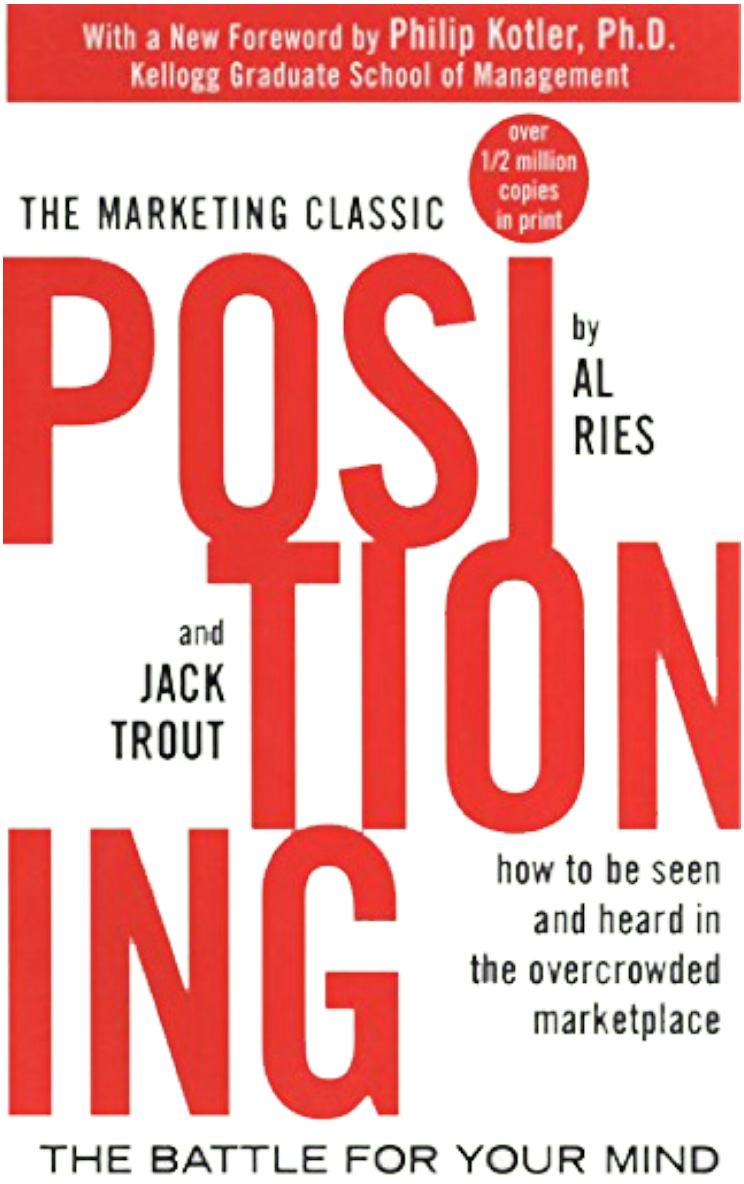
The "Death" of Product Positioning in Pharmaceutical Marketing



By Richard B. Vanderveer, *Ph.D.*
Chief Innovation Officer of ThinkGen

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This is Where it All Started

Several decades ago, Al Ries and Jack Trout wrote the book pictured on the first page. In it, they argued that in a very crowded marketplace, a marketer needs to follow some very specific principles of communications to get their product's story heard above the background noise, and to establish a beachhead in customers' minds.

At a time when new prescription products were being introduced into the American marketplace at breakneck speed, and when many of these products were virtually identical, the pharmaceutical industry welcomed Al and Jack with open arms. Product teams wandered around mumbling about concepts like "Aspirational Positioning," i.e., the way you want customers to be thinking about your product. As a result, "product positioning" became big business among marketing and marketing research consultants. In the ensuing years, tens of millions of dollars have been spent testing "positioning statements." ***Doctor, which of these statements do you find most compelling? Which do you find the most meaningful? Which is most likely to make you try the product? Etc.***

And as we sit here in 2019, this "positioning mania" continues to this day, moving commas around to create the best "message" to launch the product. Positioning continues to seek a unifying theme that will bond all of a brand's communications messages together.

There is only one problem with the Ries and Trout positioning mantra. Product success is not driven by which words a customer finds the most compelling (*whatever that means*) or which statement a customer finds most memorable. Or what turn of a phrase makes the product occupy a unique spot in the mind of the customer. Think about it. Can you really develop a loyal customer by continuing to say exactly the same words, time after time? Not likely!

A brief vignette to illustrate the point. At a recent pharmaceutical industry marketing research conference, a vendor was demonstrating a software package that purportedly could help the marketer decide what "message elements" should be combined to constitute the strongest message. At a workshop demonstration of this package, an attendee from one of the major pharmaceutical companies asked a great question. It went something like this:

"I understand how this software can help to develop the best story to tell the first time you go in to talk with a doctor about a new product, but what do you say or do on the second visit? Or the third? What do you do then?"

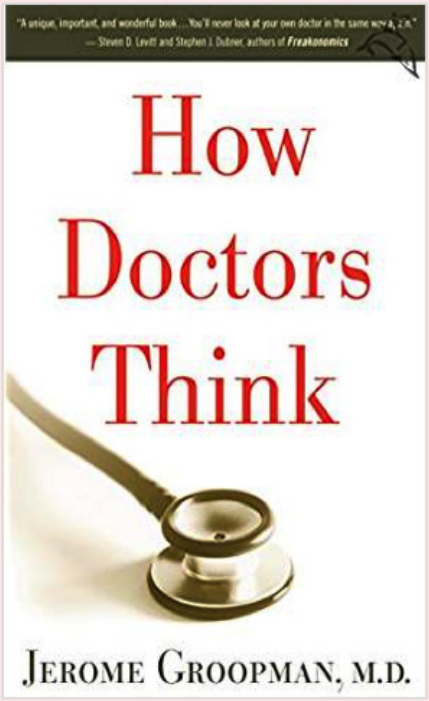
The presenter had no answer.

Another Product Positioning Fallacy

So here is another tough question. If we get that positioning statement stuck in the mind of customers, what do we expect them to do with it? Ask most pharmaceutical marketers this question in 2019, and they will tell you that they expect the positioning to influence "prescribing decisions." In the world that they envision, a doctor about to treat a patient goes through each and every possible drug that might be prescribed, and makes a prescribing "decision" based on which product has the best positioning. That is NOT the way things actually work in the practice of medicine.

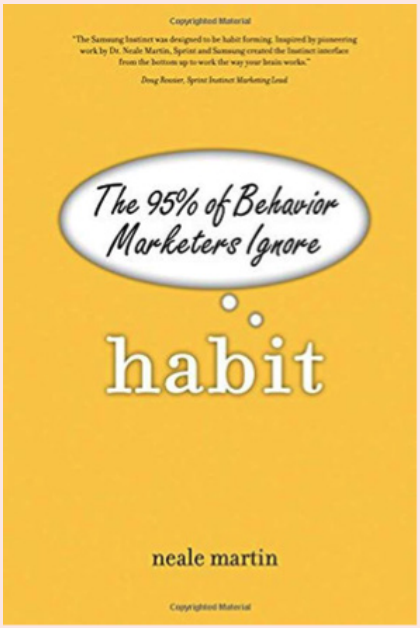
How Doctors Think

For example, consider the book, How Doctors Think. There is a tremendous amount of good information in this book, and as indicated by the title, it is a book that every pharmaceutical marketer and marketing researcher should read from cover to cover. Let me share just two of Dr. Groopman's most important and relevant insights. First, contrary to popular belief and medical school training, practicing physicians do not go through an exhaustive list of signs and symptoms to reach a differential diagnosis. Nope. They do pattern recognition. Often in only a few seconds. They do this just as a chess grandmaster plays multiple games at once, using pattern recognition on the various boards rather than considering individual moves. Second, once the diagnostic pattern is recognized, a treatment is selected based not on a systematic review of all options that are available, but on habit.



Habit

That takes us to the next and final book in our bibliography, **Habit.** Consider this "recent" offering. No, this book wasn't written yesterday. In fact, it was written over a decade ago. But most pharmaceutical marketers still have not come to understand the crucial role that habits play in marketing success. They don't understand that marketing success is not driven by pithy positioning statements, but rather depends on understanding "how to become your customer's habit." As we will see, making your product a "habit" is a lot more complicated than simply mouthing a catch phrase, but unfortunately making your product a habit is exactly what you need to do to get significant market share. Fortunately, we can tell you what you need to do to make your product part of a doctor's routine.



How Product Adoption Actually Works

In order to get a new product to become a habit of your customer, the pharmaceutical marketer must deal with the two separate minds of a potential customer, and must take that customer successfully through each of four separate steps. In classical parlance, these steps are:

- Awareness
- Interest
- Trial, and
- Usage

Arrayed according to marketing reality, they look like

Model 1

this:

In *Habit*, Dr. Neale Martin introduces us to the fact that everyone has two minds, the Executive Mind and the Habitual Mind. The Executive Mind, which does all of the intellectual "heavy lifting," resides in the frontal cortex, while the Habitual Mind, which takes care of most of our daily behavior, resides in the basal ganglia.

When a physician first becomes aware of a new product, her Executive Mind gets to work, giving the product an initial evaluation. If the product looks like it might have potential for offering something meaningfully new to her practice, she might then become interested enough to start to try to learn more about it. If further information continues to make the product appear interesting, she might proceed to a trial of the product. At the other end of this process, the doctor might decide based on the trial that she knows specifically where to use the product, and develop the habit of doing so under certain circumstances.

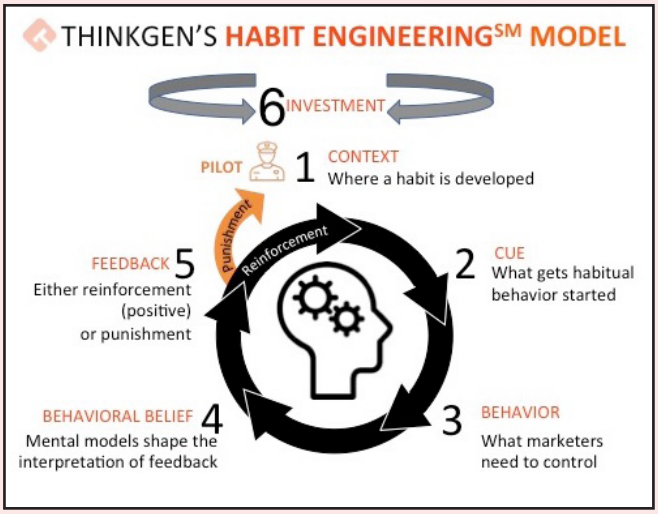
A couple things to note about this process. First, it is only at the Awareness and Interest stages that the product's message, its positioning, receives any attention whatsoever. By the time a product reaches the Trial stage with a physician, it is the product's actual performance that understandably becomes the physician's focus.

Second, it is at the Trial Stage that the product may progress from being actively thought about in the Executive Mind to residing more permanently in the Habitual Mind—if the Trial were successful. It is important to note here that there is no way for a product to be "positioned" or "messaged" directly into habitual usage. As will be discussed more thoroughly, the physician's behavior in trying the product and getting reinforcing feedback for doing so are the key steps in successfully bridging this gap.

But how does all this really work, and how does the marketer help the potential customer through each of these different steps? To help you to understand these important practicalities, we will need to explore a somewhat more detailed and complicated picture than the one that focuses on product positioning.

The ThinkGen Habit Engineering℠ Model

Take a look at this model:



Model 2

What you see here are ALL of the specific steps we must understand, and walk a physician through, to get from Awareness to habitual Usage. Let's look at them individually.

CONTEXT

Habitual behavior is seen under a specific set of circumstances and conditions. A good example, believe it or not, can be found in my refrigerator, which is actually three different habitual contexts. In the morning when I open the refrigerator door, the context is simple. I want orange juice! That's all I see. The habit? Grab a glass from the cabinet (I habitually use the same size glass for my OJ), pour the juice, end of story.

The lunchtime habit context is a little more complicated. I open the door and browse what is available that I might feel like eating at the time.

Dinnertime? Part of that context is completely habitual. Reach in and grab the chardonnay. Yes, it is always chardonnay, and always the same brand. Served in the same Riedel wine glass. All of this despite a fully stocked wine cellar.

No dinner food habit? Nope. My wife is in charge of that. I don't cook.

At this point, you might be asking yourself what the heck my refrigerator has to do with physician prescribing and pharmaceutical marketing. The answer? Everything! Doctors prescribing habits operate in a context. For example, the hospital. The office. The clinic. Each of these contexts creates a separate set of treatment habits.

CUE

Psychologists call this the "Stimulus". Once formed, this is what gets the habitual behavior started. A patient presents in the doctor's office with a urinary tract infection. A patient asks the doctor for help in losing weight. A patient reports that she is having painful intercourse. Each of these events, in many practices, sets off specific and predictable habitual behavior of tests, assessments, and treatments

BEHAVIOR

This is the part of the habit that we can see. And this is the part of the habit that the marketer needs to control. You might be thinking that this part of the habit should be fairly straightforward. The behavior of interest is the doctor simply writing a prescription, right? Not exactly!

Other key behaviors of interest include what advice the doctor offers the patient, what expectations he establishes for the patient in terms of efficacy and side effects, whether samples are distributed, whether the patient is told to make a follow up visit to evaluate the drug's performance, etc. As we will see in some examples, many of these behaviors are as important to control as the writing of the prescription in ensuring the success of a new pharmaceutical product.

BEHAVIORAL BELIEF

This is an aspect of habit formation that is especially important in pharmaceutical marketing.

For many consumer products, the reward one gets for using the product is immediate. Eat some ice cream; be rewarded by its good taste (Okay, let's forget the calories!).

But write a prescription for a statin product for hypercholesterolemia and what feedback does the doctor frequently get? Patient complaints about taking ***another*** pill, patient reports of leg cramps, diarrhea, etc. The bottom line here is that behavioral belief shapes the interpretation of feedback. A doctor needs to ***believe*** that writing the prescription for the statin is in the long-term best interest of the patient in order to be able to discount the short-term negatives. And for compliance, the patient must have the same behavior belief.

FEEDBACK

Feedback, be it reward and/or punishment, is what the physician receives as the result of writing the prescription for the product. It can come in such forms as patient comments about feeling much better or having side effects, or in the form of lab test results.

And here we find a fork in the road. If the doctor is rewarded for his behavior at the feedback stage, the likelihood of the behavior being repeated increases. Eventually, if all continues to go well, the doctor will get into "Autopilot" mode with the use of this product, i.e., using the product without a lot of thought or attention. If he is punished, the formation of the habit can get derailed as the Executive Mind ponders what went wrong and whether the use of the product should be continued. As Dr. Martin would describe this derailing outcome, the doctor's use of the product goes back into "Pilot" mode, with the doctor's conscious mind flying the "airplane" and paying close attention. (To complete Dr. Martin's model, a Co-Pilot mode exists between the two extremes. In Co-Pilot mode, the doctor is using heuristics and biases. For example, in Co-Pilot mode the doctor might use product X every time she encounters a patient with a particular condition ***unless*** the patient has a specific comorbidity).

INVESTMENT

As this habit cycle repeats itself time after time, the physician becomes "invested" in the product's use. She knows the outcomes she can expect. She knows what questions the patient will ask, and how to answer them. She knows which insurance companies will cover the drug, and which won't. Each time the doctor writes for the product, it therefore becomes easier for her to do so, which in turn makes it more difficult for another product to try to occupy the same slot.

As an example, think about Facebook. For most of us, we have spent embarrassing amounts of time using this app. We have established our timeline, populated the app through Friend Requests, pictures, etc. And we know very well how to navigate through the app's various features. All of our time and effort that we have made in FB are investments. And these investments make it difficult for another app to come along and replace Facebook in our daily activities.

Opportunities and Challenges

In the marketing of a new pharmaceutical product, it is important to note that a marketing team can have both opportunities and challenges at each of the stages in this habit cycle. It is essential that the marketing team have plans to support the product at all of these stages. Failure to do so can lead to a product getting "stalled" at one or more of these junctures.

Habit Disruption

Product management teams must keep in mind when they are about to introduce a new pharmaceutical product they will have to deal with ***all*** of the physician habits that are in place in the market they will be entering. Said another way, every treatment area is "full," even if there are no drugs available for a specific indication. Physicians have developed compensatory habits for dealing with everything that comes through their doors, and these habits need to be taken into consideration in deciding how, or even if, to enter a market. In fact, a number of Habit Engineering℠ projects we have done to try to assist underperforming products discovered that the major reason for the failure was the product teams did not take into consideration the entrenched nature of the habits their products would have to disrupt.

"Fight" or "Feed On"

Physician treatment habits are sometimes so difficult to "unlearn" that we recommend that clients not even try, at least in that particular market. In other cases, we were able to find ways in which a new product could "leverage" existing habits. In one Habit Engineering study we conducted, we determined that lower urinary tract symptoms often present as a "constellation" of daytime and nighttime symptoms. Physicians had deeply entrenched (long standing, frequently and consistently demonstrated) habits of treating only the daytime symptoms with one pill every morning, which they believed treated the nocturnal symptoms as well, though they admitted that they weren't sure how well. Therefore, rather than focus on patients with only nocturia (frequent nocturnal urination), we recommended that the client promote ***adding*** their product to the treatment regimen for patients with ***both*** diurnal and nocturnal symptoms to provide "uncompromising therapy." If research determines that existing physician habits do in fact need to be changed for the new product to succeed, the client needs to take a different tact.

Here, it is important to remember that habits can only be changed if they are elevated out of the Habitual Brain and back into the Executive Brain. How does a marketing team make that happen? Most typically, by changing the Context (see model 2) in which the habit has been formed, or the Cue to which it is a response. In another case on which we worked, for example, we found that doctors treated relatively unmotivated patients in a treatment area by offering them a cafeteria of different products and letting them choose which therapy best suited their needs. In that case, we worked with the client on ways to have patients identify themselves as being highly motivated and getting physicians to use our client's product for that treatment Context and Cue.

The Habit Blueprint℠

Hopefully, you are starting to get a feel for how all of this works. But let's crystalize it with the following thought.

In order to successfully introduce a new pharmaceutical product, you not only need a carefully thought out plan to optimize the product at each stage (Awareness, Interest, Trial, Usage), you need a plan to make your product a habit. To do that, marketers must address each of the six steps of the habit formation process.

1. Context
2. Cue
3. Behavior
4. Behavior belief
5. Feedback
6. Investment

This is ThinkGen's Habit Engineering Blueprint℠. It is an action plan not a "positioning statement." Habit Engineering provides specific direction to get a product through each of the necessary stages.

Examining the AITU model, for example, we must first create physician Awareness that the product

exists. We have nothing especially sage to discuss at this stage, since product awareness is raised through good, old-fashioned promotional media and PR. Where habit research can help is in understanding what messages are likely to resonate and how big a disruption is necessary to get a doctor to pay attention.

The Interest stage is where we see a product's "positioning" actually do its work. Quite simply, the information about the product that is initially presented must be sufficiently tantalizing for the physician to want to explore the product's use. But even here, traditional positioning can fall short. Why? So often a product team develops a positioning statement that focuses ***exclusively*** on their product and its benefits. If this view is sufficiently myopic as to ignore the existing physician habits in the treatment area, it will be difficult to gain marketing traction.

It is important to note that once a product has made its way through the Interest stage, the product's positioning loses much of its power to influence marketing outcomes.

If all has gone well up until this point, the product moves next to the Trial stage. This stage merits careful attention for several reasons. First, this stage deserves special focus since providing good support for the product at the Trial stage is so frequently ignored. More specifically, it is amazing to see how frequently marketers apparently believe that supporting a Trial is simply a matter of repeating the product's message over and over, rather than following the Trial hygiene principles discussed below.

In addition, as we have already discussed, it is the Trial stage that constitutes the all-important bridge between the Executive Mind and the Habitual Mind. It is this bridge that takes us from the Awareness and Interest stages where we want our customers to be thinking like crazy about our product, to the Usage stage, where they use the product automatically within a specific context. Habitually.

Finally, we need to focus on the Trial stage because it is here that so many things can go wrong. Here's how to do it right! Several decades ago, an advertising maven developed a process he called EST (Engineering Successful Trial). The skill set necessary to lead a physician through the conduct of a successful trial was taught to their Pharmaceutical Sales Representatives (PSR's) rather routinely in preparation for the launch of a product by their company. During this training, PSR's were taught to ask Physicians for:

- The Right Kinds of Patients. If the trial of a new drug in a doctor's practice is going to be successful, it must be conducted with the right "kinds" of patients. But what does this mean? Clearly, the product needs to be tried with patients with the approved condition(s). But what else?

Most importantly, we want the product to be tried with newly diagnosed patients who have not failed on one or more other therapies. This consideration is especially important, since many doctors, if left to their own devices, tend to try a new product as a "Hail Mary" effort for patients who have failed on everything else. A successful trial coming out of this latter group of patients is obviously rather unlikely.

Product Managers would also like to have their drug's trial be conducted with patients likely to adhere to the recommended regimens, starting with being able to afford the drug or co-pay.

- The Right Number of Patients. Recall that the habit formation process is a cycle. The more times the cycles is traversed, the more likely that a successful trial will be the outcome and a habit will be formed. If a product has a 60% efficacy, it is important that the Trial is large enough for the doctor to see the overall effects.
- For the Right Period of Time. Physicians ***and their trial patients*** must have reasonable expectations established as to how much of an effect they should expect to see. And when!

- With the Right Feedback. During the Trial stage, physicians must be encouraged to seek patient feedback actively. Failure to establish such appropriate follow up means that the only patients from whom a physician will hear about the drug are those calling to complain about the drug, the product's price, side effects, etc.

Once the product makes it into the Usage stage, the doctor has by definition decided where the product fits into his prescribing armamentarium. And the product team's job is done, right? Nope. Not by a longshot. There is still much work to be done. In the ThinkGen model, we call this work encouraging Investment. We need to continue to make sure that the doctor finds it worthwhile and easy to use the product compared to competitors which seek to unseat it. How do we do that? By Habit Maintenance, keeping the product part of the doctor's routine, supplied with patient aid materials if appropriate, and involving him in other programs that make it clear to him that the product is being used and positively perceived by colleagues.

Marketing Research Implications

So what do we learn from all of this? We learn that for a pharmaceutical company to launch a new product without a thorough understanding of the physician habits in the marketplace they will be entering is folly. The brand team needs a Habit Map℠ of what habits exist, how strong they are, and what we are going to have to do about them. AND. We need a Habit Blueprint℠ of what we are going to do to make sure that our product successfully traverses each step in the Habit Model. We need all of this before we go to market.

But, there is a hurdle to getting all of this information. And here it is. We often get asked a very good question by our clients' marketing research professionals. How, they want to know, do we conduct marketing research on habits for our Habit Maps℠ after we have just told them that habits are unconscious and not available to the Executive Mind questions? The answer is not an easy one. In order to gain an understanding of physicians' habits, we needed to develop a new marketing research methodology. We call that methodology Data Collection Encounters, or "DCE's." Unlike Individual Depth Interviews (IDI's), where the model is "Ask-Listen," the model of a DCE is "Listen-Ask." More specifically, in the most open-ended style you can imagine, we promise the doctor that we will listen carefully to her description of what kind of patients she encounters in a particular treatment area, what she does for them and why. And then we actively listen. Carefully. Here is an example of a setup question we use:

"My job today is simply to listen to you tell your story. Talk to me about how the treatment of____ fits into your practice. What kinds of patients are you seeing, what do you do for them and why? If there are multiple "kinds" of patients, please talk to me about them in descending order of frequency and tell me what differentiates them."

We then probe our way around the Habit Model to collect the data (Hence the name of this methodology!) to gather actionable insights.

For example, the first thing we probe to make sure that we understand is Context. Probes here deal with the conceptual environment in which the habit is being formed. Two specialist might look at the same patient through very different contexts. How big of a part does this treatment area play in the physician's practice? How does it relate to other parts of the practice? What are the defining characteristics of patients that fall into this treatment area? How do they differ? Specific probes are used to understand how each patient type "presents."

At the other end of the Habit Model, we probe to make sure that we understand Investments. Here we search for the extent to which the physician has begun to take "ownership" of the treatment approach. What has he done or what has happened to make the treatment approach likely to become a permanent part of his armamentarium?

Listening is the important skill in working with DCE's. What do we listen for as we go through this process?

- **Physician terminology**. The specific words that physicians use, and don't use, can be extremely important for marketers to note in understanding their habits. For example, we have already discussed the fact that in a recent Habit Engineering℠ case study, a product team believed that patients were presenting with nocturia, for which their product was specifically indicated. However, respondents in the Data Collection Encounters℠ for that study ***never*** used that term. Rather, they described patients as presenting with a "constellation" of lower urinary tract symptoms both day and night.
- **Habit catch phrases dealing with consistency.** If a doctor says "whenever I encounter_____, I always...," this is a reliable indicator that the doctor is on Autopilot in that behavior. On the other hand, comments like, "I sometimes...," "I either...," or "Recently, I have been trying...." indicate that the doctor is either in Copilot or Pilot mode.
- **Frequency.** A physician behavior that is exhibited frequently in the practice is likely to become habitual.
- **History.** A physician behavior that has been in place for a long period of time is likely to have become habitual.
- **Social norms.** If a physician perceives that what he is doing is consistent with the behavior of other physicians, and/or is a standard of care in a treatment area, that perception is supportive of the behavior becoming, and remaining, a habit.

Data collected in a series of DCE's are then reported out on a Habit Map℠ that follows the circular flow of the ThinkGen Habit Model

Bottom Line: So is Product Positioning in Pharmaceutical Marketing Really Dead?

Well, not exactly. Product teams, working with their advertising agencies, still need to figure out the best things to say about their product to get it through the Awareness and Interest stages of product adoption. There are, however, some old perspectives related to positioning and messaging that, if not dead are at least dying, and should probably be put out of their misery. On the critically ill list are:

- The belief that once a brand team has developed the "message" for the new product, they're work is done. Just keep shouting that message at the physician over and over, this belief holds, and he will prescribe your product. We now know this is wrong. Instead of just a positioning message, we now know that what we need is a Habit Blueprint℠ that will organize our efforts in ways consistent with supporting ***all*** of the steps in the Awareness, Interest, Trial and Usage product adoption model.
- The belief that what we are trying to influence is "prescribing decisions." Marketing success is defined by establishing "prescribing habits," and this is accomplished by carefully taking a product through all of the steps of the Habit Model with each physician.
- The belief that which "positioning statement" physicians find most "compelling" actually matters. The answers to most marketing research questions, we now know, come from the Executive Mind, and are largely out of touch with the Habitual Mind from which most prescribing behavior emanates.
- The belief that we can ignore the habits that already exist in the marketplace that we are entering and only focus on promoting the features and benefits of our own product.
- The belief that once we have created physician Trial of our product, that is the same as creating Usage.

In brief, we need to disabuse ourselves of all of these antiquated beliefs, and move on to firmly embrace the Habit Marketing paradigm.

About the Author

Dr. Richard Vanderveer has been a recognized leader in the field of pharmaceutical marketing and marketing research for over four decades. The origins of his career began at Temple University, where he received a Ph.D. in Industrial and Organizational Psychology. While at Temple, he honed his formal survey research skills as a Project Director for the University's Institute for Survey Research, which conducted large scale survey research for the Federal Government and other clients." Dr. Vanderveer then moved into the private consulting sector, becoming Director of Custom Research at IMS. A series of business roles followed. He is perhaps best known for his role as the founder of Physician *Micro*Marketing Inc., where he developed processes for pharmaceutical companies to use in targeting and customizing their promotional efforts to the specific mindset of the individual physician. His organizational career culminated in his role as CEO of GfK US Healthcare, where he directed and inspired a group of 225 marketing research professionals to leadership in his chosen field. In parallel, Dr. Vanderveer's efforts rapidly took on an international scope. Since retiring from his post at GfK, Dr. Vanderveer has had the luxury of studying the healthcare marketing scene at large, looking for "the next big thing" in pharmaceutical marketing. With his colleagues at ThinkGen, Dr. Vanderveer has been developing the ThinkGen Habit Engineering℠ Model.

Richard can be reached at:
richard.vanderveer@think-gen.com

About ThinkGen

ThinkGen is leading the way in healthcare marketing research. We believe that effective marketing is about creating customer habits, not just influencing decisions. Our research helps clients create plans for behavioral change. We are global in scope, led by highly experienced researchers, psychologists and the leading expert on Habit Marketing

More information can be found on ThinkGen's website: www.think-gen.com

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