EDITORIAL

# Medical Marketing, Trust, and the Patient-Physician Relationship

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**Individuals in the United States** are adept at holding 2 competing views about health care: on one hand, health care revolves around a sacred compact between patients and clinicians and local institutions; on the other hand, health care is a business that operates on (regulated) market principles. The subject of medical marketing brings into relief the tension between these 2 understandings of the health care sector. Indeed, for many years the American Medical Association and the American Hospital Association forbade their members from advertising on the principle that it would subvert professional integrity and undermine patient and public trust. While marketing of health services by health care practitioners and organizations and by other suppliers (eg, pharmaceutical and device manufacturers and laboratories) to consumers has grown rapidly in the decades since those moratoria were lifted and US Food and Drug Administration rules clarified, medical marketing continues to be dominated by marketing to clinicians rather than from them. In this issue of *JAMA*, Schwartz and Woloshin[1] paint a vivid picture of this evolution across the spectrum of health care services, including both direct-to-consumer (DTC) advertising and marketing to professionals. What do these trends reveal about the changing nature of health care demand, the role of trusted health care professionals, and the need for policy intervention?

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The most striking pattern of change identified by Schwartz and Woloshin is the rapid increase in direct to consumer advertising from $2.1 billion (11.9% of the total of $17.7 billion) in medical marketing dollars in 1997 to $9.6 billion (32.0% of the total of $29.9 billion) in medical marketing in 2016.[1] The economic theory of advertising suggests that the level of investment in advertising for goods or services is a function of the responsiveness of demand to promotion and the profit margin associated with each sale.[2] All else equal, it can be inferred that disproportionate changes in medical marketing across categories (including marketing of drugs, disease awareness, health services, and laboratory testing) signal a change in one or both of these parameters.

In this case, the growth of DTC advertising reflects and benefits from the continued movement toward patient-centered health care, which emphasizes patient agency in directing and managing health and health care decisions. But while centering health care decisions on patient preferences is a positive trend, the expansion of DTC advertising remains controversial, with evidence of both benefits and harms.[1] For health care that is mediated by a clinician's order or prescription, DTC advertising by manufacturers increases the need for clinicians to help patients understand product claims, medical need, cost, and nonmedical alternatives.

Evidence that physicians have been either misled or otherwise persuaded to act based on fraudulent pharmaceutical marketing in recent decades, however, suggests that professionals may need further education or support to serve as the arbiter of deceptive marketing.[3] Moreover, the expectation that clinicians will prioritize the patient's well-being in making care recommendations breaks down when the clinician is linked with the manufacturer, as is the case with some advertised products that help patients to find a physician who can prescribe without ever meeting the patient face to face. Scrutiny of such arrangements to ensure they do not undermine the intent of existing licensure and regulatory regimes that govern prescribing seems warranted.

For services that patients can directly obtain, such as some genetic tests, the possibility that patients will not consult with a physician before purchase raises the stakes for ensuring that consumer information is as complete and balanced as possible. Medical supervision of these services by trusted physicians may provide a safeguard for patients against the misuse of potentially unreliable and misleading genetic test results. Oversight of advertising of products not regulated by the US Food and Drug Administration appears rudimentary at best, and the lack of documented enforcement actions alongside the increase in medical marketing as described by Schwartz and Woloshin,[1] for example by stem cell clinics and DTC of genetics tests, suggests the need for consumer protection agencies to shine a brighter light on this growing practice.

While still modest compared with pharmaceutical promotion to consumers, the increasing scale and scope of spending on advertising for health services between 1997 ($542 million) and 2016 ($2.9 billion) is notable.[1] At one level, such investments in advertising point to services for which clinicians and health care organizations likely can expect to earn high margins (eg, proton beam therapy, advanced imaging, and sports medicine), whereas primary care and some inpatient behavioral health services with lower revenue margins receive relatively little, if any, advertisement investment. As with pharmaceutical advertising, in which generic medicines are never promoted on television, the marketing of these products and services will tend to raise consumer awareness disproportionately about higher cost and potentially less cost-effective care. Therefore, even if the advertisements are unbiased, they can

distort the demand for health care in ways that lower the value of spending.

The renaissance of DTC advertising of health services raises another potentially more important issue. Even as the growth of DTC advertising increases the need for physicians to serve as their patients' information brokers, marketing by health care organizations (including a physician's employer, affiliate, or competitor) may at times create a conflict with this role. Physician endorsements of certain types of treatments, either explicit or implicit through affiliation with the marketing entity, may serve as cognitive shortcuts for patients that circumvent additional information seeking or deliberation and prompt incompletely informed decision making.

While the legal landscape appears bleak for those favoring a ban on marketing by clinicians or other health care suppliers, clinicians and health care entities may do well to consider the trust consequences of their marketing schemes. This trust is established in part by expectations that physicians eschew blatent profit-maximizing behaviors such as advertising and base clinical decisions on the objective evaluation of patient needs. As Arrow observed in his 1963 treatise on the economics of medical care, trust between physicians and patients is an essential ingredient in the market's ability to function, and its diminution could harm the public's health.[4]

Examining the effect of advertising and the level of patient wariness of physicians who accept industry-based payments, for example, could prove useful. Regulation intended to monitor industry practices that may not serve patients' best interests (eg, the Physician Payment Sunshine Act), provides opportunities for investigators to explore such inquiries, as well as opportunities to more accurately measure the extent of industry reach. For example, one recent study found that although two-thirds of 1987 respondents in the study saw a physician who received industry payments, only 5% of these respondents knew of these payments.[4] The study also found that a far lower percentage of respondents in states that had enacted similar reporting requirements prior to 2010 reported seeing a physician who received payments compared with respondents in nonreporting states. As Schwartz and Woloshin note, the Sunshine Act reporting requirements will expand in 2022 to include payments from industry to physician assistants and advanced practice nurses.[1] Still, despite broadened oversight, the degree to which the Sunshine Act can achieve its intended purpose may hinge on the level of patient knowledge about physician-industry relationships and awareness of the influence of such relationships on physician behavior.[5]

Medical marketing needs no apologist; legal doctrine is in its favor in the United States and the profit motive (even when tempered by a more benevolent mission) ensures that advertising of medical products and services will continue to increase. Nonetheless, advertising can produce benefits as both theory and empirical evidence suggest; for instance, patients can learn about conditions and treatments, causing them to seek beneficial care (whether they receive the service advertised or not).[6] The fact that advertising also clearly produces harm, and the recognition that medical marketing is increasing its scope and scale,[1] should be a call to action not only for regulators, but also for payers, physicians, and health care organizations. Each of these constituencies in the health care marketplace has a role to play in ensuring that medical marketing is not misleading, including not only the content of advertisements but also with respect to patient-physician relationships. Patients' trust in physicians puts them in a position to help mitigate the harms of DTC advertising. However, trust in physicians and health care institutions may be at stake if medical marketing by practitioners, health care organizations, and manufacturers of health care products continues to increase unchecked.

## ARTICLE INFORMATION

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