a given attitude object (Fishbein 1967:477; Ajzen & Fishbein 2000:!; Fishbein 1963:233). Thus, the belief about the seriousness of hypertension, seems to influence Jette's negative attitude toward DTCA of this medicinal product. In relation to hypertension beside the seriousness of this condition, the aspect of lifestyle is mentioned, which will be further explored below.

Some of the types of prescription medicine were also by the informants assessed by the seriousness of the product in itself, whether it was known or believed to cause serious side-effects. In relation to prescription medicine for acne, Katrine says for her assessment of this type of product with the severity of the product and the side-effects,

> *"(…) Then you can also get some pills, and I don't know so much about them (…) I have just heard that, the few persons I know who have gotten them, that they're pretty harsh and that there* ***are*** *a* ***good deal of*** *side-effects to them actually"* (App. F:64-65).

Thus Katrine argues for her placing it low on the continuum (App. H, Katrine), in her experience and knowledge that prescription medicine treating acne is a "harsh" product, and that a great amount of side-effects exists for this product, for which reason she does not think that those are appropriate to advertise for (App. F, Katrine:65). Other informants agree with her in believing or knowing that there are serious side-effects to these kinds of products, for which reason they do not find them appropriate to advertise for (App. F, Cecilie:64-65; Pernille:139; Carina:139; Naja:139). In a similar manner Carina perceive prescription medicinal products for

erectile dysfunction as "hard-core" (App. F:129-130). In relation to antidepressants, Anne is also concerned with serious side-effects,

> *"(...) I know that there are many side-effects on many types of antidepressants and therefore I think the information you get, should* ***both*** *inform, about the advantages of the medicine but also the side-effects, and I can't imagine, that you in a TV-commercial will tell (…)"* (App. F:59).

In the quote Anne expresses concern with the many side-effects of antidepressants, which she believes that there are with this type of prescription medicine, in which she seems to anchor her negative attitude (Fishbein 1967:477; Ajzen & Fishbein 2000:1; Fishbein 1963:233; Feldman & Lynch 1988:421; Kardes 2001:116) toward DTCA of this medicinal product (App. H, Anne). Furthermore she states that because of these serious side-effects, it is important to be informed of both advantages with the medicinal product and the side-effects, and that she does not believe that an advertisement can do that. Thus the seriousness of the illness and the seriousness of the product in terms of side-effects, for some of the informants, seem to be influential in evaluation the appropriateness of DTCA for a specific product.

In line with the studies mentioned in the beginning of this paragraph, the type of prescription medicine, which was perceived as generally most appropriate to advertise for among the informants was antihistamines (Miller & Waller 2004:399-400). The informants explained the appropriateness of advertising this type of prescription medicine with the product being relatively harmless,

> **Carina**: "*I think also because there's like relatively precisely harmless alternatives, Benadryl, which there's not really any evil (…) therefore it can be placed high"* (App. F:136).
>
> **Michael**: "(…) *Because it's harmless (…)"* (App. F:136).
>
> **Mie**: *"(…) It's not that serious that I don't think that one isn't able to take a decision about it (…)"* (App. F:187).

In the quotes above all three informants argue that antihistamines can be placed high because they see it as a harmless type of prescription medicine or as Mie puts it, not that serious so that people are not able to take a decision about it themselves. In connection hereto, Joakim and Anne are asked to explain their assessment of antihistamines as appropriate to advertise for, they argue,

> **Joakim**: *"(…) It's a more normal, or a bit more* ***common*** *illness, which you suffer from (…)"* (App. F:63).

> **Anne**: "*But it's a bit more like an everyday-thing, also because there are over-the-counter medicine you can get*." (App. F:64).

Above Joakim expresses how he perceives antihistamines as more normal and common, which Anne similarly expresses. Furthermore she compares it to OTC medicine. From these quotes it can be interpreted that as they believe that antihistamines are widely used in society and because many people suffer from allergy, then it does not seem to be such a serious product, for which reason it is then assessed as appropriate to advertise for. Furthermore, from Anne's way of speaking of it, it could appear as if she makes a link to OTC medicine and thus anchors her attitude in this type of medicine, which maybe is perceived less dangerous because you do not need a prescription medicine to get it. This way of evaluating a type of prescription medicine as appropriate because it is "normal" can also be seen in Lau's way of reasoning in relation to birth-control pills,

> Lau: *"(…) I totally agree (…) that there are some problems with it [advertising for* birth-control *pills] on the other hand (…) then it's a medical preparation which I think is so widely used that (…) it for my sake would be okay to justify why one should be better than the other (…)"* (App. F:120).

Thus Lau expresses in a similar way as the other above-mentioned informants that because it is a product widely used, it would be okay for pharmaceutical companies to advertise for and here through justify why their specific medicinal product is better than a competing one. However, he also notes that he recognizes the problems with the severity in the product due to hormone content, which is of other informants' concern (App. F, Line:198/199; Carina:120). On the ground of Lau's reasoning, this can be interpreted as he in the same manner as Joakim and Anne did above, seem to evaluate on the ground of his belief that use of birth-control pills is normal, whereby it is appropriate to advertise for them. Birth-control pills are also by Michael assessed as relatively harmless (App. F, Michael:121).

In interpreting why those more normal and everyday products are evaluated as more appropriate to advertise for, it might be useful to consider Allan's explanation as he in an supplementary interview is reminded of the differentiation in the focus group and asked which aspects he believes are important in differentiating between different types of prescription medicine,

> Allan: *"(…) if you are, have a depression, then you also think that it's normal to hear about depression medicine, so I think it's difficult to put a limit to what kind of medical preparations you cannot advertise for, because as soon as you are in a situation where you have that illness or suffers from some of those problems, then it will be completely natural for you to watch those advertisements and have probably also heard about the products and*

something like it before, so I think it's only for us who doesn't suffer from something like that, that we think it's a bit strange (…) because it's so distant for us." (App. K:15.54).

In the quote Allan suggests that those products that people know and are familiar with somehow seems less strange than those, which the informants are unfamiliar with. Thus Allan's statement could suggest some kind of what is normalised and familiar seems appropriate whereas unfamiliar items are distant, thus causing informants forming and more reserved attitude toward advertising of those types of products. Connected to the expression of Allan, the belief that birth-control pills and antihistamines are more appropriate to advertise for, might be linked to the informants' own experience with prescription medicine, as seen in paragraph 6, as many of the informants use of have used either of these two. In a similar way, US end-consumers Lily who herself uses antihistamines seem more positive toward DTCA of precisely this type of product (App. A, Lily:24-25). This could be connected to empirical findings about product involvement influencing people's attitudes toward DTCA in a positive direction (Limbu & Torres 2009:51/55/68/71-72/81; Desphande et al. 2005:508-512; Hausman 2003:231).

6.1.7.2. Lifestyle and other reasons

An aspect which was conspicuous in the evaluation of the appropriateness of different types of prescription medicinal products were the informants notions on lifestyle. Prescription medicine for diabetes and hypertension were sometimes compared (App. F, Anne:53; Naja:137) and both assessed to be inappropriate to advertise for due to of some informants' beliefs, that these illnesses are linked to bad lifestyle (App. F, Naja:132-133; Pernille:132-133; Carina:132-133; Cecilie:54-55; Katrine:45-46; Simon:201). The below quotes are examples of this,

Naja: *"(…) It's with a little reservation because diabetes, that is uhm.. conditional on lifestyle, as far as I have understood (...) Both yes and no"*
Pernille: "*...there's a type one and type two."*
Naja: *"(...) type two yes, that's right (…)"*
Carina: *"Yes, and type two that's the one which they call "old man's diabetes", that's the one you can eat your way to"* (App. F:132-133).

Cecilie: *"But I know that number two also implies lifestyle-changes, at elderly people who gets diabetes two."* (App. F:54-55).

Katrine: *"(…) hypertension is also like where you have to take a lot of other things into consideration before you start to think "**Now** I should have those pills, so that I can get rid of this hypertension". Well, you can do a lot yourself, like lifestyle-like."* (App. F:45-46).

In the above quotes, the informants emphasize the aspect of lifestyle in how they assess respectively diabetes and hypertension. In the first sequence Naja assesses diabetes on the

ground of her belief that it is conditional on lifestyle. Pernille corrects her belief by saying that there are two types of diabetes and differentiating between type one, and type two. Moreover, Carina expresses the belief that you can eat your way to diabetes. Independently of these informants, Cecilie expresses in another focus group interview, that having type two diabetes implies lifestyle changes. In relation to hypertension, Katrine expresses the belief that with hypertension you have to take other things than medicine into consideration, such as doing something yourself in relation to lifestyle. Hence, as argued by Fishbein & Ajzen, that these informants' attitudes toward DTCA for diabetes or hypertension, is anchored in a belief about these being related to lifestyle (Fishbein 1967:477; Ajzen & Fishbein 2000:1; Fishbein 1963:233; Feldman & Lynch 1988:421; Kardes 2001:116). These examples imply that lifestyle is one aspect, which some of the informants have in mind when assessing the appropriateness DTCA for some prescription medicine products. Katrine and Lau explain their attitudes in relation to hypertension in the following manner,

> **Katrine**: "*It can easily become an easy solution, just to take that medicine (…)"* (App. F:46).

In this regard, Katrine just simply states that she thinks medicine for hypertension can become an easy solution. Connected hereto Lau says that he thinks people with hypertension should go see a dietician instead (App. F, Lau:137). Furthermore Pernille, Lau and Lise explain their attitude in relation to diabetes in the following sequence and Sara independently,

> **Lau**: *"I also just fear that it would become a sop and give people uhm.. well, like starting to advertise (…) because then I think that they maybe slack a little on what they else should do."*
> **Lise**: *"Yes, I'll also say that there's a difference of which kind it is, because if you suffer from type one, then I think (…) you know a lot about it (…) if you suffer from type two, well, then it can probably be the easy solution"* (App. F:134).
>
> **Sara**: *"(…) I think it's wrong if you can go and see "Oh well I can take this medication for diabetes two"(…) I think it's a bit too easy if you can then yourself read about the medicine, that you can then quickly become affected to just take the medicine."* (App. F:195).

These informants argue, that it is not appropriate to advertise for prescription medicine for type two diabetes as they fear that this will become an easy solution for people to just take medicine instead of taking responsibility, take care of your health by e.g. seeing a dietician and live a healthy lifestyle. From these expressions it appears that the informants' predominantly negative attitudes toward advertising for prescription medicine for diabetes and hypertension is due to their beliefs that these illnesses to a large extent is due to an unhealthy lifestyle, and that advertising for these types of prescription medicine will provide persons with such illnesses an easy solution, so that they avoid doing the other things which is needed when hav-

ing such conditions. This fear, that DTCA will give people an easy way out, is also apparent at other points the focus group, as treated in paragraph 6.1.5.1. Of course not all informants hold this belief, where some try to nuance the picture, and explain that it is not always that simple (App. F, Line 201; Anne:56; Katrine:56-57: Cecilie:56-57).

In a similar way as with prescription medicine for diabetes and hypertension, with types of medicine treating impotence, sleeplessness and depression, a dominant argument for it not being appropriate to advertise for, was that medicine in many cases is not the best solution, that there are other reasons for the condition and therefore medicine should not be presented as the best solution. This notion is mentioned in relation to impotence by Pernille, Alex, Joakim (App. F, Pernille:129; Alex:190-191; Joakim:62), in relation to sleeplessness by Helle and Carina (App. F, Helle:52/53; Carina:142) and in relation to depression by Katrine and Pernille (App. F, Katrine:58; Pernille:126). Below are some examples of these notions,

> **Carina** [In relation to sleeplessness]: *"(…) I think also that sleeplessness is also often caused by, well lifestyle, well you live a busy everyday life, you're generally busy and the body can't relax, but there are many other ways to cure this, right, go for a run (…) get some fresh air, right (…) instead of taking such medication, I think at least."* (App. F:142).
>
> **Katrine** [In relation to antidepressants]: *"(…) There can be really many **other** solutions than just to take some pills, because those pills (…) they take away the symptoms, they do not take away the **reason** that you **get** it. So there you have to be careful just to take medicine"* (App. F:58).

In the above quote, Carina expresses that she thinks sleeplessness is often caused by lifestyle, where she believes that there are many other ways to cure it rather than just taking medicine. Connected hereto, Katrine says that she thinks that there can be other solutions than just taking pills for depression. In this way, these informants express beliefs about sleeplessness and depression as possibly having other causes, which they in a similar way believe sometimes should be solved by other means than just medication. Thus it could be interpreted that they might fear that DTCA for these conditions could encourage the use of medicine in cases where other things can be the solution, thus promote unnecessary use of prescription medicine. This notion is also mentioned by opponents of DTCA (Cunningham & Iyer 2005:412-413; Mintzes 2001:27). This concern is furthermore mentioned in relation to acne (App. F, Carina:140; Lau:140; Alex:196-197). Here the notions of Fishbein & Ajzen concerning attitudes being anchored in beliefs, might also be helpful in trying to understand these informants' attitudes.

In a previous study, it was found that consumers were particularly concerned with antidepressants prescription medicine, in part because they felt they could recognise themselves in the symptoms described in the DTCA for antidepressants, thus they could see themselves as de-

pressed (Hausman 2003:231). In a similar way, some informants evaluated antidepressants and also medicine for sleeplessness as inappropriate to advertise for, because they felt, that everybody sometimes can recognise the symptoms of depressions and everybody can sometimes have trouble sleeping, thus they believe that people can easier come to believe that they need prescription medicine, and thus DTCA could lead to overconsumption and can create an unnecessary need as mentioned by opponents of DTCA (Cunningham & Iyer 2005:412-413; Mintzes 2001:27). This notion is made in relation to antidepressants by Helle, Catja and (App. F, Helle:58; Catja:192; Anne:72) and in relation to prescription medicine for sleeplessness by Anne, Mie and Alex (App. F, Anne:52; Mie:202; Alex:51). The quotes below are examples of these notions,

> **Helle** [In relation to antidepressants]: *"(…) it's some of that, where you can easily get convinced, again. I think. You could quickly be convinced that you was depressed, because if you have a bad day, or something"* (App. F:58).
>
> **Catja** [In relation to antidepressants]: "*Well I think, that you can create an unnecessary need by (…) advertising, because if you're a little sad or something, then you should take these pills for depression"* (App. F:192).
>
> **Anne** [In relation to medicine for sleeplessness]: "(…) *One of them is (…) a* ***rather common*** *symptom, most probably have, someday when you can't sleep or where you wake up in the middle of the night and you don't know why you suddenly are fresh at four o'clock or. Well, it's a rather normal thing (…)"* (App. F:52).
>
> Mie [In relation to medicine for sleeplessness]: *"I've placed it rather far down towards "totally disagree" because, I'm afraid that many would feel that they had a problem like it, which they didn't. Because sleeplessness can be something physical or something like that, but I can easily imagine "Well I can't really sleep at night and.. isn't there something about that you can get a pill" or something like that. That's probably what I fear the most."* (App. F:202).

In the quotes above Helle and Catja express a concern for that advertising of antidepressants can easily convince people to believe that they are depressed, if they are sad or have a bad day and that they therefore need antidepressants. Hence, the notions of Fishbein & Ajzen in relation to attitudes being anchored in beliefs, can again be included (Fishbein 1967:477; Ajzen & Fishbein 2000:1; Fishbein 1963:233). Furthermore Anne and Mie express in the above a concern that everyone can have trouble sleeping which is a rather common symptom. Therefore it is feared that people can easily be convinced that they need medicine for sleeplessness. It is furthermore feared that this will lead to unnecessary use of this type of prescription medicine. This aspect is also mentioned by two informants in relation to prescription medicine for impotence (App. F, Line:90; Mie:90). Thus for some informants their attitudes toward DTCA of certain types of products are affected by whether people would easily recognise presented

symptoms, and thus believe that they needed medicine. Furthermore this seemed to be related to a fear that this will create a need for certain medicinal products, which can be connected to some of the informants' notions about DTCA possibly leading to hypochondria as seen in paragraph 6.1.4.1.

6.1.8. Sum Up

On the basis of the constructed knowledge, when constructing their attitudes toward DTCA, the informants seem to collectively as well as independently consider a variety of aspects. Hereby the attitude formation process could be said to be complex, which also means that some of the informants' attitudes are of great complexity. An overview over the aspects, which the informants seem to take into consideration when constructing their attitudes, as explored in paragraph XX, can be seen below,

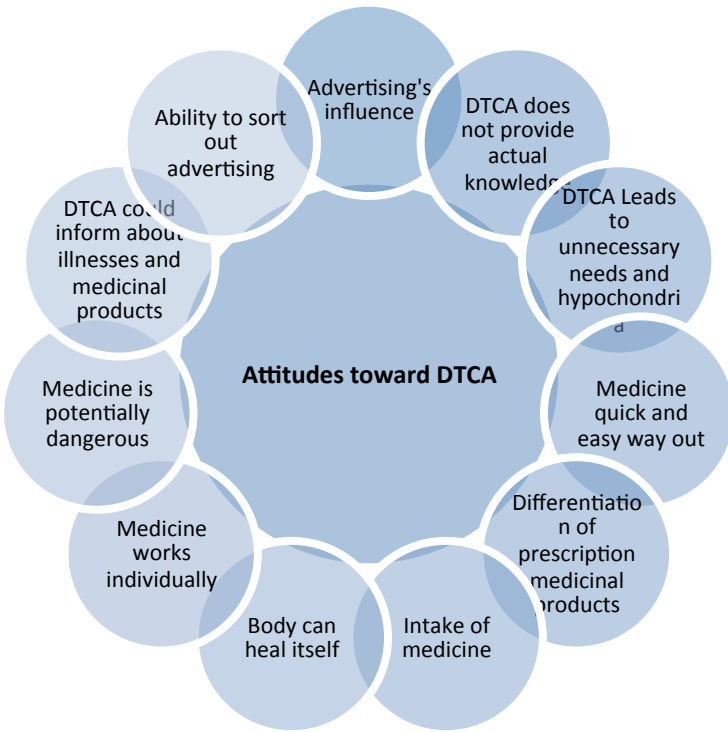


Figure 14: Overview over informants' attitudes toward DTCA and underlying constructions (Own construction)

Hence, these are the aspects, which from the interpretation of our constructed knowledge seem to be the one's influencing the informants' attitudes toward DTCA. These aspects should not be understood as separate aspects, as they also seem to affect each other crosswise with

differing degrees. As mentioned, the amount of aspects individually considered by the informants varies, in the sense that not all of these aspects are mentioned by all of the informants, but rather one or several aspects. Thus, which aspects the individual informants consider differs, also in relation to how much they emphasize them. Moreover, these aspects also seem to differ in the sense that, these might be connected to experiences, beliefs and pre-existing attitudes for the individual informant, functioning as anchor-points for constructing their attitude toward DTCA. Here we e.g. saw that Jette mentions that she has not had any bad experiences with her GP, that Helle believes that DTCA would lead to hypochondria and that Cecilie has a pre-existing attitude toward medicine, as being something she would rather avoid.

As seen in the above paragraphs, most of the informants' attitudes toward DTCA are of a negative *direction.* However, informants with similar attitudes toward DTCA also differ in which aspects they emphasize, e.g. Helle and Lau who both have negative attitudes toward DTCA, anchors these in different aspects, as Helle emphasizes that it would lead to hypochondria, where Lau anchors it more in his negative attitude toward the *institution* of advertising. Additionally, adding to the complexity of the informants' constructions of attitudes, the inclusion of similar aspects, will not necessarily result in the same *direction* of attitude. As an example both Mike and Catja consider the possible advantage of DTCA in terms of informing people about medicinal products and alternatives, even though Mike seems to be very positive toward DTCA, where Catja's attitude has a more negative *direction*. In this way, this could again be connected to, which aspects the individual informants weigh as important. Yet, to interpret the informants' attitudes toward DTCA precisely and clearly in terms of *extremity* seem difficult. Nonetheless, as it was seen, some informants seem *extreme* in their attitudes where others appear to be of more *moderate extremity*. Hence, a tendency toward a negative attitude can be interpreted on the basis of the analysis above of our informants' attitudes toward DTCA, where it has been tried to reach an insight into some of the aspects underlying the informants' constructions of attitudes in trying to understand these.

6.2. The Proposal

The societal development of increasing access to great quantities of information has given the consumers the opportunity to obtain more information (Hamilton 2005:35/77/87; Pulizzi & Barrett 2009:xvii), which also includes information on health and illnesses (Galarce et al. 2011:167; Sundar et al. 2011:181). Obtaining health knowledge could thus imply active engagement in health seeking behaviour (Galarce 2011:167). In other words, a lot of information exists on health and illnesses, and therefore we wish to have at look at what the informants think about the information coming directly from the pharmaceutical companies if the proposal is enacted. However, before addressing the informants' attitudes toward the proposal, we will have a look at the informants' use of this availability of information online.

6.2.1. Information Searching – Illnesses and Medicine

This following paragraph concerns the informants' perceptions and use of online information searching about medicine and illnesses. The use of online resources for obtaining information about illness and medicine were indicated in paragraph 1, and thus it could be relevant to understand if online resources are used to obtain information about medicine and illnesses by the informants, as the lack of use of online resources for this purpose could make the proposal irrelevant for the informants and cause indifference.

More than half of the informants mention that they are engaged in information searching also in relation to illness (App. F, Helle:6-7; Cecilie:7; Allan:7; Katrine:7-8; Jette:8; Joakim:35-36; Michael:84; Pernille:84; Carina:85; Alex:161/163; Line:168-169; Catja:163). However, three informants mention that they do not search on information concerning this issue (App. F, Mike:162; Naja:95; Lise:106; App. K, Lise:10.34). As mentioned in paragraph 6.1.1. most of the informants are only concerned with illness unless they are ill or becoming ill. This can also be connected to the information searching on illness and medicine, as this appears to take place when the informants feel ill (App. F, Helle:6-7; Cecilie:7; Allan:7; Katrine:7-8; Jette:8; Joakim:35-36; Michael:84; Pernille:84; Carina:85; Alex:161/163; Line:168-169; Catja:163). These findings can be connected to the notion of involvement, as these informants might incline toward high involvement in a situation when being ill, as illness can have personal consequences, consequently being personally relevant (Petty & Wegener 1999:45; Petty et al. 1981:107). Hence these informants seem to be motivated to engage in a form of information processing (Burnkrant & Sawyer 1983:46/48) by e.g. going online to look up medicine or symptoms related to the presumed illness (App. F, Helle:7; Cecilie:7; Katrine:7; Catja:163). Pernille and Carina also express that they search for information online to find alternatives to prescription medicines, which can be connected to their attitudes toward prescription medicine in general (App. F, Pernille:84; Carina:85) as seen in paragraph 6.1.5.2. Thus the level of involvement seems to be in direction of the higher end of the continuum, and as a result it is assumed that these informants are more likely to use the *central route* of elaboration, when being ill. The concept of *personal relevance* is further highlighted by the opposite situation mentioned by Lise saying that she does not have a relation to illness and searching for information on this topic, as she has not been ill that often (App. F, Lise:89), as seen in paragraph 6.1.1. These interpretations correspond with what is found by White et al. that the people, who feel healthy, have little interest in information related to illness and medicine (White et al. 2004:65). This tendency is similar to the findings of Perri & Dickinson, which show that if people are not personally involved in a condition they are not likely to pay attention to it (Perri & Dickson 1988:69). Thus it seems that *personal relevance* in the form of being ill or having a health condition is an important factor when searching of information on the topic. Even though illnesses do not seem to be of general interest among the informants, information

searching when being ill appears to take place, which could mean that if the proposal is enacted, the information on prescription medicine from the pharmaceutical companies could also be a part of the obtained information.

In searching for information online some informants also seem to be preoccupied with the source providing the information e.g. Sara, Alex, and Simon say,

> **Sara**: *"(…) I look a lot on the National Board of Health and such… I assume that it's a bit more correct (…) well, that you probably will do automatically, when you attend university, then just checking, who is it really, who is saying that, something like that maybe seem more source-reliable than something else… definitely."* (App. F:162-163).
>
> **Alex**: *"Yes.. yes.. in that way trying to respond critical to what I now have found."*
> **Simon**: *"Well I also think, that it's.. now the National Board of Health and Denmark's Radio[19], which is public service, it's not commercial institutions, which should make a profit on selling (…)"* (App. F:164).

These informants seem to have a critical approach in searching for information in regard to the source. As seen Alex expresses that he looks at the information source with a critical stance. Additionally, Sara also appears to have this response to information, which she links to her role as a university student. Hence, from Sara's statement it could seem that the presumed influence of the university as a socialization agent could have an influence on the informants, in this case increasing the likelihood of approaching the information in a critical manner. Linked hereto Cecilie also mentions that she is source critical, when searching for information (App. F, Cecilie:5). In the quote Sara specifically mentions the *National Board of Health*, which Simon also does along with *Denmark's Radio*, which they seem to believe, are reliable sources. Linked hereto Line, Mie, and Alex also point to official boards, as they believe that some control exists as to what these institutions present, thus increasing the reliability (App. F, Line:163; Mie:163; Alex:163). In connection hereto Katrine also mentions *OBS*, which is a part of *Denmark's Radio's* programs, as a reliable source, which she wishes for in sources of health information (App. F, Katrine:33). These statements appear to contain a similar thought process of what was found in studies of Bell et al. and Singh & Smith, as beliefs about regulatory control seem to affect individuals' assessment (Bell et al. 1999:654-655; Singh & Smith 2005:373), which in this case is the *credibility* of these abovementioned institutions. Hence it seems that these informants focus on the *credibility* of the source of the information they obtain, which could be connected to their beliefs about these sources' ability to present correct information. Additionally, Helle also expresses that she finds the webpage *Netdoktor* credible, which is also used by Carina as the information is written by GPs, but also infor-

[19] In Danish "*Danmarks Radio*".

mation about other people's experiences can be obtained (App. F, Helle:7; Carina:95). This could indicate that these informants do not only find experts credible, but also values others' experiences, which is also acknowledged by Joakim (App. F, Joakim:35-36). Hence this could indicate a use of a combination of interpersonal sources and the mass media source of the Internet (Gerson 1966:48; Ward & Wackman 1971:418; Moschis 1985:902/907; Dahl 2006:268-270), as the media channel of the Internet is used to obtain information from GPs and forums.

Returning to the notion of *credibility*, another aspect, which is also mentioned in the above quote by Simon, is information coming from sources with commercial interests. He explains that he does not find this information credible and will stay away from it, if the objective behind the information presented is to make a profit, which Katrine agrees with (App. F, Simon:164; Katrine:33). These expressions of focusing on *credibility* of the source, despite not being expressed by all informants, and the lack hereof connected to commercial sources as stated by Simon and Katrine could be influential in understanding the informants' attitudes toward the proposal as these beliefs could be an underlying construction influencing this attitude, as argued by Fishbein & Ajzen (Fishbein & Ajzen 1975:223; Fishbein 1967:477; Ajzen & Fishbein 2000:1/12-13; Fishbein 1963:233).

Hereby it has been found that more than half of the informants use the Internet to search for information on illness indicating that these informants might be likely to come across the information on prescription medicine from the pharmaceutical companies if the proposal is enacted, which could make this issue relevant for these informants. Furthermore insights into these informants' view of *credibility* of sources when searching for information could also play a role in the informants' attitudes toward the proposal and the constructions underlying this, which is the focus of the following paragraphs.

6.2.2. Attitude toward the proposal

In the process of aiming at getting insights into the informants' attitudes toward the proposal, several aspects seem to affect this construction as these are emphasized by the informants, thus their beliefs and attitudes toward related attitude objects appear to be influential trying to obtain an understanding of the attitudes toward the proposal. In the following paragraphs the relevant aspects will be touched upon and related to part of the problem formulation concerning the proposal.

6.2.2.1. Objective Information?

As mentioned in paragraph 2.1.1.2. *The Consumer Counsil*, *Denmark's Apothecary*, and *Danish Patients* are in relation to the suggested proposal concerned about and doubt the possibility of the pharmaceutical industry to deliver objective and unbiased information about their pre-

scription medicine (Toustrup 2008:8-10; Huset Markedsføring 2009; Danske Patienter 2009:2). Linked hereto we also addressed this question by arguing that this information could be marketing if employing a wide understanding of the concept, as this information concerning prescription medicine will create some form of relation with the end-consumers, however thereby not claiming that the information cannot be objective. Thus the sceptics have given their point of view on the matter. Nonetheless, as we are interested in the informants as end-consumers' point of view, it is interesting to find out what they think about this issue in trying to understand their attitude toward the proposal.

When going through the constructed knowledge of the different interviews one of the emphasized issues is the aspect of the pharmaceutical industry's ability to deliver objective information. Michael indicates the supposed problem in the following way,

> **Michael**: *"That was just what I was about to say, of course it can also be a problem now, when people, it seems, people go a lot online to search, then they suddenly come across some information, which they think is objective and then it's from the manufacturer (Naja: Mmm) (...). That's in principle also hidden advertising."* (App. F:107).

In the quote Michael pinpoints that it could be a problem that people searching online could come across information, which they think is objective, when the source of the information, is the company behind the product. Naja appears to acknowledge and agree with Michael's claims though without elaborating on it. Additionally, Michael also indirectly addresses our point from the beginning of the paragraph 6.2.1. i.e. that it could be a problem exactly due to the informants actually using the Internet to obtain information. If this was not the case then it would probably not be necessary to care about. This could be linked to the notion of personal consequences as Michael himself search for information on illness (App. F, Michael:84), which is a part to the concept of involvement, as the proposal appears to become important to consider when it can have personal consequences (Petty et al. 1983:136; Petty & Cacioppo 1979:1916; Petty & Cacioppo 1981:107; Mittal 1989:148; Mitchell 1979:194; Day 1970:80; Zaichkowsky 1985:342-343; Celsi & Olson 1988:211; Grunig 1989:5). Returning to pinpointing this exact aspect of the proposal could be connected to the *Accessibility-Diagnosticity Model* of Feldman & Lynch, which focus on the *accessibility* and *relevance (diagnosticity)* of the inputs in the formation of attitudes toward an object (Feldman & Lynch 1988:421; Kardes 2001:116), which in this case is the proposal. In relation to the accessibility of the inputs, the presentation of the different aspects of the proposal is of the same *recency*, as the informants were all told about these at the same *time*, thus accessibility might not be of substantial influence in the formation of this attitude. Instead it seems that, in what Michael knows about this proposal, the beliefs about objectivity have high perceived relevance in relation to other presented issues at the same time (Kardes 2001:116; Feldman & Lynch 1988:424-426; Bargh 1984:22), as

Michael mentions this first and several times (App. F, Michael:106-107/116/153-154). From the quote it seems that Michael does not believe that the information from the pharmaceutical companies can be objective, as he terms the information *"hidden advertising".* Hence the direction of his attitude toward the proposal in regard to this aspect seems to be negative as he states that it can be a problem. Thus Michael's attitude could be anchored in his beliefs, as argued by Fishbein & Ajzen (Fishbein & Ajzen 1975:223; Fishbein 1967:477; Ajzen & Fishbein 2000:1/12-13; Fishbein 1963:233) about the ability of the pharmaceutical companies to present objective information, which he does not appear to think is possible. However, this focus on objectivity, which Michael connects to advertising, might be an example of the joint construction of knowledge due to the interaction between us as researchers and the informants, which is a epistemological consequence (Kvale 1997:45-46; Guba 1990:27; Hirschman 1986:238; Bo 2002:70) as advertising had been brought up and discussed prior in the focus group (App. F, Interviewer:96). Consequently it might be that the notion of accessibility of input should not be completely disregarded as this subject has just been discussed, which could make Michael's pre-existing beliefs and attitudes toward this subject more accessible (Feldman & Lynch 1988:421/426/428; Kardes 2001:116; Reyes et al. 1980:11; Wyer & Srull 1986:340/345/352).

Michael and Naja are not the only informants, who question if the pharmaceutical companies can create objective information,

> **Joakim**: *"Then it's almost the same as advertising, that is."*
> **Katrine**: *"Yes."*
> **Interviewers: *(…)***
> **Joakim**: *"But if it's something you suffer from, then you only think about, or "What of these fits with my symptoms, of the things they mention here"."*
> Interviewer: *"So you think the information can turn into, it can be a way of advertising?"*
> **Joakim**: *"Undoubtedly."*
> **Interviewer**: *"Yes."*
> **Katrine**: *"Mmm."* (App. F:73).

> **Helle**: *"(…) I think that it should be information, you can say like objective, I don't know if you can say that, but not from a certain company. I don't like this that it's a company, because you know, what they have in mind, and that is, that you should buy their product.* (App. F:72).

> **Pernille**: *"Well, I maybe also question, if it's objective, that is, if it's possible? Uhm.. it's because (…) I actually think that the pharmaceutical industry has big and strong interests in society (…) then I don't think they can avoid affecting in some particular direction."* (App. K:01.30). *"(…) if it's the **only** place you can find information about the product, the I*

think it's precarious, that is, if there isn't someone, who's really, you can consider to be objective." (App. K:02.25).

Allan: *"Yes, I don't know if they can do it objectively, as they would like to sell their things, so…"* (App. K:02.09).

From the above quotes it becomes clear that each of these informants question the possibility of the pharmaceutical companies to present information objectively. In this regard, Allan and Helle mention that companies are interested in selling their products. Pernille says that this industry has strong interest, where Joakim and Katrine in line with Michael and Naja who directly compare the information with advertising in the previous quote. Thus these accounts all seem to be similar to the sceptics' worries about the EU-proposal. These informants' apprehension as to the pharmaceutical companies' ability to present objective information can be connected to the informants' beliefs about the *credibility* of sources of information concerning medicine and illnesses as seen in paragraph 6.2.1., since the source behind the information is commercial and thus has an objective. This could mean that the information might be biased influencing their *credibility*. Hence this thought about *credibility* could be helpful in understanding this lack of belief of the pharmaceutical companies' ability to present objective information. Thus as also indicated by the result in Sundar et al. showing that sites, which are sponsored by the company behind the product, are the least credible (Sundar et al. 2011:195) the informants might not find the pharmaceutical companies credible as a provider of objective information about their own products.

Despite these similarities of scepticism, there seems to be differences as to the *extremity* of these attitudes and beliefs, as Joakim, Helle, and Pernille seem clear as to their beliefs about this aspect. On the other hand Allan seems a bit hesitant and perhaps also doubting, as he straight after the above quote says that exactly this industry might be able to present information objectively since they know that they have responsibility for their marketing due to the product they sell. Allan uses a current case of Lundbeck (Skovmand 2011; Ullerup 2011; Lambek & Simonsen 2011), which he mentions have stopped selling their medicine for executions in the US, as an example of the conscience of the industry (App. K, Allan:02.11). It seems that Allan is affected by the portrayal of the Lundbeck in the mass media, which as suggested by authors can be a socialization agent (Bandura 1986:20; Thornton & Nardi 1975:874; Lee et al. 2007:109/112; Gerson 1966:41/44/49-50; Bush et al. 1999:19-22; Ward & Wackman 1971:424-425; Backer et al. 1992:170-172). Consequently, Allan uses this information as a part of his beliefs about the pharmaceutical industry, which influences the assessment of the possibility of objectivity, as the industry might not only be interested in selling their products. However, later in the supplementary interview Allan states that he thinks some objective will always be present in both advertising and information (Appendix d, Allan:03.57). Thus Allan

seems to have doubts as to the *direction* of his attitude in this regard. Opposite of the above-quoted informants Lise thinks that the pharmaceutical industry is able to create objective information (App. K, Lise:04.25/04.40). In order for this information to be objective, she compares its form to that of the patient information leaflet, which she believes is fairly neutral and objective as it presents concrete information about the active ingredient, side-effects and when not to take the medicine. Thus she thinks it can be done if it is straight ahead information i.e. facts (App. K, Lise:03.50/04.06/04.40). Both Helle and Allan support this construction of objective information, as a, in the words of Schutz, *typification* (Overgaard & Zahavi 2009:102-103: Schutz 1970:116-117) that is understood as being founded in facts as mentioned by Helle, and Allan refers to concrete information as well as sticking to the truth (App. K, Helle:07.40; Allan:02.51). However, despite Helle's agreement to the *typification* of objective information, she still points out, that she believes that the information from the pharmaceutical companies will be somewhat selling (App. K, Helle:07.40). In relation hereto Pernille includes in her *typification* that objective information should come from some type of board e.g. the *Danish Medicines Agency* (App. K, Pernille:02.38), which might be linked to a notion of credible sources as seen in paragraph 6.2.1. Furthermore, Lise and Allan also describe objective information by stating what it is not i.e. according to Lise the pharmaceutical companies should not try to convince people that they should take this medicine, and Allan says that it is not something, which is selling and alluring such as claiming to give you a better life (App. K, Lise:03.43; Allan:03.09). Thus it appears that Lise and Allan are making use of a *typification* of advertising, as seen in paragraph 6.1.2., in order to reach a clarification and *typification* of objective knowledge. This differentiation from advertising returns us to Joakim's belief about the information from the pharmaceutical companies being advertising, which he is very clear about in comparison with Allan. Consequently, he makes the construction of viewing this type of information as a form of advertising.

6.2.2.1.1. Advertising or Information

As mentioned, Michael's immediate and most pervasive focus in regard to the proposal is the point of view that the information from the pharmaceutical companies is not objective, but rather he regards it as hidden advertising, which according to Michael can be problematic if the end-consumer thinks that it is objective. Michael further elaborate on his perspective by saying,

> **Michael**: *"I almost think that advertising is better because it gets set up as if, well, it gets done in a way, where you can more easily sort out whether it's reasonable or not, where if it's information, then you, then you could be in doubt, if you read it somewhere, where it gets presented as facts."*
> **Pernille**: *"Yes, as you said with advertising, that you can bloody well tell what is."*
> **Michael**: "Yes, exactly."

Pernille: *"… and just sort out, right."*
Michael: *"I'll almost rather have advertising for prescription medicine than just information"*
Interviewer: *"Is it because you think you can, well…"*
Michael: *"Well, then I think it's easier to sort out, that is, then you* ***know*** it's an advertisement, and then it's something they write because they would like to sell it"
Carina: *"Then you know it, then you know it's a bunch of trash, you don't need to relate to (Michael: Yes) (Pernille: Mmm, yes), whereas if it's information, then you think, that this can be important (Michael: Yes), you have to pay attention. (Pernille: Yes)"*
Michael: *"Yes, exactly."* (App. F:116).

In the above quote Michael emphasizes that he would almost rather have advertising for prescription medicine than information, as he could better sort it out, because he knows it is an advertisement, whereas you could be in doubt about whether it is advertising, when it is presented as information. Later on Michael elaborates that he would prefer advertising over information as it is easier to see through (App. F, Michael:153-154). In interpreting Michael's perspective it is as if he, in the term of Schutz, makes use of *typifications*, thus preferring advertising over information from the pharmaceutical companies could be based in his knowledge of this "type", which Pernille also underpins in the quote. Linked hereto Michael's attitude could furthermore be viewed as a way of structuring and organizing his surrounding world, which is part of an *object appraisal function* (Smith et al. 1956:41), *instrumental, adjustment or utilitarian function* (Katz 1960: 170) or so-called *knowledge function* (Argyriou & Melewar 2011:3; Katz 1960:170/173; Triandis 1971:5). Hence, the attitude of preferring the advertising type could be a part of structuring his construction of reality, as advertising is a familiar component in his context. Consequently, Michael seems to view it as problematic when the information is presented as objective and is not, then he would prefer advertising as people can see through it and then sort it out (App. F, Michael:106/153-154). Thus Michael's attitude toward the proposal has a negative *direction* (Kardes 2001:85; Katz & Stotland 1959:428; Petty et al. 1997:611; Ajzen & Fishbein 2000:3). Additionally, in the preference for advertising Michael also points to the GP as a form of guardian as the GP is necessary for obtaining a prescription, as touched upon in paragraph 6.1.6. Sara has a somewhat similar view on the proposal as Michael, as she thinks it would be worse and confuse the end-consumers if the information contains a selling element. Consequently according to Sara it is preferable that people know that it is advertising (App. F, Sara:184). Hence, Sara seems to think that it is important for the end-consumers to know, if the message portrayed can be trusted. Consequently, the aspect of not being certain of whether the information can be trusted consequently preferring advertising as a known type could be a part of the construction of the attitude toward the proposal if focusing on Michael's and Sara's opinions.

However, other informants do not appear to agree with the preference for advertising. Despite interacting with Michael in the focus group in the elaboration of his statements, as seen in the above quote, both Pernille and Carina seem to disagree as they both think that even though people can recognize advertising, it will still affect them (App. K, Pernille:04.04; App. F, Carina:154). Specifically, Carina refers to individuals being convinced that they are ill and need medicine (App. F, Carina:154) thus focusing on the presumed negative consequences also mentioned by sceptics of DTCA (Cunningham & Iyer 2005:412-413). Additionally, Helle recognizes the point of Michael and Sara, but disagrees as she does not think everything should be changed into advertising, just because it is easier to relate to (App. K, Helle:06.50). If Lise should choose she would prefer information, as she thinks it is possible for the pharmaceutical companies to present objective information as mentioned earlier (App. K, Lise:05.42), thus the variation in preference between Lise and Michael and Sara seem to be based in the belief about the objectivity.

However, in relation to the problem formulation, the informants' beliefs as to whether or not it is possible for the pharmaceutical to present objective information about their products do not necessarily need to have influence on the informants' overall attitudes toward the proposal, as seen with Michael. As proposed by Fishbein & Ajzen, the informants base their attitudes on the many beliefs they have about the attitude object and its attributes (Fishbein 1967:479-480; Ajzen & Fishbein 2000:1/12-13; Fishbein 1963:233) and the informants might value these attributes differently (Fishbein & Ajzen 1975:228) and consequently might emphasize different attributes in their construction of the attitude toward the proposal. Linked to the thoughts of Feldman & Lynch and Cohen & Reed, the informants might also anchor their attitudes toward the proposal in pre-existing attitudes toward related attitude objects (Feldman & Lynch 1988:421; Kardes 2001:116; Lynch 2006:25). Thus continually we will return to the question of objectivity of the information and how it is emphasized in relation to other aspects in trying to understand the informants' attitudes toward the proposal.

6.2.2.2. The Cons

Despite posing just above that the belief about the objectivity of the information might not be related to the attitude, Joakim's *typification* of the information from the pharmaceutical companies as advertising seems to be related to his attitude toward the proposal. When directly comparing the proposal to advertising, he also seems to emphasize negative consequences of advertising as seen in paragraph 6.2.2.1., which could then also be a consequence of the proposal from his point of view. Joakim indicates that if people feel they have symptoms then they try to locate the medicine that fits these symptoms (App. F, Joakim:73), thus referring to the presumed consequence of this proposal of unnecessary use and over-consumption of medicine (App. K, Joakim). These consequences of the proposal as well as for DTCA is also pinpointed by the sceptics (Toustrup 2008:8-10; Huset Markedsføring 2009; Andersen

2010b:4-5; Cunningham & Iyer 2005:412) as seen in paragraph 1 and 2.1.1.2. Other informants in the assessment of the Proposal also mention the negative consequences proposed by the sceptics,

> **Lise**: *"(…) at least them, who maybe (…) think they are ill, then they go, as mentioned many do here, uhm.. uhm online and search on all kind of different things, and now they are becoming available, and then they can seek on all these different medicinal products and say: "Well, I think, I should try this, because it sounds as if it can save or cure, what I have"."* (App. F:107).
>
> **Naja**: *"I think a bit about what Lise said, that you can make yourself believe something about it, you get informed about, if it's prescription medicine uhm then you suddenly have some kind of suffering, what it's called, when you think about yourself in that way."*
> **Lise and Carina**: *"Hypochondriac."*
> **Naja**: *"Yes, hypochondriac, exactly, yes."* (App. F:114).
>
> **Alex**: *"(…) it, as it was said fantastically, becomes such a hypochondriac catalyst. Again, it concerns this that you read about this product, "Well, this is exactly what I need. I just need the doctor's accept of, that this is what I need"."* (App. F:184-185).

Thus Naja says that the information suggested by proposal could make people believe that something is wrong, creating hypochondriacs, which could be affected by the interaction in the focus group as she refers to Lise's prior statement (Krueger 1988:23). Additionally, Lise and Alex also recognize that the information could further tendencies for hypochondria and additionally create a demand for medicine, as these people would like to try the product they have come across. Moreover, Alex also point to the risk of overconsumption, as it seems from the quote that people want the GPs' accept of their wish for a certain medicine. Another consequence, which Lau points out, is that this information could put the GP under pressure, as people might on the basis of the information obtained demand this medicine from their GP (App. F, Lau:108). This is another supposed consequence of the proposal, which has also been stated in relation to DTCA of prescription medicine and linked to the websites concerning illnesses produced by the pharmaceutical companies (Cunningham & Iyer 2005:413; Hollon 1999:382-384; Kravitz et al. 2005:1999; Mintzes et al. 2002:279; Andersen 2010c:4). In regard to the presumed disadvantage of pressuring the GP to prescribe certain medicines, the Danish interviewed GPs appear to differ in their view of this presumed effect. Jannik has a hard time imagining that people would actually ask for a certain prescription medicine (App. C, Jannik:22). Bente thinks it could lead to questions from the patients about the usability of the product for their condition and Jan says that it may give rise to pressure, but he thinks that GPs can resist this pressure (App. C, Bente:48; Jan:73).

From the above it seems that some informants recognize and agree with the arguments posed by the opponents, and thus these arguments seem to be relevant in the eyes of some of the informants. From the knowledge constructed in the focus groups it seems that Naja's attitude toward the proposal could be somewhat negative as the aspects she touches upon in relation to the proposal is the creation of hypochondria, which could be problematic. Hence, as suggested by Fishbein & Ajzen the beliefs about these attributes (Fishbein & Ajzen 1975:223), that is the presumed disadvantages, could be a part of the construction of the attitudes toward the proposal by some of the informants. Moreover the possibility of hypochondria could also be an aspect of the proposal, which could affect the attitude *direction* toward the proposal of Lise and Alex together with the view of the role of the GP, which we will return to later on in paragraph 6.2.2.6. However, Lau's belief about the risk of pressure on the GP does not seem to be of most relevance in determining the *direction* of the attitude toward the proposal, when Lau's beliefs are combined to form the attitude as proposed by Fishbein & Ajzen in their *Expectancy-Value Model* (Fishbein & Ajzen 1975:223), which will also be returned to in paragraph 6.2.2.6.

6.2.2.3. Channels

As indicated earlier, the belief about the pharmaceutical industry's ability to present objective information about prescription medicine is not necessarily connected to the informants' attitudes toward the proposal. In this regard Helle is an example, as she, as mentioned, believes that the information will be somewhat selling, but still has a positive attitude toward the proposal, which is connected to the use of the Internet as a channel through which the information is presented. Hence, like proposed by authors the media channel, i.e. *instrument* (Muehling 1987/36/39) seems to have an impact on the formation of attitude (Friman 2010:13; James & Kover 1992:81; Metha & Purvis 1995:5; Metha 2000:67/71; Mittal 2004:40), which in this case is the attitude toward the proposal. From the following quote it becomes evident that the instrument used to pass the information is an important aspect in assessing the proposal for Helle,

> *"(…) I think… actually it's okay, if it's just online (…) I think at any rate, it was a problem, if they did it through brochures, because then it would again come across like advertising and that I absolutely don't think medicine should be. I'm also against some of these, what's it called, non-prescription medicine that this is advertised for, so I'm at any rate against advertising for prescription medicine. Uhm.. then I think, that the Internet is a good way to* ***inform****, so it does not become advertising (…) I think it's information, (…) if it's not some banner ad or something like that (…) if it's not a banner ad, which pops up or something like that, but if you have to search on the pharmaceutical company or where the heck they place it (…), then I actually think it works as information, and then I think it's alright."* (App. K:02.03).

As seen the in quote Helle emphasizes the media channel, as an influential aspect for her attitude toward the proposal, which has a positive *direction* (Kardes 2001:85; Katz & Stotland 1959:428; Petty et al. 1997:611; Ajzen & Fishbein 2000:3). She prefers the Internet as other media channels to a higher degree resemble advertising, which she is against when it concerns medicine (App. K, Helle:10.20) as seen in paragraph 6.1.4. Thus as this information does not pop up in the face of the end-consumer Helle does not see it as that it is advertising (App. K, Helle:02.03/05.35). In connection hereto, despite her prior mentioned belief that the information presented by the pharmaceutical companies cannot be completely objective Helle's attitude is still positive toward the proposal, thus other aspects could be more important among others the media channel used. Regardless of having been told a range of different aspects of the proposal she immediately focuses on the *instrument* of the Internet (App. K, Helle:01.56). Hence, the prominence of this aspect could be related to Feldman & Lynch's notion about *perceived relevance* as from what is known about the attitude object, Helle might perceive her beliefs about the use of the Internet as a media channel, as having high relevance in the assessment of the proposal (Kardes 2001:116; Feldman & Lynch 1988:424-426; Bargh 1984:22). This could also be linked to the argument of Fishbein & Ajzen that the attributes which a person values as important is assessed more positively (Fishbein & Ajzen 1975:228). Thus the attribute of portraying the information online, as suggested by the proposal, could be of personal value to Helle and thus being evaluated positively. This interpretation is underpinned by her statements about personal experiences about having an illness, which is difficult to obtain information about and her negative experiences with doctors (App. K, Helle:03.49/09.06; App. F, Helle:8, App. G, Helle). These aspects will be further elaborated on in paragraph 6.2.2.4. and 6.2.2.6. Thus Helle's attitude toward the proposal could be based in her personal experiences, which is by several authors claimed to have a great effect on one's attitude (Allport 1935:810/819; Argyriou & Melewar 2011:6; Fazio et al. 1978:49/51; Reed et al. 2002:386; Schiffman & Kanuk 2004:267; Bagozzi et al. 1991; McGuire 1985:240), and in this way her personal experience related to the aspect of the proposal focusing on the media channel of the Internet may overrule the other aspects (Argyriou & Melewar 2011:6; Fazio et al. 1978:49/51; Reed et al. 2002:386; Schiffman & Kanuk 2004:267; Bagozzi et al. 1991; Fazio & Zanna 1981:195) e.g. her belief that the information cannot be completely objective. Consequently, Helle's attitude seems to be more firmly anchored in her attitude toward the Internet as an *instrument* due to personal experiences than the possibility of objectivity. Her positive attitude is furthermore underpinned by expressing that she would use this information if the proposal was enacted (App. K, Helle:08.33), thus her attitude might also consist of the *conative component* of the *Tricomponent Model* (Rosenberg & Hovland 1960:1-3; Schiffman & Kanuk 2004:256; Ajzen 2005:20). However, despite this positivity about the proposal interpreted from the supplementary interview, Helle's attitude toward the proposal seemed a bit more negative in the focus group interview as she states,

> *"(…) I think it's fine the way it's now. I **don't** think, that it should be changed, I don't like any of these ways, they can advertise for it."* (App. F:74).

From this quote it seems as if Helle to a higher degree emphasizes that the information could be advertising, which is also underpinned by questioning the pharmaceutical companies' ability to provide objective information (App. F, Helle:72). She furthermore elaborates by saying that she does not like the information from the pharmaceutical companies to directly aimed at her (App. F, Helle:74). Thus in the focus group interview Helle seems to consider the information as a form of advertising due to the lack of objectivity, whereas in the supplementary interview her emphasis is on the aspect of the media channel, which gives her attitude a positive direction despite still agreeing to the lack of objectivity. As pointed out in relation to Michael's focus on objectivity and advertising, Helle's focus on these aspects in relation to the proposal might be connected to the accessibility of input as proposed by Feldman & Lynch, due to the recent discussion about advertising in the focus group (Feldman & Lynch 1988:421/426/428; Kardes 2001:116; Reyes et al. 1980:11; Wyer & Srull 1986:340/345/352). Thus is becomes evident that different aspects can have different emphasis on different occasions, making it a bit difficult to understand the overall *direction* of Helle's attitude toward the proposal, but it can be concluded that different aspects point in different directions. Moreover, by including the notions of *ELM* and *HSM*, then participating in a supplementary interview may have given Helle more time to assess the issue-relevant information thus engaging in a more thoughtful elaboration (Petty & Wegener 1999:42/46; Petty & Cacioppo 1986a:7; Petty & Cacioppo 1986b:125-126; Chen & Chaiken 1999:74/80-81), which could affect her attitude. In addition this is also a good example of our paradigmatic stance that the construction of reality happens in connection with one's context and as argued by Goldman & McDonald the answers are framed in accordance with the situation people are in (Goldman & McDonald 1987:166-167). Connected hereto, Petty & Cacioppo and Chaiken, also notes that attitudes are situational dependent (Petty & Cacioppo 1986a:7-8; Petty & Wegener 1999:42/44; Chen & Chaiken 1999;74).

Returning to the main focus of this paragraph namely the importance of media channels, then the media channel of the Internet also seem to make a difference to some of the other informants. Thus whether the media has a "push" or "pull" nature as noted by Schlosser et al. and Ducoffe (Schlosser et al. 1999:51; Ducoffe 1996:21-22) could be influential. In this regard, Lise says,

> *"(…) if it's something that people they should like go online and search for on some kind of particular site, where there's a lot of different medicine uhm.. then it's of course a bit more hidden, well, then it at least isn't direct advertising, I don't think so. It also makes it more, what can you say, information-related."* (App. K:07.14) *"(…) at least I think it should*

> *definitely be such hidden or what can you say (…) it should exactly be something that you should go online and search concretely on."* (App. K:08.44).

As seen in the quote Lise expresses a similar view to Helle in relation to the media channel being important as to whether the information is regarded as advertising. Lise says that when the consumers have to go online to search themselves for the information then it resembles information to a higher degree (App. K, Lise:07.14; App. F, Lise:124). This, *"more hidden"* in the words of Lise, information appears to be preferable. Thus the "pull" nature of the Internet seems more legitimate for the purpose of informing individual and, as seen through Helle's and Lise's statements, it might also be a part of what makes it information, when it concerns prescription medicine. However, despite Lise's preference for information and recognizing it might be a good idea to give the consumer the possibility of obtaining this information (App. K, Lise:08.30), her main focus is still on this information being unnecessary, which will be touched upon in paragraph 6.2.2.6.

Allan responses in a similar way to the proposal,

> *"Yes, that I think is fine because then it doesn't get like imposed on somebody to see it, then you yourself have to go online and search for it, so you don't, like the advertisements you just get all the time, these messages are some that you yourself should go online to find, so there's not going to be so much an idea imposed into people's heads."* (App. K:01.09).

Thus Allan seems to agree with Helle and Lise, as he has a preference for information as this information is something people themselves search for, whereas advertising is imposed on people, which might affect them. Hence, Allan appears to dissociate from the "push" aspect of advertising in relation to prescription medicine. This favouring of people actively searching for the information themselves looks as if it is related to his belief that it is more likely that it is ill people who need the medicine that go online and search for information (App. K, Allan:01.28/01.43/04.20), where he believes that more people would notice it, if it is distributed as advertising (App. K, Allan:01.43/04.20). Thus it seems that his preference for the information being online is that it could reduce the risk of people thinking they are ill, hypochondria, and hence reduce unnecessary use of medicine, which, as mentioned, is one of the disadvantages of the proposal both pointed to by sceptics but also by some of the informants. However, Allan recognizes that some people may still go online and get tempted to get some medicine that might not be necessary (App. F, Allan:72; App. K, Allan:05.15). Related hereto Helle mentions that it does not matter if the information might be a bit selling and thus objective, if it was online, as she cannot imagine why people should go online and search for medicine if they are not ill (App. K, Helle:04.40/08.22). Hence, her positive attitude toward the

proposal, which is connected to the media channels and the less emphasis on the possibility for objectivity, could be connected to her belief that people do not search for medicine unless they are ill. This belief can be connected to the concept of involvement as Helle seems to believe that people will only look for this information if they are ill, and thus this information will have *personal relevance* for the individual, as the illness might have personal consequences. Hence, connections between the content of the individual's life and the information will exist (Petty et al. 1983:136; Petty & Cacioppo 1979:1916; Petty & Cacioppo 1981:107; Mittal 1989:148; Mitchell 1979:194; Day 1970:80; Zaichkowsky 1985:342-343; Celsi & Olson 1988:211; Grunig 1989:5). This belief might in consequence reduce the emphasis on the supposed disadvantages of hypochondria and unnecessary use of medicine. Thus in this way Allan and Helle's beliefs differ, despite both believing that objectivity is not possible and being for the proposal (App. K, Allan:04.08), this could indicate that Allan might be a bit more apprehensive and seeing more risks, which could influence the extremity of their attitude even though having the same direction.

Consequently, in understanding the informants' attitudes toward the proposal, which is the wish of the problem formulation, the attitudes and beliefs about the media channel of the Internet being the instrument through which the information is presented, seem to influence the construction of their attitudes toward the proposal, due to the "pull" nature of this media channel (Schlosser et al. 1999:51; Ducoffe 1996:21-22). In relation hereto people do not have to be exposed to information about medicine if it is online, thus the avoidance of the "push" nature of the Internet seem important to the mentioned informants as they seem to be opposed to the imposing nature of advertising in relation to medicine (App. K, Lise:06.16; Helle:07.59; App. F, Allan:47). Thus they agree with Lif that the media channels through which the information is presented makes a difference (Andersen 2010b:4; Toustrup 2008:8; Lif 2009; Lif 2011a).

In more general terms, a couple of informants have also mentioned that there might be a societal preference in the informants' generation of searching for information (App. F, Line:188-189; App. K, Lise:07.53). Closely related hereto Naja also refers to that people are raised to search for information themselves (App. F, Naja:110). Hence, the preference for the information being presented through the media channel of the Internet could be related to a socialization process (Ward 1974:2; Zigler & Child 1969:474; Brim 1966:3/5; Mortimer & Simmons 1978:422; Sewell 1963:163; Inkeles 1969:615-616: Clausen 1968:139-140; Gerson 1966:42; Rosow 1965:35), where the informants are influenced to be positive about information seeking in itself. Additionally, as suggested by Liu et al. social expectations could exist in regard to being the social role of an information seeker related to health issues (Liu et al.

2005:254/262; Ward 1974:3). Consequently, Helle, Allan and Lise's valuing of this aspect in relation to the attitude toward the proposal could be influenced by these existing norms.

6.2.2.4. Pro – Knowledge and Choice

In a Danish context the proponent of the proposal Lif claims, as seen in paragraph XX, that the proposal could provide the end-consumers with information and knowledge as well as educate them (Lif 2009; Lif 2011a; Toustrup 2008:10). This aspect of the supposed advantage is also indicated in relation to Helle's evaluation of the proposal and this advantage seems to also be taken into consideration in the attitude toward the proposal. Other informants also state this advantage,

> **Helle**: *"(…) I think that if you get diagnosed with (…) a serious disease, then it could maybe be difficult to find some information about (…)"* (App. K:03.34) *"Yes, I think that some info could be missing about (…) something like that. Well, I have, I have an illness myself, not so serious (…) but it's often hard to find something about it, (…) but again I absolutely don't think that you should advertise for it, uhm.. it should be something that you yourself can go online and find and that I absolutely think is very fine (…)"* (App. K: 03.49).

> **Cecilie**: *"(…) we talked earlier about, that you choose on the basis of **price**, so there might be some **other** factors which affect, that I then choose the product. It might be that I like organic products, and it might be, that there was some considerations for the **environment**, there was something in the product that…"*
> **Interviewer**: *"Then you are returning to the issue of enlightening the consumers?*
> **Cecilie**: *"Mm, yes. Then I would not be so reserved, then I would buy it just like, I buy organic milk instead of conventional milk. That some factors existed, that affected, that I chose it."* (App. F:74).

> **Catja**: *"I think it's fine, but there should definitely be some guidelines.. uhm.. but again, it's also difficult to distinguish between what's information and what's advertising. But I once again think, it's something that could benefit the consumers."*
> **Others: "***(…)"*
> **Catja**: *"Well again, then you get a choice, you get information about, what you can choose from, and it's not certain that your doctor would give you that information, he just says "Well, this medicine exist, that you can get". Where you cannot choose yourself, but you have some alternatives and some options."* (App. F:183).

As indicated, Helle expresses that the information could provide people with missing information, which makes her positive about the proposal. Cecilie and Catja also point to positive aspects of the proposal, but their angel is a bit different from Helle's as they focus on the information from the pharmaceutical companies to give them knowledge about their options for choosing medicine. Consequently, their attitude toward the proposal could be related to the *conative component* of the *Tricomponent Model*, as Catja and Cecilie link to the proposals'

opportunity to provide information from which they might behave, thus it seems that their attitudes are connected to their behavioural intentions (Ajzen 2005:3-5/20; Rosenberg & Hovland 1960:1-3; Schiffman & Kanuk 2004:256; Fishbein 1967:481-482;). As mentioned earlier, Helle's attitude toward the proposal seem to be based in personal experience, which also might be the case with Catja as she mentions that she herself has tried a great variety of allergy medicine and it would from the start had been nice to know what her options were (App. F, Catja:188). Thus as earlier mentioned these personal experiences are by several authors argued to have a great influence on an individual's attitude (Allport 1935:810/819; Argyriou & Melewar 2011:6; Fazio et al. 1978:49/51; Reed et al. 2002:386; Schiffman & Kanuk 2004:267; Bagozzi et al. 1991; McGuire 1985:240). Consequently, the emphasis is on these advantages of the proposal in the construction of these two informants' attitudes toward the proposal. Thus, the argument of authors that personal experiences overrule other aspects (Argyriou & Melewar 2011:6; Fazio et al. 1978:49/51; Reed et al. 2002:386; Schiffman & Kanuk 2004:267; Bagozzi et al. 1991; Fazio & Zanna 1981:195) seems to help in understanding Helle and Catja's attitudes toward the proposal.

In trying to understand Cecilie's focus in relation to the proposal, the *value-expressive function* could be included as it proposes that attitudes can also express personal values i.e. expressing the way an individual perceives himself (Argyriou & Melewar 2011:3; Katz 1960:170/173; Triandis 1971:5). As indicated in the quote Cecilie seems to give emphasis to organic products and the environment, which she also expresses earlier in the focus group as she perceives herself as being organic-oriented (App. F, Cecilie:15-16). Hence, Cecilie's personal values seem to have an influence on her attitude toward the proposal. As she points to, that the information might give her the possibility of insight into aspects of the product that she values, hence affecting her attitude in a positive direction. Hence she could be involved in this issue as it can be connected to her central values (Sherif & Hovland 1961:74-79; Mitchell 1979:194; Chen & Chaiken 1999:77) and thus anchors her attitude toward the proposal in her positive attitude toward organic products (Feldman & Lynch 1988:421: Kardes 2001:116; Lynch 2006:25). Thus besides seemingly founding her attitude in the *conative component*, the *affective component* of the *Tricomponent Model* could also be a foundation point due to these values (Ajzen 2005:3-5/20; Rosenberg & Hovland 1960:1-3; Schiffman & Kanuk 2004:256).

Another aspect of the proposal, which is also given attention, is the division between information and advertising (European Commission 2008:5), which might be difficult to make as discussed in paragraph 2.1.1.1. The importance of this distinction is also pointed out by Catja as seen in the above quote. Other informants also refer to the importance of these guidelines e.g. in continuation of Catja's statement Mie says,

> *"I would definitely be more positive toward it than toward the advertisements. Again in regard to the guidelines, how good they are and stuff like that."* (App. F:183).

In a similar vein Lau expresses,

> *"(…) with regard to the information, well… it, I assume, that there would be some authority with it, so I think (…) it's okay (…)"* (App. F:154).

From these quotes it seems that the regulations surrounding the proposal is important for these informants, as Mie indicates that her attitude toward the proposal depends on the guidelines and Lau appears to base his attitude toward the proposal on the assumption that some control is carried out. This assumption is also expressed by Cecilie (App. F, Cecilie:73). Thus in the case of Lau this belief seems to be given higher emphasis, than the other aspect of pressure of the GP as a consequence of the proposal, as the *direction* of his attitude appears from the quote to be positive. Hence, informants seem to base or depend their attitudes toward the proposal on beliefs about authority carried out in relation to the existing legal requirements. This thought process appear to be similar to what is found in studies by Bell et al. and Singh & Smith about DTCA of prescription medicine, where the respondents are positive toward it, due to their belief about high regulatory control (Bell et al. 1999:654-655; Singh & Smith 2005:373). Lily the US consumer interviewed expresses a similar assumption (Appendix b, Lily:24). Thus beliefs as argued by Fishbein & Ajzen (Fishbein 1967:477; Ajzen & Fishbein 2000:1; Fishbein 1963:233) seem to be important in construction of attitudes, which seem to be the case of these informants in regard to the proposal. This might also be connected to Giddens' construct of *expert systems*, as systems in society that have *credibility* (Giddens 1996:30-31), as the informants' trust in the legal control and following the regulations seem to influence their attitudes toward the proposal due to their beliefs about the adherence of these. Hence in relation to the problem formulation these beliefs appear to be a part of understanding these informants' attitudes toward the proposal.

6.2.2.5. Misunderstandings and concerns

The next aspect to be tapped into concerns the risk of the end-consumers misunderstanding the information provided and that it could create confusion and concern, if the proposal is enacted. As indicated in paragraph 1, one of the arguments of opponents of DTCA of prescription medicine was that it could confuse the consumers, even though this paragraph concerns the proposal of online information, it might also be a worry in this regard, as a general disadvantage of online health information according to Sundar et al. is the possibility of overload, confusion and even fright (Sundar et al. 2011:184). In relation hereto Lise brings up the issue of misunderstandings in regard to the proposal as seen from the following quote,

> **Lise**: *"(…) maybe the regular consumer (…) misunderstands or misinterprets something because they may not have the whole, what can you say, basic knowledge about everything about the body's physiologically uhm.. uhm stuff, that is, then it's like the doctor, it's him who probably know most (…) because of his education."*
> **Interviewer**: *"So you think that there can be something in this, that you can misunderstand it or not quite understand or.."*
> **Lise**: *"Yes definitely, well if there's something that (…) that they don't know some element, well, I know that they for example shall write if you are pregnant or have.. some history with blood clots or something like that (…) but there can by guaranty still be some things that that they maybe don't know uhm.. can entail that if you take this product, then something consequently can happen (…)"* (App. K:09.19)

Thus Lise indicates that the information presented by the pharmaceutical companies could lead to misunderstandings and misinterpretations as the end-consumer might not have complete knowledge of the body and medicine in comparison with the GP and that this lack of knowledge, which could lead to misunderstandings, could have consequences. As indicated Lise's point of view is closely related to her view on the GPs' role, which is another element that seems to influence the attitude toward the proposal. The influence of the view of the GPs' role will be returned to in the following paragraph. Closely related to Lise's concern, Pernille and Simon respectively says that it would not be possible for them to assess and choose between similar medicinal products (App. K, Pernille:05.28; App. F, Simon:184). Pernille elaborates by expressing that she as a person cannot assess and compare these products in relation to how long these have been tested, the active ingredients and their affect, instead she refers to the GP like Lise (App. K, Pernille:05.28). Despite recognizing the possibility of these risks Helle puts less emphasis on these aspects when asked about the possibility of misunderstandings and confusion,

> **Helle**: *"(…) but of course it can probably confuse somebody, that I think, but I still think that it's more important, uhm I also think that it gives a sense of calmness or what's it called, reassurance for the person, who has the illness, that you can find some information about both medicine, but also yes, also about which side-effects it has and stuff like that, that I think can reassure many (…) it can create confusion, but it's still a better alternative."*
> **Interviewer**: *"So you think it's more positive, that is?*
> **Helle**: *"Yes, more positive than negative, yes."* (App. K:09.32).

As the quote illustrates, Helle acknowledges the possibility of the information confusing individuals, however, she believes that it is more important that the information also has a reassuring quality, which is valued more than the risk of confusion. Hence, the possibility of gaining information that could fill the need for information about an illness or medicine, which could

give reassurance in a way that does not resemble advertising according to Helle due to the media channels used, seem to be given more emphasis than the belief that misunderstandings and confusion could occur. Thus in the combination of these belief to form a attitude toward the proposal these former mentioned aspects are more influential for the direction of the attitude as seen in the quote, as Helle appears to view more positive aspects than negative. As proposed by Fishbein & Ajzen some beliefs might be more salient than others in the attitude formation process (Ajzen 2001:3; Fishbein & Ajzen 1975:218; Ajzen & Sexton 1999:119), which could be the case with Helle. Consequently, the positive aspects seem to be more salient in the supplementary interview as seen in the above quote, whereas, as mentioned, in the focus group more perceived negative aspects in that time might have been salient in the construction of the attitude toward the proposal, which could help understand the divergence in Helle's attitude in the two interviews. Whereas Helle's attitude has a positive direction, which could be connected to less emphasis on these aspects, this aspect as seen above seem to be of importance and concern to Lise and Pernille in relation to the proposal, which might affect their attitude toward it.

Despite not being a central concern in the minds of many of the informants on the basis of the constructed knowledge of this thesis, two of interviewed Danish GPs on the other hand seem to give attention to the aspect of misunderstanding and confusion,

> **Jannik**: *"I think it would be problematic given that it would be a huge quantity, so it would become completely confusing. (…) And I think it's part of increasing the confusion, we talked about. In people's heads with information. (…) People can search the information they want about the doctor's medicine already. So I don't think that you need to inform them more."* (App. C:21).

> **Jan**: *"Well, I still think it would cause, (…) I don't think that it's a good idea (…) I still think it would cause more concern than (…) benefit, that I think… so I do not like it."*
> **Interviewer**: "*(…)"*
> **Jan**: *"(…) it's again this thing with misunderstanding some things, right, well, you can't breathe, then "You should just have that, right, then you can breathe" and it's not that easy (…) so.. it could result in many… problems."* (App. C:66).

Hence Jannik expresses that he thinks it would confuse people, which he elaborates by stating that it confuses individuals to read about and assess similar products for the same disease (App. C, Jannik:22), which is closely connected to Simon and Pernille's concerns as mentioned above about the ability to assess and choose between products. Jan's statements seem to reflect what Lise pointed out about that people might not have the knowledge to interpret this information, which could cause misunderstandings. Jan furthermore mentions that this information could cause concerns. Allan seems to agree with the ability of information causing

concern, but in comparison with DTCA Allan believes that less people will become unnecessarily concerned because they have to search for it themselves (App. K, Allan:05.47). Thus it seems that by comparing information to advertising this potential consequence appears to gain less emphasis, as he focuses on the media channel of the Internet, as mentioned earlier, which consequently seem to be emphasized in this construction of attitude toward the proposal, despite acknowledging disadvantages exist his attitude still has a positive direction (App. K, Allan:01.08/04.08).

Thus despite being pointed out by the sceptics and authors as well as the GPs, the most of the Danish informants do not seem to emphasize this aspect, or at least they do not express it in the interviews. Additionally, the informants neither mention it in relation to their general search for information on medicine and illnesses as a concern or experience. However, GP Jan could indicate an explanation for the discrepancy between the GPs' experience with confused and worried patients and the lack of personal recognition or expression of these situations by the informants,

> **Jan**: *"Maybe there's also somebody, where it calms them down, but we don't see these people (…) so it can, I can't say how much there's in that direction (Interviewer: no). But there's at any rate somebody, who gets unnecessarily worried (…)."* (App. C:59)

What Jan indicates is that his experience is founded in the consultation with patients, and as a consequence he does not see the end-consumers, who get calmed by the information obtained online, but are more likely to consult with worried patients. Thus the discrepancy could be due to the different spheres of insight, as the GPs only have insights founded in the consultations, whereas the views of the informants are wider as these expand the frame of the consultation. From the constructed knowledge it is difficult to pinpoint the exact reason for the informants' lack of misunderstandings and confusion, however, one indication could be the statement of GP Nis, who has the experience that the smartest patients, seem to have a pretty good understanding of the problems (App. C, Nis:77). In this regard the missing expression of confusion and misunderstandings and the little emphasis on this in relation to the proposal could have something to do with the informants' educational level. As mentioned they are all the in process of obtaining or have gained a university education, thus they might be able to better understand the information attained, which could perhaps minimize the confusion and misinterpretations. However, another aspect, which might also be influential, which is mentioned by GP Jan, is the perception of the young educated group as having a sceptical approach to everything (App. C, Jan:73). As seen in paragraph 6.2.1., some of the informants also appear to have a critical approach to the information found online due to the source of the information, and thus this approach might be important in regard to lessening the possibility of the misunderstandings and worries. Additionally, the search of information online without

being concerned or confused could also be related to the concept of *self-efficacy*, which can be understood as person's conviction that he can successfully carry out the behaviour needed to reach a specific outcome (Janz et al. 2002:50). *Self-efficacy* could also be related to health information searching (Sundar et al. 2011:189; Galarce et al. 2011:171-172), which in this case could mean that the informants might believe that they have high *self-efficacy* in locating and interpreting information on illness and medicine, which might result in less focus on misunderstandings and confusion. This concept could also be linked to the focus of Helle, Catja, and Cecilie on the positive aspect of obtaining missing knowledge and insights into one's options from the proposal, as the conviction that they can understand and interpret this information might be necessary for this positive outlook.

Another element, which might also play a role in relation to misunderstandings, is the informants' age. As indicated prior, the informants does not seem to be generally interested in information on illnesses and medicine, which could form the constructed knowledge of this thesis be connected to the their age, since this age group might have less tendency to get seriously ill (Lee et al. 2007:110-111; Burak & Damico 1999:21), which is also indicated by Lise and Allan (App. F, Lise:89; App. K, Allan:06.30). Furthermore most of the informants have not indicated that they have taken prescription medicine for a serious illness as seen in table 3, thus the absence of misunderstandings and concerns could perhaps be linked to the informants mostly not having serious illnesses. Thus the lack of attention and information searching in this regard can be a combination of their age and the absence of illnesses, as indicated in paragraph 6.2.1. Hence the information available is not personally relevant for them, besides when being ill. Thus the worries and misunderstandings could also be lessened by the reduced information searching in this area. Additionally, it could be that the informants only have been calmed by the information, as mentioned by Helle (App. K, Helle:09.32). However, the method of focus groups to construct knowledge in this area might also have some influence in this regard, as the informants might want to present themselves in a certain way, and thus not express confusion or misunderstandings.

As the informants when searching for information about illnesses and medicine do not express worries about understanding the information, then it might be understandable that the main part of the informants do not mention these apprehensions in relation to the proposal. Thus once again Fishbein & Ajzen can be included in trying to understand the informants. Fishbein & Ajzen, as seen in paragraph 5.6., suggest that experience with an object can form beliefs about this object, which could influence the formation of attitudes (Fishbein & Ajzen 1975:217). From the constructed knowledge the informants do not seem to have negative experiences with searching online for information on medicine and illnesses, they may have as Helle and Jan mentioned, been reassured. These experiences could influence their beliefs

about their *self-efficacy* toward this practice, which might also be strengthened by being socialized into this practice as mentioned by some of the informants. Hence this belief could affect the attitude formation toward the proposal in the way that this does not seem to be an aspect, which is emphasized by many of the informants. However, this does not indicate, as seen in the prior paragraphs, that the informants necessarily are positive, it might only indicate that other aspects and attributes are emphasized e.g. the ability to present objective information.

6.2.2.6. The GPs' Role (Proposal)

In reviewing the literature on this topic several studies have shown that respondents have found that individuals seem to have a preference of obtaining information about health, illnesses and medicine from the doctor (Aikin et al. 2004:2; Doucette & Schommer 1998:1081-1082/1084-1085; White et al. 2004:58/66; Chen & Carroll 2007:278). As also assumed in paragraph 5.10., this preference could be an anchor point for the informants' attitudes toward marketing of prescription medicine including the attitude toward the proposal. From the constructed knowledge it appears that a couple of informants seem to emphasize the role of the GP, as mentioned, in relation to the proposal, especially Lise,

> **Lise**: *"(…) offhand I think, that it can be alright (…) but as I also said at the time of the focus groups, well I cannot understand why (…) the regular consumer should know uhm.. these things, because they presumably go to the doctor and say "Something is the matter with me" and then the doctor presumably* ***knows****, that some product exists that can help (…)"*
> **Interviewer**: *"So you kind of think, it maybe should be, he should be the primary.."*
> **Lise**: *"() I don't think, that it should be necessary that that the consumer need (…) to search themselves."* (App. K:01.21).
>
> **Lise**: *"(…) but again I just think he should be the primary source of the information."* (App. K:11.01).

Hence in the quotes Lise states that she cannot see the necessity of the information as the consumers probably go to the GP if they are ill, and therefore do not need to obtain this information by searching. Thus she very clearly expresses that she thinks that the GP should be the primary source of information as the GP has the required knowledge, and moreover she mentions that the GP should have the most knowledge (App. K, Lise:03.00). Alex seems to agree that it is the GP, who should get the information as the consumers go to the GP, when they have a problem (App. F, Alex:184). This is closely related to the abovementioned risk of misunderstandings, as Pernille, Lise and Alex indicate that it is the GP, who has the competences and knowledge of prescription medicine and thus can asses, which medicine is needed (App. F, Alex 184; App. K, Lise:03.08; Pernille:05.30/07.57), which is also mentioned by the GPs

Nis and Jan. In relation hereto Pernille directly states that one should trust the GP (App. K, Pernille:07.57; App. F, Pernille:109). Like the study of Gönül et al., who found that trust in an individual's physician reduces the valuation of DTCA of prescription medicine (Gönül et al. 2000:215/224), it seems that these informants' trust and belief in using the GP when ill could affect the construction of their attitudes toward the proposal and the valuation hereof. This trust could be linked to Giddens' notion of *expert systems*, which could be the medicinal profession, as some systems in society according to Giddens have *credibility* independently of the individual practitioner (Giddens 1996:30-31; Bordum & Uldal 2001:51) in this case the GP. Hence, this could indicate that these informants have learned to trust the GP through a learning process – socialization, consequently expressing the belief that the GP is important when having the social role of being ill and needing medicine (Ward 1974:2; Zigler & Child 1969:474; Brim 1966:3/5; Mortimer & Simmons 1978:422; Sewell 1963:163; Inkeles 1969:615-616: Clausen 1968:139-140; Gerson 1966:42; Rosow 1965:35). Thus this could be an expression of existing norms in relation to consuming prescription medicine (Ward 1974:3), which seem to influence the attitude toward the proposal. Thus, when valuing the GP as the primary source of health information it could be imagined, if the proposal is enacted, that the GPs' attitudes toward the proposal could affect the end-consumers' attitudes, as they are supposed by Lee et al. to be a socialization agent. In the case of the interviewed GPs their attitudes seemed as negative or sceptical, which then might have an effect. However, as mentioned by McLeod & O'Keefe and Sarbin this socialization does not have to be intentional (McLeod & O'Keefe 1972:131; Sarbin 1959:226-227). Thus the attitude of the GPs might influence the attitude of the end-consumers.

From his statements in the focus group, Alex emphasizes the role of the GP in relation to prescription medicine and expressing that the proposal could promote hypochondria. Thus this indicates a negative *direction* of his attitude toward the proposal by focusing on these aspects. Similarly Pernille's attitude toward the proposal could also be influenced by her belief that the GP is a trusted source, who has the competences that the consumers do not have to assess prescription medicine. However, the negative *direction* of Pernille's attitude toward the proposal, which she directly expresses (App. K, Pernille:04.55), also includes other aspects that seem to influence this construction. As mentioned Pernille does not believe that the information can be objective and consequently it could be a slippery slope toward DTCA of prescription medicine (App. F, Pernille:106), which she as seen in paragraph 6.1.5.2. is opposed to. Additionally, Pernille is against consuming medicine as also shown in paragraph 6.1.5.2. and she expresses that illness should not be emphasized in society as it might make people think that they are ill (App. K, Pernille:15.00), as also mentioned earlier. Thus this combination of beliefs as suggested by Fishbein & Ajzen (Fishbein & Ajzen 1975:233) and the anchoring in existing attitudes as proposed by Feldman & Lynch and Cohen & Reed (Feldman & Lynch

1988:421; Kardes 2001:116; Lynch 2006:25) in this case toward medicine and illness seem to affect her construction of an attitude toward the proposal in a negative direction.

In continuation hereof Lise's attitude toward the proposal to a high degree seems to be founded in the role of the GP as the main provider of information concerning medicine and illnesses, thus despite saying, as shown earlier, that she believes that the information presented by the pharmaceutical companies could be objective, and acknowledging that there could be some value in end-consumers searching on this information, her attitude could be interpreted as a bit negative, as she points to the disadvantages of misunderstandings and the possibility of hypochondria, and believes that the GP should be the main information source, thus making this information unnecessary (App. F, Lise:106; App. K, Lise:01.21). This attitude could be connected to Lise's personal experiences, which as mentioned by authors could have a great influence on an individual's attitude as she expresses that she has not been ill and thus not searched for information (Allport 1935:810/819; Argyriou & Melewar 2011:6; Fazio et al. 1978:49/51; Reed et al. 2002:386; Schiffman & Kanuk 2004:267; Bagozzi et al. 1991; McGuire 1985:240). Hence, the information might not be seen as necessary, which seems to be opposite the experiences of Helle. Joakim, which as shown, also indicates the possibility of unnecessary use of medicine and appears to look toward the GP when needing prescription medicine (App. K, Joakim) thus resembles some of Lise's beliefs in relation to certain aspects. However, interestingly enough he expresses that the proposal is legitimate as he does not use the Internet and does not think others use the Internet in looking for prescription medicine, thus the overall assessment seems to be based in a belief about where people look for information about prescription medicine (App. K, Joakim), which could be based in personal experiences and consequently having great affect (Allport 1935:810/819; Argyriou & Melewar 2011:6; Fazio et al. 1978:49/51; Reed et al. 2002:386; Schiffman & Kanuk 2004:267; Bagozzi et al. 1991; McGuire 1985:240), thus indicating that Joakim's attitude seem to have a *conative component* as posed in the *Tricomponent Model* (Rosenberg & Hovland 1960:1-3; Schiffman & Kanuk 2004:256; Ajzen 2005:20).

Hence, as mentioned, the trust that Pernille, Lise, and Alex have in the GP could indicate a socialization process, where norms and attitudes toward the GP as a trusted source being a part of an *expert system* in Giddens' terms has been learned (Ward 1974:2; Zigler & Child 1969:474; Brim 1966:3/5; Mortimer & Simmons 1978:422; Sewell 1963:163; Inkeles 1969:615-616: Clausen 1968:139-140; Gerson 1966:42; Rosow 1965:35; Giddens 1996:30-31). Thus social role of relating to the GP seems to consequently affect the attitude toward the proposal. However, at the same time as proposed by Brim different socialization agents can have different expectations toward the individual and compete for influence (Brim 1966:12; Brim 1968:187/192). Brim's suggestions might help in understanding some of the other informant's

attitude and underlying constructions. From other paragraphs it is indicated that people search for information on health and illnesses (Galarce et al. 2011:167; Sundar et al. 2011:181), which was also found among some the informants as seen in paragraph 6.2.1. This searching behaviour a couple of the informants connect to a general tendency, hence expectations from other socialization agents might also be that people themselves search for information in relation to this issue. Thus different norms might exist, which could have a varying influence on the informants. In relation to the latter norms of searching for information and emphasizing the positive aspects of more information Catja, Cecilie, and Helle seem to be more influenced by these expectations than that of trust in the *expert system* of the medical profession, which consequently seem to influence the construction of attitudes toward the proposal. This divergence in influence of norms and expectations could also underpin that the individual should not seen as passive in this process (Zigler & Child 1969:469/473; Brown 1965:153-154). This could also be related to Helle's negative experience with GPs and thus having a negative attitude toward them (App. K, Helle:09.09), which might be due to different expectations in regard to the patient role in relation to power and communication structures in the social interaction with doctor as a socialization agent (Churchill & Moschis 1979:25; Moschis & Churchill 1978:600: McLeod & O'Keefe 1972:132-133/159; Thornton & Nardi 1975:872; Chaffee et al. 1971:331-332; Moschis 1985:900-901; Gönül et al. 2000:216) as Helle indicates that her experience is that the GPs want to be the most wise, not appreciating the consumers' informed questions (App. K, Helle:09.09; App. F, Helle:8). Hence, this negative personal experience could mean that her attitude toward the GP consists of an *affective component* (Rosenberg & Hovland 1960:1-3; Schiffman & Kanuk 2004:256; Ajzen 2005:20), which has a negative direction. Thus this pre-existing attitude toward GPs, which is founded in experience, could be a significant anchoring point (Feldman & Lynch 1988:421; Kardes 2001:116). Thus this experience could also have furthered the norms of searching for information online, thus affecting Helle's positive attitude toward the proposal.

Thus, the informants, who have voiced their opinion about the proposal, could also be influenced by the prevalence of different norms, consequently focusing on the GPs' role as an expert in relation to prescription medicine like e.g. Lise and Alex, or emphasizing the value of additional information, which could be missing or enhancing knowledge of options like e.g. Helle and Catja. Consequently, these norms and valuing of different health sources seem influential in understanding the informants' attitudes.

6.2.3. Sum up

From the interpretations of the constructed knowledge of the different interviews it seems that the attitude toward the proposal and the underlying constructions hereof are complex as a variety of aspects are included and emphasized. The figure below is an attempt to create an

overview of the different aspects mentioned by the informants and touched upon in this paragraph.

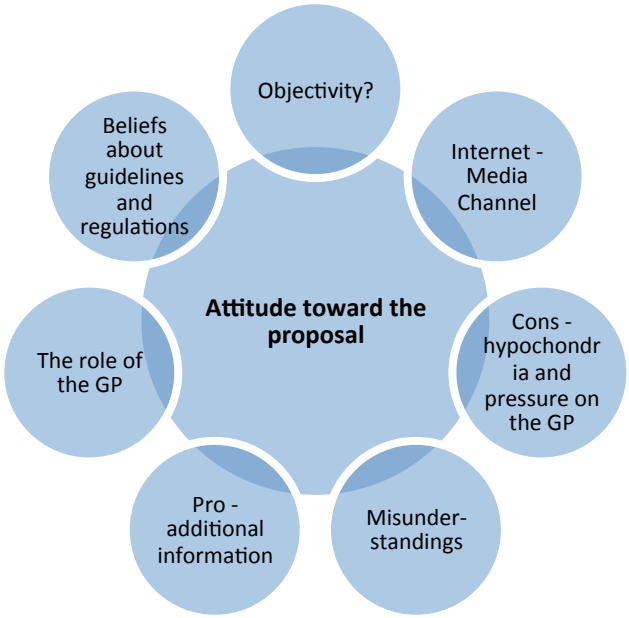


Figure 15: Overview over aspects influencing attitude toward proposal (Own creation)

Thus these are the aspects, which from our interpretation of the constructed knowledge seem to influence the informants' attitudes toward the proposal. However, as also seen in the above paragraphs not all of these different aspects are mentioned by all of the informants and are not given the same emphasis by the informants, which also means that their attitude differ in *direction*. Additionally, even if the direction of the attitude toward the proposal is the same, different aspects might be underlying this construction such as Lise's focus on the role of the GP and Michael's emphasis on his belief of lack of ability by the pharmaceutical companies to present objective information. These aspects, which seem to underlie the construction of the attitude toward the proposal, should however not, as the figure shows, be understood separately, as connections are made between these e.g. Allan linking the media channel of the Internet with less likelihood of hypochondria and Lise, who connects the risk of misunderstandings to the importance of the GP. Furthermore in trying to obtain an understanding of the attitude toward the proposal and the underlying constructions through this analysis, it has also become evident that beliefs, existing attitudes, experiences and norms appear to surround the aspects related to the attitude toward the proposal, thus functioning as anchoring point and in consequence influences the attitude toward the proposal. E.g. Pernille has a pre-existing negative attitude toward medicine and Helle has negative experiences with GPs.

In relation to answering the problem formulation, the understanding obtained about the informants' attitudes toward the proposal is that no clear *direction* of the attitude has been interpreted, as some appears to have a positive attitude, while others seem more negative. The constructions underlying these evaluations seem to be connected to the above showed aspects and the informants' attitudes and beliefs about these abovementioned aspects are influential to their attitude toward the proposal. Some of these aspects influencing the attitude toward the proposal are similar to the advantages and disadvantages put forward by different organizations speaking in behalf of the consumers, as seen in paragraph 1 and 2.1.1.2. Thus there could be some basis for these supposed advantages and disadvantages from the statements of some of these informants.

Why certain aspects are emphasized by the individual informants is a bit difficult to say but it seems that personal values, experiences, existing attitude toward related attitude objects, beliefs and also norms could have an effect. Yet, the positive *direction* of the attitude toward the proposal appears for some informants to be dependent on their beliefs about the regulations surrounding it. Beliefs directly connected to the design of the proposal were also given emphasis as the possibility of objectivity was discussed and related to advertising, however, as also seen above, the view of the ability not have to be decisive in relation to the attitude toward the proposal. Another feature of the design of the proposal, which also seemed important in some of informants' constructions of positive attitudes toward the proposal, is the aspect of the media channel of the Internet, which is preferred by the informants due to its "pull"-nature. However, from the constructed knowledge it has not been possible to find overall tendencies among the informants, which is also connected to conducting supplementary interviews, consequently leading to some informants is more prominent that others. Nonetheless, the interpretations have still given insights into aspects, which can be influential for this attitude.

6.3. Extra Active Ingredients

As seen in the analysis above, most of the informants appear to have a negative attitude toward DTCA. Reflecting upon this *direction* of their attitudes, the studies of Vatjanapukka & Waryszak and Dens et al. might be helpful in trying to understand this tendency among the informants. As mentioned in paragraph 5.1., Vatjanapukka & Waryszak found that consumers, who have not been recently exposed to DTCA, were more likely not to support this practice (Vatjanapukka & Waryszak 2004:357). Connected hereto, Dens et al. found that Belgians were less positive toward DTCA than people from New Zealand, which was assumed to be due to the first group not having experienced the practice (Dens et al. 2008:57). Hence this could also be an indication of why the Danish informants seem negative toward DTCA, as they have not yet experienced this practice and thus might be more likely to question it. This could be un-

derpinned by the Danish informant Pernille who says that she would be sceptical toward it for a long time, but that she would get used to it (App. I, Pernille:08.40), indicating that she would perhaps become less sceptical after having tried being exposed to DTCA. This could be connected to three of the US informants' notions about DTCA not being something they think about or pay attention to (App. A, Mary:6; Lily:19-20; Grace:44). This might be connected to that these US end-consumers are exposed to this practice daily, whereby they have come not to question this practice in their everyday lives, which might be connected to the fact that they are exposed to it daily. Consequently, in trying to interpret the findings, the Danish informants' negative attitudes toward DTCA, might in combination with other aspects, be influenced by the fact that they are not familiar with the practice. Furthermore the characteristics of the informants might have an effect on these overall negative attitudes, e.g. that they are young people, who belong to an age group, which is generally fairly healthy (Burak & Damico 1999:21). Thus this age group can be assumed to have a low level of involvement with prescription medicine, which might affect their attitudes, as studies have found that product involvement is influential in people's attitudinal response toward DTCA of prescription medicine (Limbu & Torres 2009:51). Additionally, it has also been found that high involvement consumers, understood as consumers with a large extent of interest in and concern with the product e.g. because they feel ill or are ill (Limbu & Torres 2009:55; Deshpande et al. 2004:508-512) had more favourable attitudes toward DTCA (Limbu & Torres 2009:51/68/71-72; Hausman 2003:231;Deshpande et al. 2004:508-512).

However as seen in the above analysis it is not as simple as just determining whether the informants are positive or negative toward DTCA, as several aspects come into play in constructing this attitude. The influence of several aspects is also found in relation to the informants' attitudes toward the proposal. However, the informants' attitudes toward the proposal were found as being more equally divided in terms of being of negative or positive *direction*. In this regard, the aspect of the fact that people would themselves need to seek the information through the Internet appeared to be emphasized in relation to the informants' seemingly more positive attitudes toward the proposal than toward DTCA. This could thus be connected to the "pull"-effect of the Internet, whereby the channel through which the information would be obtained seemed to be an aspect, which the informants took into consideration. As to what concerns their attitudes toward DTCA, the notion of "push" and "pull" could also be an influential aspect as advertising would reach a broad spectrum of people due to its "push"-effect through TV and radio. Thus people would be told about illnesses and medication, where most of them would probably not need this information as they are not ill and would thus not be in need of medication. This indirectly appeared to be a concern among the informants, where they touched upon disadvantages of DTCA such as creating unnecessary needs and hypochondria.

These concerns and thus the attitudes toward DTCA seem to be closely connected to the product of medicine. In this regard, medicine was by the informants seen as being an untraditional product in the sense that it cannot be compared to other regular products like e.g. ice-cream or a pair of pants. This might be connected to the possible consequences of medicine, as being a product that could be potentially harmful due to its individual effect on people. This might also be connected to the informants' views on the GP as having an important role in the consumption of prescription medicine. The nature of medicine as a product thus appears to influence why informants do not seem to think that DTCA and medicine should be intermixed, as seen in the analysis above. Besides the nature of medicinal products, the nature of advertising seem to be another influential aspect in relation to why the informants do not think that these should be intermixed – namely as the informants view advertising as having the objective of selling people a given product, where in the case of medicine some people might not need it, which again leads us to the possible disadvantages of creating unnecessary needs and possibly hypochondria. Connected hereto, in relation to the proposal, some informants question whether the pharmaceutical companies can give objective information, as they are businesses with commercial interests, and thus the information might become "hidden advertising".

If thinking about implications for pharmaceutical marketers, some informants note that the pharmaceutical companies should show ethical responsibility again connected to the product's possible consequences on people's health. Thus on the basis of our constructed knowledge, the informants' view on medicine as a product, might be an aspect which could be beneficial for the pharmaceutical companies to take into consideration when communicating with Danish end-consumers. As indicated in the analysis and as mentioned above, the informants dissociate themselves from the persuasive aspect of advertising and in relation to the proposal some of the informants' positive attitudes toward this are dependent on the information actually being objective. Thus this could indicate that the pharmaceutical companies should consider not being overly persuasive in their communication to the end-consumers. In regard to the implications for legislators, in connection to the proposal, as already mentioned it seems as if the informants question the ability for the information to be objective as the pharmaceutical companies are the sources hereof. Thus if enacting the proposal in considering the informants worries, the legislators should focus on making sure that restrictions are made to avoid information turning into advertising. Additionally, in relation to their positive attitudes toward the proposal, a couple of informants emphasize the suggested media channel for the information to be distributed through as important, which is connected to the "pull"-nature of the Internet. Thus from the view of these informants it seems sensible to present this information via this channel, as going online and search for information is less likely to resemble advertising.

7

Reflections on Validity: *Disclaimer*

Reaching this point of the thesis, having constructed the knowledge to answer the problem formulation, we will now have a look at the validity of these findings. As this thesis is based in the paradigmatic assumptions of constructivism, the validity criteria posed by Lincoln & Guba will, as mentioned, be used in this task of assessing the constructed knowledge. Thus the four criteria of *confirmability*, *dependability*, *transferability,* and *credibility* will be applied to evaluate the findings.

7.1. Confirmability

Confirmability is focused at assessing whether the interpretations are supported by the empirical findings and that a logical set of conclusions are presented nonprejudicely from the data and not being based on the researcher's individual biases (Hirschman 1986:246). To evaluate the findings and interpretations it is suggested that one or more external auditors go through the material of the inquiry (Lincoln & Guba 1985:319-320/323). Despite recognizing the importance of this criterion in improving the validity of this thesis, this process has not been undertaken partly due to time constraints. Additionally, it has not been possible to find an external auditor, which lives up to the characteristics set forth by Lincoln & Guba and Hirschman, as the auditor should have experience, insight into methodological issues and knowledge of the field of marketing of prescription medicine (Lincoln & Guba 1985:326). Especially, the latter is difficult as this is an unexplored field. Additionally, the external auditor should know us personally to assess bias (Hirschman 1986:246). Thus, it cannot be assured that the conclusions of this thesis are founded in the data and are unbiased, but to enhance transparency the transcriptions are enclosed.

7.2. Dependability

As mentioned in paragraph 3.2., *dependability* can be seen as an equivalent to reliability (Lincoln & Guba 1985:317-318; Hirschman 1986:245). Besides having aspired through the paragraphs, to be transparent in how this thesis is conducted, which could enhance *dependability*

(Lincoln & Guba 1985:317-318; Bryman 2004:275), Hirschman further elaborates the criterion of *dependability* by focusing on the use of multiple researches to enhance *dependability* (Hirschman 1986:245). As mentioned in paragraph 4.2.1., we have intentionally tried to use the advantage of being three researchers in the analysis by comparing interpretations to look for consistencies as this may make them more dependable, even though being aware that perfect correspondence between the researchers' interpretations is not expected, because the interaction between the individual researcher and phenomenon studied is unique (Hirschman 1986:245-246). This approach has been favourable, as we in several have made similar interpretations, thus this have enhanced the *dependability* of the thesis. However, there has of also been instances where consistencies have not been found between the researchers, where after the differing interpretations were discussed.

7.3. Transferability

Transferability is comparable to the notion of generalizability in positivist inquiries (Hirschman 1986:245). Nevertheless, *transferability* does not concern generalizability across populations and time, instead *transferability* of the manifestation of the phenomenon is an empirical matter, depending on the similarities between two contexts (Lincoln & Guba 1985:316). In stating that it is an empirical matter means that *transferability* can only happen by first comprehending and interpreting the characteristics of the second context (Hirschman 1986:245). The task of the researcher is thus to provide a thick description, on which others can make judgments about a possible transfer to another context (Lincoln & Guba 1985:316). As a consequence we have attempted to give thorough descriptions of the context e.g. in describing the Danish legislative context for marketing of prescription medicine in paragraph 2.1. as well as describing the informants, which is the basis of the constructed knowledge as seen in paragraph 6. This enhances the possibility for others to assess the transferability to other contexts. However, as we do not have insight into attitudes toward marketing of prescription medicine from other contexts we cannot assess the transferability of the findings of thesis. Nevertheless, as mentioned the informants is mostly university students and all from the Aalborg area, thus we do not necessarily believe that the findings are transferable as these are constructed in a specific context at a specific time.

7.4. *Credibility*

As an epistemological consequence of having a constructivist approach the knowledge constructed in this thesis is founded in the interaction between the informants and us as researchers (Kvale 1997:45-46; Guba 1990:27; Hirschman 1986:238; Bo 2002:70). Hence it is relevant to assess if the multiple constructions of the informants, in this case their attitudes, are represented adequately (Lincoln & Guba 1985:295-296). According to Lincoln & Guba one of the techniques of for increasing the likelihood of *credibility* is the technique of *prolonged*

engagement, which includes using sufficient time to know the context and culture of the issue studied (Lincoln & Guba 1985:295-296) in order to understand the informants' attitudes. As we ourselves are a part of the Danish context and especially live in the same geographical area as our informants, we claim that we have a profound understanding of their context, thus these insights could enhance the *credibility* of this thesis. Especially, as we are part of the same cultural context we have done our best to be mindful our own biases and values in the knowledge construction process as mentioned in paragraph 3.1. Consequently, we have been very aware of taking a point of departure in the informants' statements in the analysis in trying to understand their attitudes toward marketing of prescription in order not to distort (Lincoln & Guba 1985:302-303) these multiple constructions, however at the same being aware that we are a part of the construction of knowledge. Lincoln & Guba also contend that one must be aware of not going native, when engaging in *prolonged engagement* with the field (Lincoln & Guba 1985:303-304). In relation hereto, we do not assess this risk to be a major issue as our choice of methods i.e. interviews does not require us to spend extensive time with the informants as when using some types of participant observations (Gold 1958:220-221; Gans 1968:306/309/315-316; DeWalt & DeWalt 2002:18-19; Kristiansen & Krogstrup 1999:105; Hobbs 1988:6; Behar 1996:5). Thus the threat of over-identifying with the informants and thereby losing our academic perspective is evaluated to be minimized in this thesis. However, only having spend time with most of the informants once, seem to influence the *credibility* of this thesis in relation to *persistent observation*, which concerns identifying the relevant characteristics of the issue being studied and getting to know these in detail (Lincoln & Guba 1985:304). In this regard, our constructed knowledge have found several relevant characteristic that seem relevant, in aiming to understand the informants' attitudes and the constructions hereof, which have also been possible through being sensitized to the field be conducting interviews with US end-consumers and Danish GPs. However, the *credibility* of this thesis due its design of only having one encounter with the informants in focus group suffers in relation to getting in detail with the relevant aspects. Hence we have obtained an understanding of a range of aspects influencing the informants' attitude toward marketing of prescription medicine, which helps in adequately representing the multiple constructions of the informants, but the detail of understanding these aspects is not as profound as could wished. This could also be connected to the explorative purpose of this thesis.

In the aim of obtaining *credibility*, Lincoln & Guba have also suggested *member checks* as an important technique, thus letting the informants check the interpretations and conclusions (Lincoln & Guba 1985:314-316; Bloor 1983:157). As we are interested in the realities of the informants and want to be educated about their life world, it seems important to get the findings and interpretations evaluated by the people, who have originated the constructed knowledge (Hirschman 1986:244). However, this technique has not been used in this thesis

among others due to time constraints. Moreover, this technique has not been implemented, as it is likely that the informants could have a difficult time assessing the interpretations as the informants' statements are now in a different form and thus have been taken out of the context in which they were formed i.e. constructed in interaction with the other informants of the focus group. Additionally, as mentioned illness and medicine do not seem to be of general interest of the informants, thus due to the topic of this thesis the informants might also be likely not to be adequately involved in the check, which is also a reservation made by Bloor. This could lead to uncritical and superficial evaluations, thus not having the desired value (Bloor 1978:551; Bloor 1983:161-162). Instead of *member checks* we have as mentioned conducted supplementary interviews about topics and the individuals' attitudes, which after the focus group interview was thought to need further elaboration. This can enhance the *credibility* of the thesis as this increased understanding has led to a more adequate representation of the multiple constructions. Nevertheless, the enhancement of *credibility* of this thesis could have been furthered if supplementary interviews had been conducted with all of the informants.

Lastly it should be noted that as the attitudes' toward marketing of prescription medicine is a very complex matter including various aspects in the individual constructions hereof, is seems difficult to attain a complete understanding of this issue.

8

Conclusion: *Result of the Surgery*

In the wake of the proposal, which concerns allowing pharmaceutical companies to inform the public directly about prescription medicine in an objective manner - a practice which has so far been illegal in Denmark, a debate revolving around the implications of such legislative changes for the end-consumers has arisen. However, the Danish end-consumers have not been asked about their attitudes toward this practice. Closely related hereto, the end-consumers have so far only been given a voice in relation to DTCA of prescription medicine through one quantitative research. Thus this thesis has sought to explore and understand Danish end-consumers' attitudes toward marketing of prescription medicine and the formation of these attitudes. More specifically, in the role of end-consumers the informants' attitudes toward the EU-proposal and DTCA has been studied.

As seen in the two-part analysis above, we have tried to obtain an understanding of the informants' attitudes toward respectively DTCA and the proposal concerning allowing the pharmaceutical companies to inform directly to end-consumers. Our findings were characterised by the complexity in the informants' attitudes toward marketing of prescription medicine.

In this way, we interpreted their constructions of attitudes, which were in both cases anchored in a variety of aspects about which they either had beliefs, pre-existing attitudes or experiences with. As also seen in the two sum up's, these aspects lie at the heart of the complexities of the informants' attitudes, being considered by the informants – differing in whether one was aspect considered individually or in combination with other aspects. In this way, some of the informants anchored their attitudes in few aspect, where others considered a range of aspects, which were evaluated in terms of their *perceived relevance* for them, meaning that an aspect considered might seem to point a given informant's attitude in one *direction*, but as other aspects were considered as being more important for the informant, the *direction* of the attitude would not necessarily be congruent with all aspects considered. In this way, some of the informants mentioned both advantages and disadvantages of either DTCA or the proposal, but still ends up expressing having an attitude going in one *direction*. Some could be said to

hold attitudes of *moderate extremity*, as they evaluate and integrate both favourable and unfavourable aspects and/or acknowledge that they do not have sufficient knowledge or information thus being aware of the absence of important aspects in relation to the attitude object. Due to this complexity it was not possible to clear-cut place the informants in terms of *direction* and *extremity*. However, even though recognizing positive aspects of the practice, the majority tended to be negative toward DTCA of prescription medicine. In relation to the proposal it seems as if the informants' attitudes are more equally divided between positive and negative.

Thus from our constructed knowledge attitudes toward marketing of prescription medicine, seem to be very complex, subjective constructions, which can stem from and be affected by a vast array of aspects in the person's life world, which can be both individually and contextually dependent. In trying to answer our problem formulation in understanding these attitudes, we will now have a look at the aspects that the informants emphasize in their constructions hereof in relation respectively DTCA and the proposal.

8.1. DTCA

In regard to DTCA, several informants anchored their attitudes toward this in other attitude objects, which might be due to the informants not having an already formed attitude before the interviews. One attitude object, in which some informants anchored their attitude toward DTCA of prescription medicine, was the general and abstract category of advertising. An aspect in relation hereto that also seemed to influence the attitude construction toward DTCA, was the belief of whether one was able to sort out advertising or whether people would be influenced by it. Closely connected to the belief about the influence of advertising, some informants were concerned that it might create a need in society, whereby end-consumers might come to obtain unnecessary medicine, also leading to overconsumption of medicine. This is founded in a belief about advertising having the objective of selling people a given product, even though people do not need it. In continuation hereof the disadvantage of that it might thus lead people to believe they have illnesses that they do not have is mentioned, whereby some fear that the practice of DTCA could lead to more hypochondriacs and thus also more consumption of medicine as also mentioned by opponents of DTCA (Mintzes 2001:27). Connected to the objective of selling, another disadvantage brought out by informants, is that DTCA could make the medicinal product seem better and more harmless than it is, thus pointing at the presentation of the product. In this regard some informants furthermore seemed to perceive information brought by DTCA as unilateral and consequently not objective. In relation hereto, several informants mention the aspect of believing that people use medicine as an easy solution and in this regard, some informants are concerned that DTCA might promote medicine as a quick and easy way out and endorse that people will more easily turn to medi-

cine as a solution. In constructing their attitudes toward DTCA an aspect that also seems to be an anchor-point for some informants, is their attitudes toward intake of medicine in general. These informants see medicine as something one should try to avoid, as the body is believed to have the ability to heal itself, thus being against DTCA.

In the construction of attitudes toward DTCA, the product advertised for i.e. prescription medicine seems to be influential in their evaluation of DTCA. In this regard, some informants mention that medicine is a product which functions differently depending on the individual and it is mentioned that medicine could be potentially harmful. This view on medicine seems by some of the informants to influence their construction of their attitudes toward DTCA, as due to the nature of the product and its potential consequences, it is not a product that should be advertised for. This might again be connected to the potential disadvantage of DTCA leading to unnecessary needs and possibly hypochondria. However, some informants also mention that there might be possible advantages of DTCA, in that it might be helpful in giving attention to illnesses where people might be in need of other people showing them consideration in everyday life. Moreover DTCA is also mentioned to have the advantage of benefitting the end-consumers with knowledge of medical alternatives, thus informing and educating consumers as also mentioned by proponents of DTCA (Holmer 1999:380; Dubois 2003:99/101). Yet, these advantages does not seem as being aspects of high perceived relevance for most informants, as most of the informants have generally negative attitudes toward DTCA. However, this advantage is used by one of the informants in constructing a positive attitude toward DTCA.

Another aspect in trying to understand the informants' attitudes toward DTCA is the GPs' role, which seems to be of *perceived relevance* to many of the informants. However, a variety of different aspects are included, adding to the complexity of understanding the informants' attitudes toward DTCA. In relation hereto, a couple of informants perceived the practice of DTCA as unnecessary as they believed the GP to be the key person in consuming prescription medicine, thus devaluating the role of DTCA. Additionally, some informants anchor their negative attitudes toward DTCA in their belief that the GP should be the primary person in assessing whether you are ill or not and whether you should have some kind of medicine, which they believe should not be based on DTCA. Thus the doctor should stay a primary person in the deciding to consume prescription medicine. Connected hereto, the weight on the role of the GP is furthermore by some informants anchored in the belief that not all people are able to assess the information from DTCA and acquaint themselves with all the possible medicinal products, which is linked to these informants' trust and belief in the GP and his competencies. Thus these above aspects in relation to the GPs' role are used in constructing negative attitudes toward DTCA. One of the informants emphasizing the role of the GP in deciding whether to consume prescription medicine connects it to his positive attitude toward DTCA as he thinks that advertising is something that could be sorted out and therefore not something that would

influence him. In this way, he thinks that DTCA could be legalized as it will not affect him in the sense that the decision will always be made in cooperation with his GP. Another aspect in relation to the GP is the belief of him functioning as an intermediary and guardian, securing that people will not obtain medicine which they do not need. In continuation hereof some informants believed that if DTCA becomes legalized, the GP will get an even greater role in being a guardian. Hence it seems as if the informants' see the GP as having an important role in relation to the consumption of prescription medicine.

Despite most of the informants having negative attitudes toward DTCA, the informants' attitudes toward DTCA also seem to be affected by different types of prescription medicine. However, the informants being most either positive or negative, seemed to differentiate very little between different types of medicine, where the majority of the informants thought that there was differences between different types of prescription medicinal products. An aspect which seemed to influence, whether the informants found DTCA appropriate in relation to these different prescription medicinal products, was the seriousness of the illness the product was meant to treat, the seriousness of the product, including possible side-effects that the product can cause the end-consumers. In this regard, medicine for hypertension and medicine treating acne was by some perceived inappropriate to advertise for. Contrary, antihistamines were for most informants assessed relatively appropriate to advertise for, which was also found in a study by Miller & Waller (Miller & Waller 2004:399-400), due to the harmlessness of the product. Antihistamines were also found by the informants to lie closer to OTC medicine, which could influence their attitudes toward DTCA of this specific product. In relation hereto, whether a prescription medicinal product is of widespread use, also seemed to influence the informants' differentiation of the products in terms of appropriateness of DTCA, in relation to antihistamines and birth-control pills. Lifestyle was also an aspect the informants applied in assessing the appropriateness of advertising for a prescription medicinal product. Thus if the informants associated a condition with unhealthy lifestyle, then it were perceived inappropriate to advertise for, as they believed it could become an easy solution as also mentioned above, instead of doing other things in relation to one's lifestyle. The informants applied this reasoning in relation to medicine treating diabetes and hypertension. In continuation hereof the informants also found it inappropriate to advertise for conditions where they believed that medicine was not the only solution for the problem, in the sense that they believed that other means should solve the problem. This was especially in relation to impotence, sleeplessness and depression, which the informants seemed to assess as inappropriate, as they believed that people easily can identify with described symptoms, thus easily be convinced that they needed the product. This was also a concern expressed by informants in the study of Hausman (Hausman 2003:231). Thus this notion can again be connected to the informants being concerned of DTCA leading to overconsumption and use of unnecessary medicine.

Consequently, from our constructed knowledge there seems to be a vast array of aspects underlying the construction of the attitudes' *direction*, whereby these become highly complex.

8.2. The Proposal

One aspect that seemed to be of relevance for the informants in regard to the proposal, is the view of the pharmaceutical companies' ability to provide objective information, which as mentioned is an important part of the proposal. In line with Danish opponents of the proposal (Toustrup 2008:8-10; Huset Markedsføring 2009; Danske Patienter 2009:2), some informants were concerned as to the pharmaceutical industry's ability to provide objective information. Some argued for this concern by mentioning that companies are interested in selling their product, and in this regard some informants refer to it as advertising. Most of the informants stating their opinion about this matter, do not find the pharmaceutical companies credible as a provider of objective information about their own products, as one informant believed it could be possible for the pharmaceutical companies to present objective information. However, this belief is not decisive in influencing the *direction* of their attitudes toward the proposal, as mentioned in the analysis.

Another aspect of the proposal's design is the suggested media channel of the Internet. This media channel also seemed to have importance in relation to a couple of the informants' attitudes toward the proposal, who seemed to anchor their positive attitudes toward the proposal in the beliefs about this channel. In this regard, the Internet was preferred over other media channels, as the informants seem to think that searching for information on the Internet, makes the information resemble advertising to a lesser degree than other media channels where the information would be involuntarily encountered. Thus it seems that whether the media channel has a "push" or "pull" nature is of importance to these informants, where the "pull" nature of the Internet seems more favourable. This seems to be connected to some informants believing that people will only seek the information on the Internet if they are ill, which might also reduce the disadvantages of this proposal; hypochondria and unnecessary use of medicine. The favouring of the Internet as a media channel might also, as suggested in the analysis, be connected to social tendencies of the informants' generation to search information themselves, as indicated by some informants. In relation to channels of information some informants also emphasized the role of the GP in relation to the proposal, as with the informants' attitudes toward DTCA. Here a couple of informants thought that the GP should be the primary source for obtaining information about illness and medicine, as the GP has the required knowledge, which is linked to informants believing that one should trust the GP. This belief about the GPs' role as a primary source of information could be an anchor point for these informants' negative attitudes toward the proposal.

As with DTCA, some informants expressed worries about that enacting the proposal might lead to unnecessary use, hypochondria and create a demand for medicine. Another disadvantage mentioned by some informants is that people might misunderstand or misinterpret the information, because they do not have complete knowledge of the body and medicine as the GP has due to his education. This concern was also mentioned by a couple of GPs who believed it could confuse patients and create worries, as they would have difficulties in assessing and interpreting the information due insufficient medical knowledge. However, this aspect was not emphasized by the informants, for which different reasons were put forward in the analysis. Opposite of the informants arguing that the information might create misunderstandings, one informant instead emphasized that it could be reassuring on end-consumers who are ill. Another advantage posed by the informants, is that the information suggested from the proposal might provide end-consumers with information and knowledge, as well as educate them, as also noted by proponents for the proposal (Lif 2009: Lif 2011a: Toustrup 2008:10). Moreover, one informant emphasized the possibility of providing end-consumers with missing information in relation to their disease, where a couple of informants said that it might give knowledge about options for choosing medicine. These beliefs about the information's disadvantages and advantages seemed to influence their attitudes toward the proposal.

For some of the informants' who were positive toward the proposal, yet another element seemed important, which concerned the regulations and guidelines surrounding the proposal. In this regard, these informants found some kind of control necessary, in ensuring that a boundary between information and advertising was sustained. Thus their positive attitudes toward the proposal seemed to be reliant on their belief about regulatory control with the practice.

Hence, from our constructed knowledge about the informants' attitudes toward the proposal, it also appears that these are affected by a range of aspects. In this way, similarly to the informants' attitudes toward DTCA, the constructions of the attitudes toward the proposal also seem to be highly complex. Yet, it seems as if more informants are positive toward the proposal than toward DTCA, where this positivity seems to mainly stem from the fact that the information will be something the informants should themselves seek for, and additionally closely dependent on that this information would actually be objective, which are both aspects that informants seem to differentiate from advertising.

Consequently, and as it might be apparent from this paragraph, in trying to obtain an understanding and gain an insight into informants attitudes as Danish end-consumers toward marketing of prescription medicine - hereunder DTCA and the proposal of allowing the pharmaceutical companies to inform directly to the end-consumers, a variety of complexities revealed

itself. In this way, this explorative study, contributed to the knowledge gap in the sense that it was found that these Danish end-consumers' attitudes toward marketing of prescription medicine is highly complex as they are anchored in a variety of attitude objects about which they have beliefs about, experiences with or pre-existing attitudes toward, which affect each other crosswise as seen in the sum up's of the two analyses. Furthermore, in constructing these attitudes, the informants note both pros and cons in relation hereto, as also mentioned by opponents and proponents of DTCA and the proposal, whereby some of these might seem to find some kind of legitimacy in a Danish context, as these have thus been voiced from an end-consumer perspective instead of being argued on behalf of these. Yet, as the scope of this thesis is explorative, the findings should naturally merely be seen as indications and insights into the topic, which could guide further research. This can be also related to the specific group of informants in studying this topic in this thesis, as it has specific characteristics, whereby the findings might be influenced hereby. Consequently, other aspects might have been found to influence the construction of attitudes toward marketing of prescription medicine, if the composition of informants had been different. However, we have found a number of seemingly relevant characteristics in trying to understand these informants' attitudes. Nevertheless, due to the complexity of these informants' attitudes formed toward marketing of prescription medicine, additional studies might beneficially be conducted in going deeper into some of these aspects and pursuing aspects that this thesis also pointed toward but which were however not possible to go further into. Going deeper into the seemingly relevant aspects, might also be helpful in relation to providing more specific practical implications for legislators and marketers.

9 Appendix

9.1. Interview guides

9.1.1. Explorative Interviews with US end-consumers

Introduction

Thank you for participating and helping us with our master thesis. As we do not know how much Lauren have told you, we will tell you a bit about the subject we are writing about before we move on. We are writing about marketing of prescription medicine and we are interested in your point of view in order to get a deeper insight into the topic from a consumer perspective. To set the record straight, you will naturally be anonymous, but we would like to record it in order to remember it better.

Background information

Before talking about the topic, could you please tell a bit about yourself?

- Age, state, occupation

May I ask you if you have ever taken any prescription medicine?

Advertising of prescription medicine

As you probably know, advertising is legal for prescription medicine in the US. However, it is not legal in the European countries – including Denmark. What are your thoughts when I tell you this?

Have you noticed any advertising for prescription medicine? And can you tell us something about them?

- Do you reflect upon such advertisements? (*The sender, the specific product and the disease it is meant to treat*)

- *(NB: Which kind of information e.g. disease-awareness, product ads) content*

Have you deliberately taken any actions after seeing/hearing advertisements for prescription medicine?

- What do you intend to use it for? (*E.g. before visiting the GP*)
- Have you asked your GP for a specific brand or product?
- What do you think should be the GPs role in terms of prescription medicine?
- Do you seek health-related information on the Internet? (*Health, illnesses and medicine*)
- When seeking information on the Internet, do you reflect upon the sender? (*Whether it is information and advertisement*)
- How do you feel about the information you seek online compared to advertisements?

What is your attitude toward advertising for prescription medicine?

- We have read that there has been a lot of public debate in the US about this topic. Are you aware of this? How do respond to this debate?
- Which advantages and disadvantages do you see in advertising for prescription medicine?
- Do you feel different about advertisement for prescription medicine when used in different media channels? (*TV, printed, radio, Internet*)
- Do you think that there are kinds of prescription medicine that are more legitimate to advertise about than others?

Round-off

Do you have any additional thoughts?

Do you think it was difficult to reflect upon the topic? Why?

I think that was about that for us. Thanks a lot for helping us and have a great day.

9.1.2. GPs

Introduction

Thanks for wanting to help us. Our master thesis concerns marketing of prescription medicine from the pharmaceutical companies directly toward the end-consumers. We are interested in this as possible amendments will make it possible for the pharmaceutical companies to inform directly to the end-consumers about prescription medicine. In the master thesis our focus is the end-consumers and we are therefore interested in your experience in relation to the in-

teraction with patients in order to get an insight into the end-consumers/patients from a different perspective. More specifically, we are interested in your view on the end-consumers'/patients' use of information about health and medicine. To set the record straight, you will naturally be anonymous in our thesis and the recordings will only be available to us. We would very much like, that you tell everything that you find relevant and you are welcome to give examples, naturally without breaking your patient confidentiality.

Background information

Before we move onto the topic, can you please tell a bit about yourself?

- Age, how long you have been a GP, how many patients do you in average have a day

Topic

Do you experience in your daily practice, that your patients are engaged in health and illness?

- In which way, who and what?

Patients' information seeking/use of information

Do you notice that your patients have sought information about illness, symptoms or medicine before they come at your consultation?

- How do you notice that?
- Is it specific group that seem more informed/information seeking? (Age)
- Do you experience that people seek information about specific type of illnesses?
    - "Embarrassing diseases", less serious illnesses
- Do you notice that your patients have sought information other places, but without bringing it up during the consultation?

We talked to a group of end-consumers yesterday. They mentioned that they often seek information before going to the GP. In connection hereto, one mentioned that the person in question would never mention the acquired information during the consultation? Why do you think that is?

- Where do you think patients should primarily get their information about medicine and health?
- Differences in information channels? *(Explorative interviews)*
- People's reaction to the information they have acquired or have the possibility of acquiring? *(Explorative interviews)*
    - *Scared, stubborn/have decided, unnecessarily worried, self-diagnosis*
- Change in patients' behaviour while you have been a GP?

    - *More engaged in own health, more informed*
- Do you feel, that your expertise is questioned more often?
    - *Seek information after consultation or second opinion*
- How would you characterize your interaction and communication with the patients? *(Explorative interviews)*
    - *Dialogue, counselling, one-way, discussion, distributor – differences in age*
- Do patients ask for information besides the verbal conversation with you?
    - Which possibilities are there?
        - *Brochures, websites, books. Can we see some? Is some of it from the pharmaceutical companies? What do you say to that and what do the patients say?*

Over-the-counter Medicine

You talked about a change in patients' behaviour. Is that in your opinion connected to the fact that it was in 2003 made legal to advertise for OTC medicine?

- Do you feel, that your expertise is questioned more often?

What do you think about that this became legal?

Prescription medicine

As you might know, it is legal to market prescription medicine directly to end-consumers in the US and in New Zealand, but it is not legal in Denmark. What do you think about this difference?

In the EU it is being discussed, to liberalize the existing rules, in a way in which it will become legal to inform directly to the end-consumers about prescription medicine, albeit not through TV and radio.

What is your attitude toward the possibility of informing about products to the public?

- *Advantages/disadvantages*
- Do you think it will affect your interaction with the patients? *(Explorative interviews)*
    - *In what way, positive/negative*
- Do you think such changes would affect patients and their behaviour in relation to illness and use of medicine? *(Explorative interviews)*

Round-off

Do you have any supplemental thoughts about something we have not talked about?

Any questions?

Thanks for now – we have a little thing for you, as thank for your help.

9.1.3. Focus Groups

9.1.3.1. Background Questionnaire

- Name.
- Age.
- Occupation.
- Use a couple of minutes to write down your initial thoughts about the subject – marketing of prescription medicine to the end-consumers.
- How would you rate your knowledge about the subject on a scale from one to five? Please elaborate.
- Are you at the current moment taking any prescription medicine? If you wish, you are welcome to write which as well as how long you have been taking it.
- Have you earlier been taking any prescription medicine? If you wish, you are welcome to write which, as well as how long you took it.
- Is there anyone in your close social circle, who is taking any prescription medicine? If you wish, you are welcome to write which.
- Can we contact you again, if we have any further questions?

9.1.3.2. Interview Guide

Welcome

Welcome. Thanks for wanting to participate in this focus group in connection with our master thesis.

Orientation

Today, we are going to talk about marketing of prescription medicine.

Rules

I am the interviewer and XX who is sitting beside me, is here to see the big picture/create an overview/keep a sense of perspective for me. In the thesis you will naturally be anonymous but for the sake of the analysis we will record you in audio and video, which XX who is here in the back will control.

Our wish is naturally a natural conversation among you and therefore it is all right to ask each other questions. Naturally we will speak one at a time for the sake of the audio recording and therefore it is also best if you do not eat during the interview, but make do with drinking.

Moreover, we would like to hear everyone's opinion and there are no right or wrong thoughts. You are very welcome to tell about personal experiences if you wish. If I ask about something it is jus tin order to get the discussion going or to get back on track.

Program of the Day

We will slowly start out with talking broadly about the topic, which will slowly become narrower. Besides sitting and discussing we are going to play a little "game" and moreover we are going to see some TV-commercials. Additionally you will finally have to fill in a small evaluation scheme.

Round of Introduction

Before we start, we would like, if all of you would briefly tell your name and occupation.

Information society

Theory: Social role, informed consumer, consumer knowledge

- In your everyday life, are you generally concerned with health, illness and medicine?
- What are you concerned with when you are ill?
- Have you sought information related to health and illness?
    - *Internet (health portals, forums), friends, family, GP, apothecary.*
- Is there a difference in how you would like the information?
    - *To prevent illness, to fight illness. Depends on the situation.*
- What kind of information are you interested in? And from whom?
    - *Guides, prevention, side effects, diagnosis, symptoms, combating.*
- What do you want to use the information for?
- What do you think about the quality of the information?
- Have you sought information for others?
- How do you see the communication/interaction at the GPs? *(Explorative interviews)*
    - *Dialogue, monologue, discussion, advice.*
- What do you think about the GPs role in terms of prescription medicine? *(Explorative interviews)*
    - *Differences in how quick you seek the GP.*

- **Shift:** None of you have mentioned advertisements for over-the-counter medicine? What do you think about that?

Over-the-counter medicine

Theory: Formation of attitude through anchoring and adjustment

- Have you noticed any information/advertisements for over-the-counter medicine? Which?
    - *Show commercials (Zymelin, Kodimagnyl, Ipren, AC3 Comfort).*
- What do you think about them?
    - *Generally about advertising for over-the-counter medicine. Advantages, disadvantages – e.g. decrease taboos.*
- Have you in any way reacted to these? In which way?
    - Theory: Behavioural Intentions
    - *Change or affect behaviour. Searched online, asked at the apothecary, talked to GP, friends or family, bought it.*

Danish vs. American legislation

- It is legal to advertise for prescription medicine in the US and in New Zealand, but not in Europe and thus not in Denmark. What do you think about this difference?
- What are your thoughts when I say prescription medicine?
    - *Definition.*
- What are your opinions towards advertising of prescription medicine directly to the end-consumer?
- What are your opinions toward medicinal companies addressing you directly as end-consumers about prescription medicine?

Game – Differentiation of products

Each of the illnesses are placed on a continuum in relation to marketing and

- Why do you have this opinion?
    - *Which norms and values are these opinions founded in. What are the arguments (The GP is more trustworthy, social relevance, image, taboo concerning some types of medicine; a social role that you do not want to be connected to).*
- Are some media channels more suited or legitimate to use when advertising for this product? *(Explorative interviews)*

    - *Differences in how the information is presented. Neutral, happy, sad. Marketing versus information.*
- Can you mention other kinds of medicine?
    - *In relation to different places on the continuum/place them on the continuum.*

American advertisements

Show advertisements for prescription medicine. (Cymbalta – depression, Rozerem – sleeplessness, Latisse – eyelashlenghtener). Write thoughts down on paper.

- What are your immediate thoughts?
- What if you have the illness yourself? *(Explorative interviews)*
    - Theory: Personal relevance
- Which aspects do you see as important?
    - Theory: E.g. ELM. Cognitive or more fluffy aspects.
- Could such advertisements change or affect your behaviour? *(Explorative interviews)*
- Is there a difference between how you see advertisements in general and these advertisements?
- How would you like this information? *(Explorative interviews)*
    - *Information versus marketing. E.g. media channels.*
- If this became a reality in Denmark, do you think you would change your mind? Could something change your mind?
- Do you think there is a difference between advertising for over-the-counter medicine and prescription medicine?
    - Theory: Attitude formation. Constructive view or functional view.

Debriefing

- In the EU it is currently being considered to liberalize the legislation in a way, which will make it legal for to inform the consumers about prescription medicine – not advertisements through TV and radio.
- Do you have any further questions or thoughts?
- Thanks for wanting to participate. Then we have a brief evaluation scheme that we would like you to fill in, where you can decide whether you would like to be anonymous.

9.1.3.3. Evaluation Schema

- Name (optional).

- Do you think it was interesting to participate?
- Do you think it was a hard topic to discuss? Please elaborate.
- During the focus group, which aspects do you think was good and which things do you think was less good?
- Do you feel that you was heard and got your opinion across?
- Do you have any further comments?
- Yet again, thanks for the help!

9.2.4. Supplementary Interviews

The Proposal

What do you associate with information?

Explain proposal

- Purpose: To ensure assess to quality information about prescription medicine.
- Means: Will be objective information from pharmaceutical companies about medicine's characteristic and the illness it is to treat, *but* it cannot look like advertising.
- Information will be accessible on the Internet (*not* magazines, TV and radio).
- What do you think about this proposal?
    - Objective – what is understood by objective information?
    - Who can be the sender of objective information?
- Where is the boundary? (How liberal can it be).
- Rather advertising than information?
    - *Mads: "Well, offhand it sounds pretty harmless, but as it will be presented as being objective and as it might not be, then it might be more dangerous than advertisements, because you know that an advertisement, it's an advertisement, but if you read information and think they're objective and they're not, then it might be a bit more problematic."*
- Push and pull channels. Does it do any difference to seek one self and or to be exposed to it involuntarily.

Informationseeking

- Do you think you would use it?
- Do you think you would be able to navigate and see through the information? *(GP interviews – misunderstandings or worries).* What would you trust?

Advertisement of prescription medicine

- What is your general attitude toward advertisements for prescription medicine?
    - *Lonnie: "I just can't see why it should be necessary, when it's prescription, then you go talk to your GP."*
- Has the GPs' role any influence in relation to the attitude you have to advertisements for prescription medicine?
- Why/why not do you think advertisements and prescription medicine go together?
    - *Pia: "I think it seems wrong to advertise, or something that looks like advertisements, for prescription medicine"*
    - *Camilla: "I have a hard time, taking it seriously when they're advertising and I don't really think it fits with medicine actually. It kind of ruins my trust to the products"*
    - *Pia: "(…) In some way I think it seems, uhm, I shiver a bit over it, like untrustworthy, or like I think it's a bit, uhm, frightening with… medicine in some way, advertising for it as it was liver paste (…)"* (Appendix X, Pia:96)
- Is medicine a special product and why?
- Is medicine something the pharmaceutical companies cannot earn money on?
- It has been expressed that advertising for prescription medicine could influence end-consumers to take medicine. Do you think that you can take a stand in relation to such advertisements or should it advertisements for prescription medicine be regulated?
    - *Societal responsibility versus individual responsibility*. Should someone "protect" you?
- Could advertising for prescription medicine affect your decision about medicinal products? In which way?
    - *E.g. when being at the apothecary.*
- Differentiation of illnesses – weight on marketing in relation to?
    - What makes it ok to market some and not others?
    - Which factors play a role?
        - *How serious, lifestyle, abuse etc.*
    - In relation to proposal: Does this mean anything in relation to what prescription medicine is being informed about?

9.2. Analysis Strategy - Transcription

Moreover, we wish to transcribe word for word - also when words are repeated and furthermore also write when people are saying "Uhm" and "Mmm" (Kvale 1997:165/171-172; Stewart et al. 2007:111; Bloor et al. 2001:60; Halkier 2009:70-71). Thus we aim at transcribing as precisely as possible e.g. slang and incorrect inflections (Halkier 2009:71). In order to ensure an understanding of the informants' statements, the transcription will include sentences

where the informants are stumbling or tripping over the words or talking gibberish as a part of their immediate thinking as these might be vital part of trying to understand their meanings, knowledge and attitudes toward the topic. This could be edited in order to make it more readable (Atkinson 1992:25-26) but as these are a way of learning how informants think and talk about the topic (Stewart et al. 2007:111) the transcription will be just as the speech occurs and not edited (Bloor et al. 2001:60; Halkier 2009:71), thus comprising all the sentences said, which is preferable (Bloor et al. 2001:60). However, as the transcription should also be readable, we have written words correctly even though the informants at times cut of the endings of the words. In order to make the transcription more precisely understood when read (Kvale 1997:171) we will have a small set of "guidelines", as seen below, in order for all of us to transcribe in a specific manner:

Transcription	Meaning
Italic	When informants verbally emphasize words or sentences with their tone of voice (Templeton 1997:115)
(Parenthesis)	Will be used when people are laughing, when there is utter silence (Kvale 1997:165/171-172; Stewart et al. 2007:111; Bloor et al. 2001:60) or used for non-verbal communication, when it is vital for understanding (Stewart et al. 2007:111; Bloor et al. 2001:60)
…	Short pause (Kvale 1997:171).

Figure 16: "Guidelines" for transcription

All of these precautions are thus also a way for the reader to understand how the interviews went and what actually happened (Bloor et al. 2001:61). After transcribing the interviews we will listen to them again in order to decrease possible misunderstandings (Krueger 1993:114; Bloor et al. 2001:62; Halkier 2009:70-71) and, where words or passages cannot be figured out, the other members of the research team will listen to these.

9.3. List of Responsiblities[20]

[20] Unless otherwise is specified, a given paragraph is written among the authors of this thesis in collaboration.

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