ANONYMOUS NON-CONTACTABLE EMPLOYEE v BOEHRINGER INGELHEIM

Call rates

An anonymous, non-contactable employee of Boehringer Ingelheim complained about representatives' call rates and numbers of target customers. The complainant was concerned that a number of representatives had been managed out of the company for failing to hit their call rate targets; in that regard the complainant queried how representatives with fewer target customers could meet their daily call rates and still comply within the Code. The complainant referred to a culture of bullying and fear and that he/she could not discuss the matter with his/her first line manager for fear of being let go.

The detailed response from Boehringer Ingelheim is given below.

The Panel noted that as the anonymous complainant was non-contactable, it was not able to go back to him/her for further and better particulars.

The Panel noted that supplementary information to the Code stated, *inter alia,* that the number of calls made on a doctor or other prescriber by a representative each year should not normally exceed three on average. This did not include attendance at group meetings and the like, a visit requested by the doctor or other prescriber or a visit to follow up a report of an adverse reaction, all of which could be additional to the three visits allowed.

Based on the quoted activity rates, Boehringer Ingelheim assumed that the complainant had referred to a general medicine role. The Panel noted Boehringer Ingelheim's submission that the call rates per day cited by the complainant were not target call rates but overall target contact rates for individual primary care specialists (PCS) and therapy area specialists (TAS) respectively. The Panel noted Boehringer Ingelheim's explanation that as the minimum target list lengths in 2017 were 120 and 180 for the PCS and TAS roles respectively, and as the majority of interactions for general medicine were group meetings, these target list sizes were easily sufficient to ensure representatives were not required to breach the Code.

The Panel further noted Boehringer Ingelheim's submission that the average contact rate for a TAS was 76% of the target contacts/day and for a PCS 77% of the target contacts/day. The Panel noted Boehringer Ingelheim's calculations which showed an average of 0.83 and 1.28 unsolicited contacts per health professional per year for a PCS and TAS respectively. In the area with the smallest target list the maximum number of unsolicited calls would be 1.19 for a PCS and 1.92 for a TAS.

The Panel noted Boehringer Ingelheim's submission that whenever told about contact rates representatives were also reminded about the limit of 3 unsolicited calls per year under the Code. The Panel also noted that this reminder was not included in management forms which set performance objectives for 2017 and referred to the required contact rates. The Panel noted that the key account manager (KAM) performance objectives provided by Boehringer Ingelheim incorrectly referred to a minimum number of calls based on customer-facing days instead of the number of contacts and this document did not refer to the requirements of the Code.

The Panel noted that one incident of overcalling in general medicine was due to a failure to accurately record the nature of interactions namely that contacts at a group meeting were not correctly categorised. Whether a second incident of apparent overcalling was an error in recording or a genuine incident of overcalling could not be confirmed as the individual had left the company.

The Panel noted the complainant's comments about representatives being managed out of the company. The Code did not govern contractual matters such as general terms and conditions including the decision to invoke disciplinary proceedings and dismissal. The Panel also considered that if a company had created an environment where there was a clear unequivocal pressure to overcall, that environment might be relevant to matters potentially within the scope of the Code irrespective of the acceptability of briefing material. The Panel noted Boehringer Ingelheim's submission that no representatives had been managed out for failure to achieve a certain call rate, because Boehringer Ingelheim did not set call rate as a target. Nor had any representatives been managed out either for failure to achieve target contact rate or activity volumes. The Panel considered that in the particular circumstances of this case the complainant's narrow allegation about representatives being managed out of the company and a bullying culture were outside the scope of the Code; no breach of the Code was ruled.

Whilst the Panel had concerns regarding some matters outlined above, it noted the narrow allegation and that the complainant bore the burden of proof. The Panel did not consider that the complainant had established on the balance of probabilities that some representatives had only 60 target customers and a 'hit' rate of 4 per day which was likely to lead to a breach of the Code. Nor was the complainant's concern about target lists combined with call rates reflected in the briefing material. Based on the narrow allegation, the Panel ruled no breach of the Code including of Clause 2.

An anonymous, non-contactable employee of Boehringer Ingelheim complained about call rates and the number of target customers at the company.

COMPLAINT

The complainant was concerned about the number of representatives who had been managed out of the company because they had not hit their call rate per day in primary care or secondary care (details were provided). In that regard the complainant referred to at least 10 people in the last year in one particular region.

The complainant stated that he/she knew of some representatives who only had about 60 target customers; with a call rate of 4 per day, the complainant queried how they could comply with the Code in terms of activity.

The complainant referred to a bullying culture and a fear culture which made people ill. The complainant was saddened that good, honest representatives had lost their jobs because of call rates.

The complainant submitted that there was no point discussing the matter with his/her first line manager as it would be escalated up through the company and would result in the person who complained being subsequently no longer employed.

When writing to Boehringer Ingelheim, the Authority asked it to consider the requirements of Clauses 2, 9.1, 15.4 and 15.9.

RESPONSE

Boehringer Ingelheim explained that its sales force teams were divided into general medicine and specialty medicine. General medicine comprised the respiratory, cardiovascular and metabolic (diabetes) therapy areas, while specialty medicine comprised lytics (comprising Actilyse and Cathflo), idiopathic pulmonary fibrosis (referred to as IPF or Ofev) and oncology.

Customer-facing sales roles within general medicine comprised primary care specialists (PCS), therapy area specialists (TAS) and key account managers (KAM) within 22 defined geographic areas. TAS and KAM roles covered both primary and secondary care health professionals.

In specialty medicine, the customer-facing role was a key account specialist (KAS) or senior key account specialist (S-KAS). The number of geographic areas in specialty medicine varied by therapy area. KAS and S-KAS roles tended to be largely (but not exclusively) focussed on secondary care health professionals given the nature of the therapy area. The sales teams in lytics and IPF were much smaller than the other sales teams given the nature of these therapy areas.

When considering sales activity/activity rates/coverage, Boehringer Ingelheim explained that it used a defined target list for a given therapy area within a given geographic area. Target lists represented individual health professionals, in primary or secondary care, identified by a process of data analysis and input from local representatives as relevant to the therapy area and appropriate for promotional discussion. The local representatives had the final say on who was allocated to a target list based on their local insights. Boehringer Ingelheim submitted that it ensured that the target list was sufficiently long to ensure individuals could achieve the required activity levels without being under pressure to exceed the call limits set by the Code.

1 Clause 15.4: Frequency of calls

a) Call rate

Boehringer Ingelheim noted that although the complainant referred to target call rates per day these were not target call rates but overall target contact rates for individual general medicine representatives. 'Contact rate' was defined in accordance with in-house guidance issued in June 2016 on Clause 15 as:

i) those contacts that are speculative or appointments, which must not exceed 3 per year as clearly stated within the Code,

ii) those that are additional to the speculative call rate which includes: attendance at meetings (including audio-visual presentations), a visit which is requested by a doctor for example requested meeting interactions (contracting and follow ups) or contacts that are in response to an enquiry.'

Boehringer Ingelheim explained that contacts falling within i) above were classified as 'unsolicited' (ie not requested) and those which fell within ii) above as 'solicited' (ie requested by a health professional) and in this regard referred to an email to the sales force dated 3 June 2016.

Boehringer Ingelheim noted that the template performance measures (MAG) for a PCS and TAS clearly stated the required rate was a contact rate not a call rate.

Boehringer Ingelheim submitted that in general medicine, it measured its sales force on an overall activity volume, which was an aggregate of contact rates and expected days per year in the field to see health professionals. This could be achieved against any target health professional and included unsolicited and solicited contacts in an individual or a group meeting setting. Boehringer Ingelheim noted that the majority of contacts occurred in group meetings.

b) Target lists

Boehringer Ingelheim noted the complainant's reference to a representative with a target customer list of 60 individuals. Based on the quoted activity rates, the company assumed that the complainant had referred to a general medicine role. However, no representative in general medicine had such a small target customer list.

General medicine

In order to ensure that representatives had ample opportunity to achieve their target contact volumes within the Code requirements, Boehringer Ingelheim explained that it set minimum target list lengths for the PCS and TAS role. For example, in 2017 the minimum target list length for a PCS was 120; in 2016 it was 115. Typically, however, target lists were longer than this, for example the average list length for a PCS in general medicine was 173. As the majority of interactions for general medicine (on average 67.9% for PCS) were group meetings, target list sizes were easily sufficient to ensure representatives were not required to breach the Code.

By way of example, details of average target call rate and the number of working days giving an average contact rate for unsolicited contacts per year were given for PCS and TAS:

Boehringer Ingelheim noted that even in the area with the smallest target list size, the maximum of unsolicited calls would be 1.19 per health professional per year for a PCS or 1.92 for a TAS.

Boehringer Ingelheim submitted that the two worked examples given were conservative as other non-group meeting activities could also be classed as solicited by a health professional (requested visits, response to a specific enquiry, follow-up of an adverse event report).

The company provided the 2015-2017 target list analysis (2017 with full geographic breakdown) and examples of 2016 and 2017 targeting exercises which demonstrated minimum list length.

Boehringer Ingelheim submitted that whilst KAMs had a contact rate of 2 per day, they did not have a target list, so any contact with any health professional qualified as a contact. They were also only expected to spend three days a week in contact with customers. A copy of the KAM performance objectives was provided. Boehringer Ingelheim had identified that although the 2017 objectives for a KAM referred to a minimum number of calls based on customer-facing days, this was incorrect terminology and should refer to contacts. The company would ensure this was corrected but since KAMs did not have a target list and therefore could achieve this call rate by reference to any health professional, this would not advocate a breach of the Code.

Boehringer Ingelheim noted that while these contact rates were measured by the company, in practice the majority of representatives did not achieve them, therefore the above examples represented the worst case scenario in terms of call rate.

Specialty medicine

Although Boehringer Ingelheim did not believe that the complainant had referred to a specialty medicine role given the quoted contact rates, in the interests of completeness it nonetheless detailed the targeting process for each specialty medicine therapy area (IPF, lytics and oncology).

In specialty medicine a target list of customers (either at health professional or organisation level) was defined by the representatives and objectives were set in relation to coverage of those targets (where coverage meant there had been at least one interaction with that customer). An analysis of unsolicited contact rates (see section below on overcalling data) confirmed that no representative in specialty medicine had exceeded the limit of three per year.

- Idiopathic pulmonary fibrosis (IPF)

  In both 2016 and 2017, the incentive scheme implemented for the KAS and S-KAS IPF team set expectations of coverage of target customers. The key performance indicators set for a KAS/S-KAS in 2016 were 90% coverage of target A customers by April 2016 and 80% of target B customers by June 2016. Target A customers were health professionals that could prescribe Ofev ie clinical specialists, whereas target B customers were health professionals that could influence a choice of IPF therapy. In 2017, the target coverage rate for a KAS was 85%. IPF was an orphan indication and only treated in specialist centres in the UK, so the target list for different geographical areas varied.

  For the first half of 2017 additional guidance was communicated to the KAS team at the January sales conference 'At least 1 Platinum and 1 Silver/ Gold customer call per day on territory (daily unique health professionals >2) in 1:1/ group call'. This could be achieved against any target health professional within an organisation classified as Platinum, Silver or Gold and could include unsolicited and solicited contacts in an individual and a group meeting setting. This guidance did not form part of the formal performance management objectives for the IPF team as it was recognised that some of the representatives had smaller territories. The primary performance objective was the 85% coverage rate. Boehringer Ingelheim noted that the slide at issue also specifically included a reminder to the IPF team to comply with Clause 15.

- Lytics

  In the lytics therapy area, the targets were set in relation to coverage (which meant any contact with a customer) with reference to a target list of customers. There was no call rate or contact rate expectation. In 2017, the annual target for a KAS was 85% coverage on the target list. There was no minimum target customer list length set, but in 2016, representatives were encouraged to aim for at least a certain number of customers. Details of the 2017 total target list and the average was per representative were provided). Since the only target that Boehringer Ingelheim set was that a KAS should have one contact with 85% of their target list, this would not put them under any pressure to exceed the call rate limit.

- Oncology

  In oncology, the target customer coverage was 80% per six months (ie a maximum of 2 contacts per year) with local frequency key performance indicators of between 2 and 3 contacts per day for A and B target customers. Target A customers were prescribers and target B customers were clinical nurse specialists in lung cancer. The average target list length for an oncology KAS was provided as was the target customer-facing days per year, the size of the target lists was easily sufficient to ensure representatives were not put under pressure to breach the Code requirements to achieve activity targets.

  Boehringer Ingelheim noted that it had identified that the template performance requirements for an oncology KAS incorrectly referred to a requirement of 3 calls per day. This should refer to 3 contacts per day in line with the Boehringer Ingelheim definition, but the company understood from the sales operations manager for this team that this requirement was communicated correctly verbally, with a reminder about the requirements of Clause 15. Boehringer Ingelheim stated that it would ensure this was corrected although its data analysis revealed that no oncology KAS had called upon a health professional more than three times in a year.

c) Records of overcalling

Boehringer Ingelheim noted that within its customer relations management (CRM) system representatives could indicate whether a contact was solicited (ie requested by a health professional) or unsolicited (ie not requested by a health professional). Training on how to do this was provided to all new employees in their initial week's training programme.

Boehringer Ingelheim submitted that this complaint had triggered a detailed review of its CRM database over the last 24 months of contact history. It had run a report on all unsolicited interactions – which under the Code and consistent with in-house definitions must not exceed 3 per year – and identified instances where a representative had exceeded this frequency on a given health professional. The company provided the data and submitted that of these interactions, only 4% were considered to be unsolicited. One of the key drivers for this low figure was the high dependence that the company had on group meeting contacts, with over two thirds of interactions being this.

Analysis of the unsolicited interactions had identified one individual in general medicine who had recorded four unsolicited visits to one particular health professional. These interactions took place over two calendar years, but fell within a rolling twelve month period. Unfortunately, Boehringer Ingelheim could not establish if this was a genuine occurrence of overcalling, or a failure to accurately record the nature of interactions as the representative in question was currently on annual leave. An analysis of the interactions recorded as unsolicited by this representative highlighted some inaccuracies which required validation with the individual, for example he/she had recorded a number of group meeting contacts as unsolicited which was inappropriate. Boehringer Ingelheim undertook to investigate the case with the representative upon their return and provide the final findings to the Panel.

For completeness, Boehringer Ingelheim had also analysed the historic activity of a number of individuals who were no longer active users and had left the organisation. This figure was driven beyond normal staff turnover by a large organisational restructuring that took place in late 2015. Within this population a second individual was identified who saw a single doctor five times within both a calendar year and a rolling 12 month period. The representative held a multi-portfolio role working across four brands. Boehringer Ingelheim was unable to confirm whether this was an error in recording or reflected a genuine incident of overcalling.

The analysis of unsolicited activity had identified a training need for a small number of individuals to ensure that they were confident to accurately record contacts with health professionals in line with the company's definitions of solicited and unsolicited contacts. The potential for overcalling was limited to 0.225% of past and present representatives or 0.00049% of unsolicited activity.

Whilst the level of potential overcalling was extremely low, Boehringer Ingelheim submitted that it would ensure that:

1 Information was obtained from the current representative about the level of unsolicited contacts to confirm if overcalling had taken place. The outcome of this would follow.
2 Retraining was provided to the individuals identified as having recording inaccuracies, particularly in relation to classification of group meeting contacts.
3 The sales force activity dashboard was updated to allow easier monitoring of unsolicited contacts. Currently the report provided an overview of contacts with health professionals based on frequency which allowed managers to flag high frequencies of contacts and run further reports if necessary. However this included all contact types. Boehringer Ingelheim would add in the functionality to show this information by individual for health professionals and to distinguish between unsolicited and solicited contacts.

d) Managing representatives out for failure to meet call rates

Boehringer Ingelheim submitted that the complainant's statement that 10 people had left a particular region in the last year for failure to achieve call rates was not correct. No representatives had been managed out for failure to reach call rate, because Boehringer Ingelheim did not set call rates as a target. Although 7 people had left the named region in the last year, no representatives had been managed out either for failure to achieve target

contact rate or activity volumes. In fact, the majority of the field force did not achieve their target contact rates, so it would be impractical to operate in this manner. The average contact rate for a TAS was 76% of the target contacts/day and for a PCS 77% of the target contacts/day.

2 Clause 15.9: Briefing material

Boehringer Ingelheim provided copies of all documents sent to representatives in the last two years in relation to call/contact rates, split by therapy area. The company noted that it had described above the contact rate and target list process and submitted that none of the briefing materials provided advocated a course of action which would be likely to lead to a breach of the Code.

3 Clauses 9.1 and 2

Boehringer Ingelheim submitted that contrary to the complainant's assertion, it did not set a call rate for its representatives but did set a contact rate in the majority of its therapy areas. This varied between 2-4 per day.

Contact rates were clearly defined and included solicited and unsolicited interactions. When contact rates were communicated to representatives, they were reminded about the limit of 3 unsolicited calls per year under the Code. No documents advocated a course of action which would be likely to lead to a breach of the Code. Boehringer Ingelheim submitted that it had not managed out any representatives for failure to meet either expected call rates or expected contact rates. Target lists were set by a 'bottom-up' process with extensive input from representatives. These lists were of a sufficient size that representatives were not required to breach the Code in order to achieve their expected contact rate.

Boehringer Ingelheim submitted that it had not failed to maintain high standards nor had it brought the pharmaceutical industry into disrepute, it thus denied breaches of Clauses 9.1 and 2.

Summary

Boehringer Ingelheim submitted that the contact rates mentioned by the complainant applied to a PCS and a TAS in general medicine. However, the complainant had incorrectly represented this as a call rate rather than a contact rate. Boehringer Ingelheim had a clear definition of contacts and regularly reminded representatives that the limit of three calls should not be exceeded. In general medicine the smallest target list length per representative was 121 which, given the high rate of group meetings in primary care, would not put pressure on a representative to breach the limits under the Code (see worked examples above). Data showed that in practice representatives rarely even achieved the target contact rate. Accordingly, there had been no breach of the Code.

On analysis of its CRM records for the last 24 months, Boehringer Ingelheim had identified only two instances where the call rate limit of 3 might have potentially been exceeded. This represented an extremely small percentage of the overall number of unsolicited contacts. The company stated that it would be able to confirm or eliminate one of these when the relevant representative returned from annual leave, but would be unable to assess the remaining instance as it no longer employed the individual in question. A need for re-training in a small number of cases on how to accurately record customer interactions had been identified and new functionality would be added to its activity dashboard to facilitate easier monitoring of the unsolicited call rate by managers.

Further information

Boehringer Ingelheim noted that as detailed above, one of its representatives had called (unsolicited) four times on one health professional within a twelve month rolling period. Following that representative's return to work after annual leave, Boehringer Ingelheim conducted an investigation to ensure that the records of his/her interactions to date accurately reflected the nature of the interaction that occurred and that he/she was consistent with the company's definitions of contact type, which was in accordance with guidance on Clause 15 as:

i) Those that are speculative or appointments requested by a representative (which must not exceed 3 per year as clearly stated within the Code).

These types of contacts were classified as 'unsolicited' in the CRM system unless the appointment fell within the category below.

ii) Those that were additional to the unsolicited call rate which included:

- Attendance at group meetings (included audio-visual presentations),
- a visit which was requested by a doctor, for example requested meeting interactions (contracting and follow-ups), or contacts that were in response to a specific enquiry, or
- a visit to follow up a report of an adverse reaction.

These types of contacts were classified as 'solicited' in the CRM system.

Boehringer Ingelheim submitted that an exercise whereby the employee was provided with a file extract from the CRM system and asked to review his/her classification of interactions against the above definitions and to make any corrections if necessary, showed that the apparent overcalling was due to a failure to accurately record the nature of interactions. Specifically this was caused by contacts at a group meeting not being correctly categorised. The individual had confirmed the true nature of the interactions and the CRM system was being updated as appropriate. The individual had also been issued with training models aligned to CRM use for completion.

Boehringer Ingelheim was confident that the findings of the investigation were accurate, that the intervention was appropriate for the individual and

would prevent future errors of this nature. As noted above, the position with regard to the employee who had left the company could not be clarified.

PANEL RULING

The Panel noted that the complainant was anonymous and non-contactable. The Constitution and Procedure stated that anonymous complaints would be accepted, but that like all complaints, the complainant had the burden of proving his/her complaint on the balance of probabilities. The Panel was not able to go back to the complainant for further and better particulars.

The Panel noted that the supplementary information to Clause 15.4 stated, *inter alia*, that the number of calls made on a doctor or other prescriber by a representative each year should not normally exceed three on average. This did not include attendance at group meetings and the like, a visit requested by the doctor or other prescriber or a visit to follow up a report of an adverse reaction, all of which could be additional to the three visits allowed.

The Panel noted the complainant's concern that a number of representatives had been managed out of the company because they had not hit their call rate and that he/she queried how representatives with only 60 target customers could comply with the Code in terms of activity based on the required call rate.

Based on the quoted activity rates, Boehringer Ingelheim assumed that the complainant had referred to a general medicine role. The Panel could not contact the complainant for further information. The Panel noted Boehringer Ingelheim's submission that the call rates per day referred to by the complainant were not target call rates but overall target contact rates for individual primary care specialists (PCS) and therapy area specialists (TAS) respectively. The Panel noted Boehringer Ingelheim's explanation that it set minimum target list lengths for the PCS and TAS role. For example, in 2017 the minimum target list length for a PCS was 120 and in 2016 it was 115. Comparable figures for a TAS were 180 and 162. The Panel noted Boehringer Ingelheim's submission that actual target lists were typically longer than this. As the majority of interactions for general medicine were group meetings, target list sizes were easily sufficient to ensure representatives were not required to breach the Code.

The Panel further noted Boehringer Ingelheim's submission that the average contact rate for a TAS was 76% of the target contacts/day and for a PCS 77% of the target contacts/day. The Panel noted Boehringer Ingelheim's calculations which showed an average of 0.83 and 1.28 unsolicited contacts per health professional per year for a PCS and TAS respectively. In the area with the smallest target list the maximum number of unsolicited calls would be 1.19 for a PCS and 1.92 for a TAS.

The Panel noted Boehringer Ingelheim's submission that it ensured that the target list length was of a sufficient size to ensure individuals could achieve the required activity levels without being under pressure to exceed the call limits set by the Code and that local representatives had the final say on who was allocated to a target list. In that regard the Panel also noted Boehringer Ingelheim's submission that as the majority of interactions for general medicine were group meetings, target list sizes were easily sufficient to ensure representatives were not required to breach the Code.

The Panel noted Boehringer Ingelheim's submission that whenever contact rates were communicated to representatives, they were reminded about the limit of 3 unsolicited calls per year under the Code. The Panel also noted that this reminder was not included in the MAG & Talent Management forms 2017 which set performance objectives and referred to the required contact rates. The Panel noted that the KAM performance objectives provided by Boehringer Ingelheim incorrectly referred to a minimum number of calls based on customer-facing days instead of the number of contacts and this document made no reference to the requirements of Clause 15.

The Panel noted that one incident of overcalling in general medicine was due to a failure to accurately record the nature of interactions namely that contacts at a group meeting were not correctly categorised. Boehringer Ingelheim was unable to confirm whether a second incident of apparent overcalling was an error in recording or reflected a genuine incident of overcalling as the individual who held a multi-portfolio role had left the company.

The Panel noted Boehringer Ingelheim's submission that with regard to idiopathic pulmonary fibrosis (IPF) the incentive scheme implemented for the KAS and S-KAS team set expectations of coverage of target customers; the target coverage rate for a KAS in 2017 was 85%. Similarly in the lytics therapy area the targets were set in relation to coverage and the target for a KAS was 85%. There was no call or contact rate expectation. There was no minimum target customer list length set but in 2016 representatives were encouraged to aim for at least 80 customers which was similar to 2017.

The Panel noted Boehringer Ingelheim's submission that in oncology, the target customer coverage was 80% per six months (ie a maximum of 2 contacts per year) with local frequency key performance indicators of between 2 and 3 contacts per day for A and B target customers. Target A customers were prescribers and target B customers were clinical nurse specialists in lung cancer. The average target list length for an oncology KAS was provided and the number of customer-facing days per year. The Panel noted Boehringer Ingelheim's submission that the size of the target lists was easily sufficient to ensure representatives were not put under pressure to breach the Code requirements to achieve activity targets.

The Panel further noted Boehringer Ingelheim's submission that it had identified that the template performance requirements (MAG and Talent Management Form 2017) for an oncology KAS incorrectly referred to a requirement for 3 calls per

day and should have referred to 3 contacts per day in line with the Boehringer Ingelheim definition. The Panel noted Boehringer Ingelheim's submission that it understood from the sales operations manager of this team that this requirement was verbally communicated correctly, with a reminder about the requirements of Clause 15.

The Panel noted the complainant's comments about representatives being managed out of the company. The Code did not govern certain contractual matters between a representative and a pharmaceutical company such as general terms and conditions including the decision to invoke disciplinary proceedings and dismissal. The Panel also considered that if a company had created an environment where there was a clear unequivocal pressure to overcall, that environment might be relevant to matters potentially within the scope of the Code irrespective of the acceptability of briefing material. The Panel noted Boehringer Ingelheim's submission that no representatives had been managed out for failure to achieve a certain call rate, because Boehringer Ingelheim did not set call rate as a target. Nor had any representatives been managed out either for failure to achieve target contact rate or activity volumes. The Panel considered that in the particular circumstances of this case the complainant's narrow allegation about representatives being managed out of the company and a bullying culture were outside the scope of the Code; no breach of the Code was ruled.

Whilst the Panel had concerns regarding some matters outlined above, it noted the narrow nature of the allegation and that the complainant bore the burden of proof. The Panel did not consider that the complainant had established on the balance of probabilities that some representatives had only 60 target customers and a 'hit' rate of 4 per day which was likely to lead to a breach of the Code. Nor was the complainant's concern about target lists combined with call rates reflected in the briefing material. Based on the narrow allegation, the Panel ruled no breach of Clauses 15.4, 15.9, 9.1 and 2.

During its consideration of this case the Panel was concerned about the briefing material with regard to the varying explanations of calls and contacts. It was important that instructions to representatives about contact and call rates were consistent, clear and unambiguous across all communications to representatives and reflected the requirements of the Code as set out in the supplementary information to Clause 15.4.

The Panel was further concerned to note Boehringer Ingelheim's submission that while contact rates were measured by the company, in practice the majority of representatives did not achieve them. The Panel queried if by setting the activity targets so high in relation to contact rates it could be argued that they advocated a course of action which would be likely to lead to a breach of the Code. The Panel was also concerned to note that the requirements of Clause 15.4 were not referred to in all key documents that discussed call and contact rates.

The Panel asked that Boehringer Ingelheim be advised of its concerns.

Complaint received **25 April 2017**

Case completed **1 August 2017**