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## THE MEDIA, PUBLIC PERCEPTIONS & HEALTH, AND HEALTH POLICY

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### INTRODUCTION

The mass media are increasingly powerful in society, addressing the public with words and images at an extraordinary rate. Today, much of the media are controlled by special interests that seek to shape recipients' frames of reference whether to promote political or ideological attitudes or to entertain, promote products, or inform.<sup>1</sup> There is a great intermixture of purpose, often making it difficult to separate objective information from advertising and promotion. In this article, I illustrate this confusion by examining the managed care backlash and how selected images in news reporting and entertainment helped shape public conceptions that were highly discrepant with much of the evidence on performance of medical care models. I then examine the contentious issue of direct-to-consumer advertising and its influence. I consider some possible correctives that have been inadequately explored.

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<sup>1</sup> The media are increasingly concentrated across national markets and types of communication. Ben H. Bagdikian, former Dean of the Graduate School of Journalism at the University of California—Berkeley notes in *THE NEW MEDIA MONOPOLY* (2004), "Five global-dimension firms, operating with many of the characteristics of a cartel, own most of the newspapers, magazines, book publishers, motion picture studios, and radio and television stations in the United States." *Id.* at 3. He further notes in an interview that when they have dominance, "the less competition there is, the more control they have on what economists would call price and quality." Interview with Ben Bagdikian, *Smoke in the Eye, Frontline*, <http://www.pbs.org/wgbh/pages/frontline/smoke/interviews/bagdikian1.html> (last visited Aug. 8, 2005). One example of such partisan control is the Sinclair Broadcast Group, which allegedly planned a partisan political attack on presidential candidate Senator John Kerry on its sixty-two stations prior to the 2004 presidential election. See Jim Rutenberg, *Campaign Briefing: The Democrats: Party to File Complaint Against Broadcaster*, N.Y. TIMES, Oct. 12, 2004, at A22.

## I. THE INFLUENCE OF THE MEDIA

The media have immense influence on how people see the world. People directly experience only a small facet of institutions that affect them, so their conceptions of these institutions are fundamentally shaped by television, movies, radio, the Internet, newspapers, and magazines.<sup>2</sup> Such institutions include major corporations, mental hospitals, prisons, the CIA, and even Congress and the White House, and people's conceptions of these institutions come predominantly not from direct experience, or even the experiences of those they know, but from movies, television dramas, and other media portrayals. The media present conflicting and contradictory images, and the public selectively exposes itself on the basis of interests, ideologies, and personal inclinations.<sup>3</sup>

The media are shaped by varying values and interests, including the need to capture market share.<sup>4</sup> Thus, media producers and

<sup>2</sup> See, e.g., Jack C. Ling et al., *Social Marketing: Its Place in Public Health*, 13 ANN. REV. PUB. HEALTH 341, 342 (1992) (stating that social marketing is a means of using mass communication to influence personal choices and decisions).

<sup>3</sup> Leon Festinger, A THEORY OF COGNITIVE DISSONANCE (1957) established the theory and research approach that elucidated how persons selectively seek information to reduce decisional dissonance and this approach continues to influence work in this area. The media present contradictory and conflicting information and people vary in exposure and the credibility they attribute to various media. The Pew Research Center for the People and the Press in their 2005 *Trends* report reveal that more Republicans watch Fox News Channel than competing media, and Democrats prefer CNN. Democrats were much more likely than Republicans to believe CNN, *CBS News*, National Public Radio, *The News Hour with Jim Lehrer*, *60 Minutes* and *ABC News*. Republicans were less likely than Democrats to believe most news sources other than Fox News. Conservatives regularly watched or listened to Rush Limbaugh, the *O'Reilly Factor*, religious radio and Fox News, while liberals preferred NPR, literary magazines and political magazines. See PEW RESEARCH CENTER FOR THE PEOPLE AND THE PRESS, MEDIA: MORE VOICES, LESS CREDIBILITY, <http://people-press.org/commentary/pdf/105.pdf> (last visited Aug. 8, 2005). The Program on International Policy Attitudes (PIPA) used seven opinion polls in 2003 to study perceptions and beliefs about U.S. policy in the Iraq conflict. One analysis focused on the frequency of misperceptions concerning al-Qaeda links, whether weapons of mass destruction were found, and whether world opinion was favorable to the U.S. going to war. The extent of misperceptions varied substantially, and correlated with where people got most of their news. Eighty percent of Fox viewers reported at least one misperception; 23% of PBS-NPR viewers had misperceptions. It remains unclear to what extent people who have particular views seek out support for these views or how much different media shape these views. See Steven Kull et al., MISPERCEPTIONS, THE MEDIA AND THE IRAQ WAR, PIPA/KNOWLEDGE NETWORKS 2003, [http://www.pipa.org/OnlineRports/Iraq/Media\\_10\\_02\\_03\\_Report.pdf](http://www.pipa.org/OnlineRports/Iraq/Media_10_02_03_Report.pdf) (last visited Aug. 8, 2005).

<sup>4</sup> In seeking to recapture market share from Fox News, CNN's president, Jonathan Klein, is said to have adopted the mantra "that the network's prime time programs should spend less time reporting the news of the day and more time spinning out what he hopes are emotionally gripping, character-driven narratives pegged to recent events." See Jacques Steinberg, *CNN Seeks New Ways to Battle Fox News*, N. Y. TIMES, Mar. 23, 2005, at E1.

writers seek content that elicits interest and excitement, rather than trying to balance perspectives and information. News and entertainment, as well, are built on anecdotes and personal stories, often quite unrepresentative of the actual state of affairs. Scandals and violence, reports of abuse and corruption, and disagreements and controversy are more successful in eliciting interest than more bland—and perhaps more accurate—depictions of the state of affairs, the changing prevalence of crime, the rate of pregnancy among unmarried mothers, or the misdeeds of public officials. Some components of the media do strive to achieve accuracy and balance in their depiction of events—e.g., the *News Hour with Jim Lehrer* on PBS—but they too represent particular perspectives, and in any case are overshadowed by more popular media.<sup>5</sup>

The public, while nominally informed about social and political events, has the sense to be skeptical of what they hear, read and see. This skepticism is particularly keen when the matters are of personal concern. Surveys of the public repeatedly show considerable skepticism toward information about health coming from most formal sources of influence, including the media, advertising, health insurance plans, and government.<sup>6</sup> Overwhelmingly, when faced with important personal health choices, members of the public give more credence to information they glean from relatives, friends, neighbors, their personal physicians, or acquaintances who work in the health area.<sup>7</sup> Expertise, apparently, is also suspect, judging from surveys suggesting that people much prefer familiar hospitals to those recommended by experts.<sup>8</sup> Government agencies and other organizations provide information in their mission to improve consumer health choices. The public's skepticism about this information may not be unwise. However, such skepticism poses challenges in developing a competitive marketplace where consumer information assisting decision-making is intended to affect

<sup>5</sup> See sources cited, *supra* note 3 (reporting the variations in misperceptions about the Iraq war among persons who depend on various media for their primary source of news; only a small minority of respondents report PBS and NPR as their primary source of news).

<sup>6</sup> HENRY J. KAISER FAM. FOUND. & AGENCY FOR HEALTH CARE RESEARCH AND QUALITY, NATIONAL SURVEY ON AMERICANS AS HEALTH CARE CONSUMERS: AN UPDATE ON THE ROLE OF QUALITY INFORMATION (Dec. 2000), Survey Highlights at 6, available at <http://www.kff.org/kaiserpolls/3093-index.cfm> (last visited Aug. 8, 2005) [hereinafter KAISER FAM. FOUND., SURVEY].

<sup>7</sup> *Id.* at 6–8.

<sup>8</sup> *Id.* at 6–7.

the options available and allow consumers to obtain the price/quality mix they prefer.<sup>9</sup>

Underlying the distrust of efforts to influence their views and decisions is the public's view that the motives of media producers are suspect and lack credibility.<sup>10</sup> Thus, people often choose to consume media that already support their views and inclinations and avoid media that are discordant with their views.<sup>11</sup> Advertisers, whether of products or ideas, understand, however, that the consumer selection process is imperfect and that in any case, theme recognition is itself an important inducer to behavior and choice under uncertainty.<sup>12</sup> Having no idea which among many similar products is superior, we tend to prefer those that are familiar. The same might be said of ideas. Media can help frame our ways of looking at issues even when it fails to change specific opinions.

Credibility is key to issues of trust and influence. People are aware of and often wary of efforts to influence them. Direct programming such as political advertising seeking to change opinions and behaviors often fails because most of the public does not tune in. And, if they do, they often dismiss the credibility of the message. As a result of the above, those who seek to influence us have learned they can be more successful when "innocently" incorporating themes and messages into entertainment media.<sup>13</sup> All media project viewpoints, whether it be 1950s movies suggesting the im-

<sup>9</sup> Advocates for a more established medical marketplace aspired to promote quality of care by inducing patients and their representatives to be more prudent purchasers. They believed that providing appropriate information would encourage patients to make choices on quality as well as price and would induce providers to compete to provide the price/quality mix that consumers most preferred. The complex realities of health care provision made this an unlikely result. For a thoughtful and perceptive discussion, see Clark C. Havighurst, *How the Health Care Revolution Fell Short*, 65 LAW & CONTEMP. PROBS. 55, 67-77 (2002).

<sup>10</sup> Surveys persistently show preference for guidance by family, friends and personal physicians in contrast to formal sources of information including media. See KAISER FAM. FOUND., SURVEY, *supra* note 6.

<sup>11</sup> See generally FESTINGER, *supra* note 3 (discussing the theory of cognitive dissonance and how individuals strive to seek consistency within themselves).

<sup>12</sup> Branding can have advantages well beyond recognition, but brand recognition serves as an important reference influencing selection predisposition and thus is of significant value to marketers. For a thoughtful review, see Martha McEnally & Leslie de Chernatony, *The Evolving Nature of Branding: Consumer and Managerial Considerations*, 2 ACAD. MARKETING SCI. REV. 1 (1999), <http://www.amsreview.org/articles/mcenally02-1999.pdf> (last visited Aug. 8, 2005). For a detailed examination of cognitive processes in advertising, see generally INFORMATION PROCESSING RESEARCH IN ADVERTISING (Richard Harris ed. 1983).

<sup>13</sup> Jay A. Winsten, *Promoting Designated Drivers: The Harvard Alcohol Project*, 10 AM. J. PREVENTIVE MED. 11, 11-12 (Supp. 1 1994).

pending Communist menace, McCarthy-era paranoia, or today's programming that conveys the legitimacy of gay life.<sup>14</sup> Today we find commercial, political, and even health promotion organizations are paying to promote particular viewpoints, products and behavior. The goal is to place these viewpoints within entertainment programming and, increasingly, in news media.<sup>15</sup>

## II. THE MEDIA AND MEDICAL SCIENCE

The media play an important role in making new scientific information accessible to medical investigators as well as to the general public.<sup>16</sup> For scientists, the flow of information is overwhelming.<sup>17</sup> Additionally, search processes are imperfect. Thus, respected media such as the *New York Times*, *Wall Street Journal*, and *Washington Post* play a central role in disseminating important scientific information even among scientists.

An intriguing study by Phillips et al. examined the frequency of scientific citations for articles that appeared in the *New England Journal of Medicine* and were subsequently reported in the *New York Times*. This study took advantage of a "natural experiment"<sup>18</sup> when

<sup>14</sup> See, e.g., *THE RED MENACE* (Republic Pictures Corporation 1949) depicting Communist recruitment but eventual recognition of the communist threat to democracy; *THEM* (Warner Brothers 1954) in which mutant ants threaten American cities as army investigators search for ways to control their spread; *INVASION OF THE BODY SNATCHERS* (Walter Wanger Productions Inc. 1956) seen as a cautionary fable about black-listing hysteria; and more recently, *Queer Eye for the Straight Guy* (Bravo television broadcast, 2003), a "makeover" reality television program in which five gay men imbue a clueless straight man with good taste and fashion sense; and *Will and Grace* (NBC television broadcast, 1998-present), an NBC popular sitcom in which the titular male character is a gay man.

<sup>15</sup> See, e.g., Robert Pear, *Ruling Says White House's Medicare Videos Were Illegal*, N.Y. TIMES, May 20, 2004, at A1 (stating a recent ruling by the General Accountability Office (GAO) determined that the White House's efforts to provide and disseminate television segments as news was "covert propaganda" and illegal).

<sup>16</sup> David P. Phillips et al., *Importance of the Lay Press in the Transmission of Medical Knowledge to the Scientific Community*, 325 NEW ENG. J. MED. 1180, 1183 (1991).

<sup>17</sup> No one really knows how many medical journals there are and estimates vary greatly. However, there is almost unanimous agreement with Thomas H. Lee's view that today "few can hope to stay current in more than one or two fields" in medicine. Thomas H. Lee, *Quiet in the Library*, 352 NEW ENG. J. MED. 1068 (2005). Betsy Humphreys of the National Library of Medicine of the National Institutes of Health estimates the number of biomedical journals is between 15,000-17,000 (quoted in Wyatt Communication), <http://www.agmb.de/medibib-1/2000.09/msg00020.html> (last visited Oct. 7, 2005). For developments about a medical library of the future, see Donald A.B. Lindberg & Betsy L. Humphreys, 2015—*The Future of Medical Libraries*, 352 NEW ENG. J. MED. 1067, 1069-70 (2005).

<sup>18</sup> "A natural experiment is a naturally occurring instance of observable phenomena which approach or duplicate a scientific experiment." <http://encyclopedia.laborlawtalk.com/Natural%20experiment> (last visited Aug. 8, 2005).

the *New York Times* was on strike for three months.<sup>19</sup> Although during this period the *Times* produced an “edition of record,” it was not circulated.<sup>20</sup> The data revealed that papers published in the *New England Journal of Medicine* and subsequently reported in the *Times* received more scientific citations, than those not covered.<sup>21</sup> However, during the strike when the paper was not circulated, there was no difference in citation rates between scientific articles selected and those not selected for newspaper coverage.<sup>22</sup> Thus, newspaper coverage of scientific studies affected scientific citation rates.<sup>23</sup>

Because prestigious scientific journals are capable of influencing mainstream media, those seeking to influence health policy and decisions seek to have their research reported in these journals.<sup>24</sup> A contentious issue in health policy is the execution of clinical trials carried out directly by pharmaceutical companies or under contract with them.<sup>25</sup> And this is a growing trend.<sup>26</sup> Pharmaceutical companies organize in-house trials of their products, and then hire an information company to write up the trial and its results for publication.<sup>27</sup> For some of these papers, after the research has been done and drafts of the papers written, well-known professors are identified to serve as “authors.”<sup>28</sup> It is not clear to what extent these “authors” have an opportunity to see the raw data or to assess the integrity of the analysis.<sup>29</sup> Moreover, because the trials are increasingly carried out or controlled by interested pharmaceutical compa-

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<sup>19</sup> Phillips, *supra* note 16, at 1180.

<sup>20</sup> *Id.*

<sup>21</sup> *Id.* at 1181.

<sup>22</sup> *Id.*

<sup>23</sup> Phillips, *supra* note 16, at 1183. The study demonstrated that NEJM articles that were also reported in the *Times* were cited 72.8% more frequently than articles appearing in the NEJM and the uncirculated *Times* edition of record.

<sup>24</sup> Phillips, *supra* note 16, at 1183.

<sup>25</sup> David Healy & Dinah Cattell, *Interface Between Authorship, Industry and Science in the Domain of Therapeutics*, 183 BRIT. J. PSYCHIATRY 22, 22 (2003).

<sup>26</sup> MARCIA ANGELL, *THE TRUTH ABOUT THE DRUG COMPANIES: HOW THEY DECEIVE US AND WHAT TO DO ABOUT IT* (2004) writes, “I witnessed firsthand the influence of the industry on medical research during my two decades at *The New England Journal of Medicine* . . . I saw companies begin to exercise a level of control over the way research is done that was unheard of when I first came to the journal, and the aim was clearly to load the dice to make sure their drugs looked good.” *Id.* at xviii.

<sup>27</sup> Healy & Cattell, *supra* note 25, at 22–23.

<sup>28</sup> *Id.* at 23.

<sup>29</sup> *Id.* at 22, 25.

nies, data reflecting adversely on their products may be withheld from publication.<sup>30</sup>

David Healy and Dinah Cattell studied articles on sertraline, a commonly prescribed SSRI<sup>31</sup> sold in the United States under the brand name Zoloft.<sup>32</sup> They looked at two kinds of articles: those that were prepared by ghost-writing information agencies and those that were not.<sup>33</sup> The study revealed that articles prepared by these information agencies, as well as articles sponsored by pharmaceutical companies, are more likely to report positive results.<sup>34</sup> Additionally these ghostwritten articles had on average twice as many authors per paper, some with high name recognition, and were more likely to be published in more prestigious, high impact journals monitored by the media.<sup>35</sup> Ghostwritten articles were cited almost three times more often than were articles on sertraline not prepared or published by ghostwriters.<sup>36</sup> The scientific community engages in much soul-searching about the extent to which commercial and other interests penetrate and influence the scientific informational process and the resulting conflicts of interest.<sup>37</sup> They further wrestle with

<sup>30</sup> Kay Dickerson & Drummond Rennie, *Registering Clinical Trials*, 290 JAMA 516, 519 (2003) (In fact, “[t]here is evidence that many industry trials are never published.” A Maclean et al. study cited discovered that only 1 of 37 studies of non-steroidal anti-inflammatory drugs were published. As a result, there is now a growing interest in registering all clinical trial to reduce publication bias.) As Marcia Angell notes “[B]ias is now rampant in drug trials . . . . The most dramatic form of bias is out-and-out suppression of negative results.” ANGELL, *supra* note 26, at 106–09. See generally ANGELL, *supra* note 26, 106–14.

<sup>31</sup> See National Institute of Mental Health, Medications (explaining that Zoloft (sertraline) is a medication affecting the serotonin transmitter, one of a class of drugs called SSRI’s (selective serotonin reuptake inhibitors) including Prozac (fluoxetine), Luvox (fluvoxamine), Paxil (paroxetine) and Celexa (citalopram)), <http://www.nimh.nih.gov/publicat/medicate.cfm> (last visited Oct. 7, 2005).

<sup>32</sup> Healy & Cattell, *supra* note 25, at 22.

<sup>33</sup> *Id.* at 22. See also DAVID HEALY, LET THEM EAT PROZAC: THE UNHEALTHY RELATIONSHIP BETWEEN THE PHARMACEUTICAL INDUSTRY AND DEPRESSION (2004).

<sup>34</sup> Healy & Cattell, *supra* note 25, at 23–24.

<sup>35</sup> *Id.* at 23–25. See also Annette Flanagan et al., *Prevalence of Articles with Honorary Authors and Ghost Authors in Peer-Reviewed Medical Journals*, 280 JAMA 222, 222–23 (1998). In a study of a group of major medical journals the authors found that 19% of publications had evidence of honorary authors and 11% had ghost authors.

<sup>36</sup> Healy & Cattell, *supra* note 25, at 24.

<sup>37</sup> The New England Journal of Medicine, the Journal of the American Medical Association and many others publish many papers and editorials on these issues and continue to suggest refined policies concerning conflicts of interest. See, e.g., Catherine D. DeAngelis et al., *Reporting Financial Conflicts of Interest and Relationships Between Investigators and Research Sponsors*, 286 JAMA 89 (2001).

how to make these conflicts more visible.<sup>38</sup> The size, sophistication and influence of promoters of products and treatments make revealing the conflicts of interests an increasingly difficult challenge.

### III. THE MANAGED CARE BACKLASH

Managed care is not yet dead as some have maintained.<sup>39</sup> However, there is little doubt that health care plans and employers have retreated from many management strategies in the face of attacks by health care professionals and patients spurred on by sustained negative media coverage.<sup>40</sup> After the Clinton health plan failed to pass in 1994, employers increasingly turned to managed care organizations and care management strategies to deal with accelerating costs.<sup>41</sup> Throughout the 1990s strict managed care strategies successfully contained growth in costs.<sup>42</sup> Health care professionals resented reduced remuneration and eroding autonomy.<sup>43</sup> Patient advocates resented denial of services that patients or their doctors thought useful. Both groups did all they could do to undermine the new cost control strategies by using polemics, litigation and political action. The media's focus on horror stories of medical mistakes and inappropriate denials helped convey the belief that managed care reduced quality of medical services.<sup>44</sup> In this way, the media contributed to reduced trust in managed health care plans.

In contrast, any fair evaluation of the evidence would find that managed health care plan performance varied a great deal.<sup>45</sup> Simi-

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<sup>38</sup> See JEROME P. KASSIRER, *ON THE TAKE: HOW MEDICINE'S COMPLICITY WITH BIG BUSINESS CAN ENDANGER YOUR HEALTH* (2005).

<sup>39</sup> See generally James C. Robinson, *The End of Managed Care*, 285 JAMA 2622 (2001).

<sup>40</sup> See *infra* Section III, continuing discussion of the role of negative media coverage; David Mechanic, *Targeting HMOs: Stalemate in the U.S. Health Care Debate*, CONTEXTS, July 2004, at 27.

<sup>41</sup> For a thoughtful exposition of the dynamics underlying the failure of the Clinton health plan and its aftermath, see THEDA SKOCPOL, *BOOMERANG: HEALTH CARE REFORM AND THE TURN AGAINST GOVERNMENT* (1997).

<sup>42</sup> A 1996 analysis found that areas with high managed care penetration had much lower increases in costs. See generally Jack Zwanziger & Glenn A. Melnick, *Can Managed Care Plans Control Health Care Costs?*, 15 HEALTH AFF. 185, 199 (1996).

<sup>43</sup> See generally Jerome P. Kassirer, *Doctor Discontent*, 339 NEW ENG. J. MED. 1543 (1998).

<sup>44</sup> *Health Care Horror Stories Are Compelling But One-Sided*, N.Y. TIMES, Oct. 12, 1999, at A29.

<sup>45</sup> See Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, 16 HEALTH AFF. 8, 22 (1997) (concluding that fears that HMOs lead uniformly to poor care quality was not supported by the evidence. There were equal numbers of significantly better and worse HMO results in comparison to non-HMOs.).



larly there was a large variability in performance within all models of health care delivery.<sup>46</sup> Lastly, a fair evaluation of the evidence would reveal that HMOs and other managed care approaches had outcomes comparable to the traditional fee-for-service system.<sup>47</sup> Although fee-for-service performed better on some dimensions such as patient satisfaction, managed care provided more preventive services, had lower costs and involved less paperwork. However, studies looking specifically at quality of care outcomes found little to distinguish one health care delivery mode from another.<sup>48</sup> The majority of insured people, regardless of their type of health care plan, are reasonably satisfied with it. The media's negative coverage led a majority of the public to believe that HMOs were more concerned with costs and profits than with health and welfare.<sup>49</sup>

#### A. Media Facilitates the Backlash

A Kaiser Family Foundation study examined seventy-four episodes of four popular prime time hospital dramas for the 2000-2001 TV season: *Gideon's Crossing* (ABC); *City of Angels* (CBS); *ER* (NBC); and *Strong Medicine* (Lifetime Cable Network).<sup>50</sup> The study revealed that most health policy themes were discussed fairly and impartially by the programs.<sup>51</sup> However, the six episodes referencing HMOs were "portrayed" negatively.<sup>52</sup> Similarly, lawyers and insurance companies were also treated more negatively than positively.<sup>53</sup> The survey also examined respondents' knowledge of the movie *John Q.*<sup>54</sup> The movie tells the story of a young boy who is denied a lifesaving heart transplant because his insurance policy will not cover it, and the hospital insists upon a \$75,000 advance cash payment.<sup>55</sup> Among respondents who knew of the movie, 70% ex-

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<sup>46</sup> *Id.*

<sup>47</sup> *Id.* at 13-14.

<sup>48</sup> *Id.*

<sup>49</sup> Robert J. Blendon et al., *Understanding the Managed Care Backlash*, 17 HEALTH AFF. 80, 81, 84 (1998).

<sup>50</sup> Joseph Turow & Rachel Gans, *As Seen on TV: Health Policy Issues in TV's Medical Dramas*, HENRY J. KAISER FAM. FOUND. 4 (2002).

<sup>51</sup> *Id.* at 22.

<sup>52</sup> *Id.* at 19.

<sup>53</sup> *Id.*

<sup>54</sup> HENRY J. KAISER FAM. FOUND., NEWS RELEASE, TV MEDICAL DRAMAS ADDRESS HEALTH POLICY ISSUES, NEW STUDY FINDS (2002), available at <http://www.kff.org/entmedia/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13993> (last visited Aug. 8, 2005).

<sup>55</sup> *Id.*

pressed the belief that insurers refuse to pay for treatments like those described in the movie, and 42% of those reported it happens a lot.<sup>56</sup>

A conspiracy theory is not required to explain this phenomenon, although some consumer groups and health care professionals have an interest in providing negative images of HMOs to the media. Those familiar with the managed care industry well understand the large variability in strategies and approaches. The terms “managed care” and “HMOs” as the media presented them took on a generic identity that had little basis in reality.<sup>57</sup> Consolidation of large national health care plans made this negativity influential because isolated errors were no longer seen simply as aberrations, but rather as emblematic of how these large plans functioned.<sup>58</sup> There have always been examples of poor judgment in health care decisions among the hundreds of millions of medical transactions.<sup>59</sup> What was different now was that such events could be linked more easily to large, centralized organizations.<sup>60</sup>

Characteristics of the media market also facilitated the backlash. Evaluations of managed care strategies were complex, contained many uncertainties, and were not easy to explain or even understand. Stories reflecting those complexities and uncertainties were not likely to garner public interest, except perhaps among some niche audiences. However, stories involving treatment denials and mistakes, lack of empathy, and putting profits ahead of people promised greater public interest. Also, it was easier to demonize managed care in movies and television dramas by focusing on desperate people dealing with HMO denials than to convey the value of the trade-offs that HMOs were trying to make. Underlying the backlash was the public's unwillingness to understand and accept the need to balance care provisions in relation to available resources.<sup>61</sup> The notion of care rationing, which remains an anathema in American medical politics, is not a concept which the media ex-

<sup>56</sup> *Id.*

<sup>57</sup> David Mechanic, *Managed Care as a Target of Distrust*, 277 JAMA 1810 (1997).

<sup>58</sup> *Id.* at 1810–11.

<sup>59</sup> *Id.* at 1811.

<sup>60</sup> See JAMES C. ROBINSON, *THE CORPORATE PRACTICE OF MEDICINE: COMPETITION AND INNOVATION IN HEALTH CARE* (1999) (describing realignments of corporate medicine); for an update on more recent trends, see J.C. Robinson, *Entrepreneurial Challenges to Integrated Health Care*, in *POLICY CHALLENGES IN MODERN HEALTH CARE* 53–67 (David Mechanic et al. eds., Rutgers University Press 2005).

<sup>61</sup> See generally David Mechanic, *The Rise and Fall of Managed Care*, 45 J. HEALTH & SOC. BEHAVIOR 76 (2004). For a thoughtful exposition of the gap between expectations and reali-

plains well. In short, there were two levels of discourse on managed care. The first level focused on collective evidence of complexity, variability and uncertainty. The second discussion was based on anecdotes that fed the public's anxiety and vulnerability about dealing with illness. The media could deal more easily with notions of patients being managed "quicker and sicker," "gag rules," and patients being run through care on a treadmill than with the fact that these allegations were suspect and not necessarily representative of the reality.<sup>62</sup> An illustration of the above was a request I received from a medical publication to fact check one of their stories that was based on one of our research publications. After I twice reviewed the medical publication for accuracy and provided factual correction, the reporter finally got the description correct. However, she then concluded with a medical editor's note basically contradicting the correction. When I told her that the editor's note contradicted the text I was told, "I know what you are saying is that the data does not uphold his comment, but I am going to leave it in there as an editor's note, because it is in his experience."<sup>63</sup>

### B. Gag Rules: An Illustration of Media Facilitation

Of course, media differ. Coverage of events in sources such as the *New York Times*, the *Washington Post*, and the *Wall Street Journal* plays an important role in influencing other media and public opinion. For example, on December 21, 1996 Robert Pear wrote an article on gag rules<sup>64</sup> which appeared in the *New York Times*. The article was based, in part, on an editorial about corporate medicine.<sup>65</sup> The editorial by Steffie Woolhandler and David Himmelstein appeared in the *New England Journal of Medicine* and concluded with a foot-

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ties, see RICHARD A. DEYO & DONALD L. PATRICK, *HOPE OR HYPE: THE OBSESSION WITH MEDICAL ADVANCES AND THE HIGH COST OF FALSE PROMISES* (2005).

<sup>62</sup> David Mechanic, *The Managed Care Backlash: Perceptions and Rhetoric in Health Care Policy and the Potential for Health Care Reform*, 79 *MILBANK Q.* 35 (2001) [hereinafter *Mechanic, Backlash*].

<sup>63</sup> David Mechanic & Donna D. McAlpine, "Fifteen Minutes of Fame": *Reflections on the Uses of Health Research, the Media, Pundits, and the Spin*, 20 *HEALTH AFF.* 211 (2001).

<sup>64</sup> Gag rules generally refer to clauses in contracts between providers and health plans that appear to prohibit or limit providers from speaking to patients about coverage and treatment determinations made by the plan; see SARA ROSENBAUM ET AL., *CENTER FOR HEALTH POLICY RESEARCH, AN EVALUATION OF CONTRACTS BETWEEN MANAGED CARE ORGANIZATIONS AND SUBSTANCE ABUSE TREATMENT AND PREVENTION AGENCIES* (1997) (Among the 50 contracts the authors studied, only two had clauses that could be construed as "gag clauses.").

<sup>65</sup> Robert Pear, *Doctors Say HMOs Limit What They Can Tell Their Patients*, *N.Y. TIMES*, Dec. 21, 1995, at A1.

note stating that Dr. Himmelstein's contract with U.S. Healthcare was terminated without cause.<sup>66</sup> This suggests that corporate medicine would and does punish its critics. Pear's investigations discovered some instances of gag rules, including a directive to physicians from an Ohio Kaiser Permanente Group that prohibited doctors from discussing proposed treatments with patients prior to receiving treatment authorization.<sup>67</sup> This story initiated a significant national debate on gag rules.

In reality it turns out that gag rules were uncommon and, in the Kaiser example, the prohibition was a rare instance and counter to Kaiser Permanente policy.<sup>68</sup> Studies reviewing samples of contracts between physicians and HMOs found that "gag rules" were rare, although non-solicitation, non-disparagement and confidentiality clauses were common.<sup>69</sup> The General Accounting Office (now called the General Accountability Office) studied gag rules, interviewed physicians, and concluded that gag rules were rare, and non-solicitous, non-disparagement and confidentiality clauses were not likely to have a significant impact on physicians' actions or limit physicians' discussions of all treatment options with patients.<sup>70</sup>

Gag rules have considerable symbolic significance because they speak to the core meaning of doctor-patient relationships and to patients' strong beliefs that their doctor must be committed above all to promoting their welfare and interests. The prestigious *New England Journal of Medicine* (whose editors were hostile to managed care<sup>71</sup>) and the *New York Times* had extraordinary impact on other media, public opinion and the political process.<sup>72</sup> These well placed

<sup>66</sup> Steffie Woolhandler & David U. Himmelstein, *Extreme Risk—The New Corporate Proposition for Physicians*, 333 *NEW ENG. J. MED.* 1706, 1707 (1995).

<sup>67</sup> Pear, *supra* note 65.

<sup>68</sup> See generally David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 *J. HEALTH POL., POL'Y & L.* 661, (1998). In an interview with the author, Dr. David Lawrence indicated that the example of the Ohio gag clause was an aberration out of conformance with Kaiser-Permanente policy. Interview with Dr. David Lawrence, CEO, Kaiser Foundation Health Plan, in Oakland, Cal. (Mar. 1997).

<sup>69</sup> Rosenbaum, *supra* note 64; U.S. GEN. ACCOUNTING OFFICE, *MANAGED CARE: EXPLICIT GAG CLAUSES NOT FOUND IN HMO CONTRACTS, BUT PHYSICIAN CONCERNS REMAIN*, Pub. No. GAO/HEHS-97-175 (1997), available at <http://www.gao.gov/archive/1997/he97175.pdf> (last visited Aug. 8, 2005) [hereinafter GAO, GAG CLAUSES].

<sup>70</sup> GAO, GAG CLAUSES, *supra* note 69.

<sup>71</sup> See generally Kassirer, *supra* note 43.

<sup>72</sup> The *New England Journal of Medicine*, *Journal of the American Medical Association*, and *Annals of Internal Medicine* all have high impact among scientists and physicians as measured by citation rates. However, when each journal above was entered in the *New York Times* search option, the number of references for each since 1996 was 1,156, 963, and 163, respec-

anecdotes about gag rules ultimately energized many initiatives involving the President, senators, members of Congress and state legislative leaders as spokespersons for remedial action. For example, almost all state legislatures considered the issue of gag rules and most passed legislation prohibiting them.<sup>73</sup> Also the Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services) prohibited gag rules in the Medicare and Medicaid programs.<sup>74</sup> Finally, the prohibition of gag rules was recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry,<sup>75</sup> and it was included in both the Democratic and Republican proposals for a patient's bill of rights.<sup>76</sup>

Many factors gave the gag rule issue high saliency.<sup>77</sup> The discussion occurred in a context where large forces, including physician and consumer groups, and organizations, such as the American Medical Association ("AMA"), voiced opposition to managed care.<sup>78</sup> The gag rule issue highlighted a core concern for patients; namely,

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tively. As Noam Chomsky notes: ". . . the elite media, sometimes called the agenda-setting media because they are the ones with the big resources devoted to news gathering and commentary . . . . They set the framework in which everyone else operates . . . . These include the *New York Times*, CBS, and other elite media." NOAM CHOMSKY, *LETTERS FROM LEXINGTON: REFLECTIONS ON PROPAGANDA 2* (Paradigm Publishers 2004).

<sup>73</sup> In 1996, 16 states passed laws prohibiting gag rules followed by 19 additional states in 1997. *Organized Medicine Reaping Success in Defeating 'Gag Rule' Clauses*, AMERICAN PSYCHIATRIC ASSOCIATION (Oct. 1996), <http://www.psych.org/PNEWS/96-10-04/gag.html> (last visited Oct. 7, 2005).

<sup>74</sup> *Managed Care in Medicare and Medicaid*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (Feb. 20, 1998), <http://www.cms.hhs.gov/media/press/release.asp?Counter=335> (last visited Oct. 7, 2005). "Medicare's 38 million beneficiaries enjoy access to many of the rights in the Commission's report including emergency care, rapid appeal of treatment denials, bans on provider 'gag' clauses, a widening choice of health plans, and full disclosure of information." *Id.*

<sup>75</sup> Among the consumer rights and responsibilities presented by the President's Advisory Committee on Consumer Protection and Quality was the "right and responsibility to fully participate in all decisions to their health care." PRESIDENT'S ADVISORY COMM'N ON CONSUMER PROTECTION & QUALITY IN THE HEALTH CARE INDUS., *QUALITY FIRST: BETTER HEALTH CARE FOR ALL AMERICANS: FINAL REPORT TO THE PRESIDENT OF THE UNITED STATES*, available at <http://www.hcqualitycommission.gov/final/> (last visited Oct. 7, 2005). Specifically they note that all treatment options should be discussed including all "risks, benefits, and consequences to treatment or nontreatment." *Id.*

<sup>76</sup> *Id.*; Mechanic, *Backlash*, *supra* note 62, at 44.

<sup>77</sup> *Id.* at 42-44.

<sup>78</sup> The American Medical Association ("AMA") continues to be a critic and seeks managed care reform. See AM. MED. ASSOC., *MANAGED CARE REFORM*, <http://www.ama-assn.org/ama/pub/category/13404.html> (last visited Oct. 7, 2005). The AMA has long been an opponent of managed care. See *A Brief History of Managed Care*, TUFTS MANAGED CARE INSTITUTE (1998), [www.thci.org/downloads/BriefHist.pdf](http://www.thci.org/downloads/BriefHist.pdf) (last visited Oct. 7, 2005). For a more

whether physicians would protect patient interests in a changing medical environment.<sup>79</sup> The managed care industry handled the issue incompetently.<sup>80</sup> First, they responded defensively and only later did they, through their organizational advocacy group the American Association of Health Care Plans, discourage gag rules.<sup>81</sup> Politicians, on the other hand, saw gag rules as an issue on which they could pander to the public at no cost to them. This pandering continued well past the time when it became apparent that gag rules were, at most, a marginal issue rather than central to the serious and difficult problems faced by our health care system.<sup>82</sup> All of this activity, by highly visible spokespersons, provided good press and perpetuated continuing media coverage.

### C. Limits on Care: Another Illustration of Media Facilitation

Other HMO rules and practices—for example, limiting hospital care to twenty-four hours following childbirth, and limiting hospital care following mastectomies—received similar treatment from the media and legislatures.<sup>83</sup> “Drive through deliveries and mastectomies” made good headlines, feeding public indignation and promoting legislative activity, while the serious health care issues underlying appropriate obstetric care and breast surgery had little traction in the news.<sup>84</sup> Around 1995, under the banner of “drive through deliveries,” the media began focusing upon deaths and bad outcomes resulting from early discharge following normal childbirth.<sup>85</sup> The insurers probably displayed inept public relations by failing to exercise flexibility on hot-button women’s issues like early discharge for mastectomies and deliveries.<sup>86</sup> However, the coverage

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extensive history of AMA opposition, see PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 290–334 (1982).

<sup>79</sup> Mechanic, *Backlash*, *supra* note 62, at 38.

<sup>80</sup> *Id.* at 42.

<sup>81</sup> *Id.* at 42–43.

<sup>82</sup> *Id.*

<sup>83</sup> See generally Eugene Declercq & Diana Simmes, *The Politics of “Drive-Through Deliveries”: Putting Early Postpartum Discharge on the Legislative Agenda*, 75 *MILBANK Q.* 175 (1997); Stephanie L. Stein, *Challenge to HMO’s Maternity Limits*, *N.Y. TIMES*, Jan. 14, 1996, at L19 (describing legislation aimed at consumer protection from HMO policies for early discharge).

<sup>84</sup> Declercq & Simmes, *supra* note 83, at 184; Jon Nordheimer, *New Mothers Gain 2nd Day in Hospital*, *N.Y. TIMES*, June 29, 1995, at B1.

<sup>85</sup> Declercq & Simmes, *supra* note 83, at 185–86; Stein, *supra* note 83.

<sup>86</sup> See, e.g., Stein, *supra* note 83.

was largely built on anecdote and opinion, and very little on science.<sup>87</sup>

The reality is that deliveries throughout the world are often done quite safely at home.<sup>88</sup> In the United States, the preference for hospital delivery is largely motivated by the desire to have medical technology available to handle emergencies during delivery.<sup>89</sup> However, such emergencies are actually low probability events.<sup>90</sup> Thus, although delivery can take place safely in maternity centers and other more homelike settings, obstetricians and most patients prefer hospital delivery. Presence in a hospital setting, however, is not the main determinant of post-delivery care quality. Rather, the quality of care following childbirth depends on the entire spectrum of post delivery services.<sup>91</sup> For some time, large HMOs such as Kaiser Permanente have obtained good results by practicing early discharge in combination with home nurse follow-up.<sup>92</sup> Moreover, unnecessarily extended hospital care exposes both mother and newborn to risk and possible error.<sup>93</sup> Early discharge and ambulation

<sup>87</sup> Declercq & Simmes, *supra* note 83, at 180, 196; Stein, *supra* note 83.

<sup>88</sup> Declercq & Simmes, *supra* note 83, at 177–78.

<sup>89</sup> *Id.* at 178.

<sup>90</sup> See T.A. Wiegers et al., *Outcomes of Planned Home and Planned Hospital Births in Low Risk Pregnancies: Prospective Study in Midwifery Practices in the Netherlands*, 313 *BRIT. MED. J.* 1309, 1309–13 (1996) (showing that planned home births are comparable in safety to planned hospital births and supported by additional papers in the November 23, 1996 issue. As the editor notes: “It’s probably impossible to conduct randomized controlled trials of home birth not only because many women are reluctant to be randomized in such circumstances but also because huge studies would be needed because the outcome is usually good for mother and baby. Hence we have to resort to observational studies, and four in this week’s journal suggest that home birth can be a safe option if women are well selected.”).

<sup>91</sup> Because important changes in physiology occur in third and fourth postpartum days and beyond, it is doubtful that an increase in stay to forty-eight hours would have important clinical consequences. See Tracy A. Lieu et al., *A Randomized Comparison of Home and Clinic Follow-up Visits After Early Postpartum Hospital Discharge*, 105 *PEDIATRICS* 1058, 1058–65 (2000); see also David Hyman, *What Lessons Should We Learn from Drive-Through Deliveries?*, 107 *PEDIATRICS* 406, 406–08 (2001).

<sup>92</sup> Lieu et al., *supra* note 91. For example, in a Kaiser Permanente study, low-risk mothers and newborns with uncomplicated deliveries were randomized to either receive nurse home visits or attend pediatric clinics on the third or fourth postpartum day. *Id.* On average, the postpartum hospital stay was approximately thirty hours. *Id.* Home visits were associated with equivalent clinical outcomes and were more costly but associated with higher maternal satisfaction. *Id.*

<sup>93</sup> It is clearly established that hospitals are an important source of infections and a variety of medical, nursing and other errors. An Institute of Medicine committee has estimated annual deaths of as many as 98,000 due to medical/hospital error. See *INST. OF MED., TO ERR IS HUMAN* (2000).

has been practiced increasingly across a wide range of conditions and illnesses, often with improved clinical outcomes.<sup>94</sup>

While an extra day or two in the hospital might be convenient for new mothers, some sources assert that there is little evidence to support either its necessity (except in occasional high-risk situations), or justify the resource cost relative to alternative uses.<sup>95</sup> Further, adding a day of hospital care did not prevent rare events such as jaundice, which, in any case, might occur later in the postpartum period.<sup>96</sup> A 24-hour discharge, following an ordinary vaginal delivery, is not an unreasonable goal as long as physicians have the discretion to make exceptions when they believe the medical occasion warrants, and good follow-up care is provided after discharge. This issue's scientific arguments, both pro and con, were complex and the evidence was uncertain. However, the media debate largely avoided discussing the more important issue of what constitutes good childbirth procedures and postpartum care, including appropriately preparing the mother.<sup>97</sup>

In 1995 Maryland was the first state to respond legislatively.<sup>98</sup> It further strengthened its legislation in 1996.<sup>99</sup> New Jersey quickly followed Maryland in 1995.<sup>100</sup> By the end of 1996, twenty-eight states had passed legislation mandating minimum hospital stays, and other states instituted regulatory changes or voluntary agreements with insurers to achieve this goal.<sup>101</sup> By the end of 1997, some forty states and the U.S. Congress had passed legislation on post-

<sup>94</sup> E.g. John R. Britton et al., *Early Perinatal Hospital Discharge and Parenting During Infancy*, 104 PEDIATRICS 1070 (1999) (finding that parenting outcomes are not less positive as a result of early post-natal hospital discharge). The history of treatment across a wide range of conditions—including lower back pain, myocardial infarction, and hip fracture—indicates the value of early ambulation and activity. See R.A. Deyo et al., *How Many Days of Bed Rest for Acute Low Back Pain?: A Randomized Clinical Trial*, 315 NEW ENG. J. MED. 1064, 1064–70 (1986); A.S. Abraham et al., *Value of Early Ambulation in Patients with and without Complications After Acute Myocardial Infarction*, 292 NEW ENG. J. MED. 719, 719–22, (1975); Joseph D. Zuckerman, *Hip Fracture*, 334 NEW ENG. J. MED. 1519, 1519–25 (1966).

<sup>95</sup> Hyman, *supra* note 91. *Contra* Jesse D. Malkin et al., *Postpartum Length of Stay and Newborn Health: A Cost-Effectiveness Analysis*, 111 PEDIATRICS 316, 316–22 (2003) (finding increasing the length of short postpartum stays were more cost-effective than many common interventions).

<sup>96</sup> MATERNAL AND CHILD HEALTH BUREAU, U.S. DEP'T OF HEALTH AND HUMAN SERV., *MATERNAL AND INFANT HEALTH: FROM INSURANCE TO ASSURANCE* (1996).

<sup>97</sup> Hyman, *supra* note 91, at 407.

<sup>98</sup> Declercq & Simmes, *supra* note 83, at 175, 188.

<sup>99</sup> *Id.* at 189; Nduka U. Udom & Charles L. Betley, *Effects of Maternity-Stay Legislation on Drive-Through Deliveries*, 17 HEALTH AFF. 208 (1998).

<sup>100</sup> Nordheimer, *supra* note 84.

<sup>101</sup> Declercq & Simmes, *supra* note 83, at 193.



partum hospitalization, typically requiring forty-eight hours for vaginal delivery and ninety-six hours for caesarean section procedures.<sup>102</sup> While proponents strongly advocated for this legislation, including the American College of Gynecology and the Academy of Pediatrics, the media coverage and the horror stories provided additional motivation and help explain this legislation's rapid diffusion.<sup>103</sup> The legislative response fed the greater managed care backlash. Such legislation was not necessarily "bad," although the evidence remains uncertain. However, we lost an opportunity to educate the public about what constitutes good prenatal and postpartum care, as well as alternatives for achieving quality care more effectively. In the end, horror anecdotes gained public attention and provided an impetus for change, but the media and the many participants who became involved missed the more important issue.<sup>104</sup>

#### IV. THE CONTINUING DEBATE ON DIRECT-TO-CONSUMER ADVERTISING

As the United States' health system faces growing pharmaceutical costs,<sup>105</sup> increasing attention focuses on direct pharmaceutical advertising to consumers<sup>106</sup> through television and other media.<sup>107</sup> Critics point to the fact that the best selling brand name prescription

<sup>102</sup> Hyman, *supra* note 91, at 406.

<sup>103</sup> Declercq & Simmes, *supra* note 83, at 185–86; *see, e.g.*, Stein, *supra* note 83.

<sup>104</sup> Declercq & Simmes, *supra* note 83, at 196.

<sup>105</sup> While drug expenditures constitutes less than one-tenth of aggregate health costs, they grew more rapidly in the 1990s than other components of care due to successful new medications, increased insurance coverage, and aggressive marketing. *See* Ernst R. Berndt, *The U.S. Pharmaceutical Industry: Why Major Growth in Times of Cost Containment?*, 20 HEALTH AFF. 100 (2001), available at <http://content.healthaffairs.org/cgi/reprint/20/2/100> (last visited Oct. 7, 2005). Actuaries in the Centers for Medicare and Medicaid Services estimate that prescription drug expenditures will grow from \$191 billion in 2001 to a projected \$532 billion in 2012. The growth of such spending is expected to outpace spending for hospital and physician services and account for 14.5% of all health expenditures by that year. *See* Stephen Heffler et al., *Health Spending Projections for 2002–2012*, HEALTH AFF.-WEB EXCLUSIVE W3-54, W3-62 (2003), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.54v1/DC1> (last visited Oct. 7, 2005).

<sup>106</sup> This practice is called "direct-to-consumer" advertising to distinguish it from the traditional pharmaceutical company advertising, which typically targets physicians directly. In traditional advertising, pharmaceutical representatives (called detail persons) frequently contact physicians, but the practice also includes direct mailings, advertising in medical journals and at professional meetings, and financial sponsorship of symposia, medical conferences, and medical and continuing education.

<sup>107</sup> *See, e.g.*, Joel S. Weissman et al., *Physicians Report on Patient Encounters Involving Direct-to-Consumer Advertising*, HEALTH AFF.-WEB EXCLUSIVE W4-219 (2004), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.219v1> (last visited Oct. 7, 2005).

drugs are also those most heavily advertised to consumers.<sup>108</sup> However, the causal effect remains unclear and such advertising constitutes a relatively small proportion of all pharmaceutical marketing costs when compared to detailing<sup>109</sup> and other efforts to influence physicians' prescription choices.<sup>110</sup> The European Union prohibits such advertising<sup>111</sup> even though advocates from the pharmaceutical industry believe such promotions increase public awareness of available treatments and help bring people into appropriate care.<sup>112</sup> In contrast, opponents maintain that such advertising encourages unnecessary demands for services, places additional burdens on doctors, increases prescriptions for unnecessary drugs, and creates pressure to substitute expensive brand name drugs for equally effective but less costly ones.<sup>113</sup>

Recent surveys reveal the effects of direct-to-consumer advertising on both physicians and patients. In a national survey from the Kaiser Family Foundation, researchers found that 30% of adults reported responding to an advertisement for a prescription medicine by talking to a physician about it and 44% reported receiv-

<sup>108</sup> Six of the top ten drugs advertised directly to consumers were among the top twenty drugs in sales in 2000. The fifty most heavily advertised drugs increased in sales by 32% between 1999 and 2000 while dollar revenues for all other drugs increased by 14%. Each additional dollar spent on direct-to-consumer advertising was associated with \$4.20 in additional sales. HENRY J KAISER FAM. FOUND., *IMPACT OF DIRECT-TO-CONSUMER ADVERTISING ON PRESCRIPTION DRUG SPENDING*, (2003), <http://kff.org/rxdrugs/loadercfm?url=/commons/spot/security/getfile.cfm&PageID=14378> (last visited Aug. 8, 2005).

<sup>109</sup> Detailing refers to sales representatives who visit doctors, promote company products, and hand out free samples and gifts. Much of the promotional spending by companies is for such direct promotion to physicians (86% of an estimated \$19.1 billion in 2001) of which \$4.8 billion went for detailing to office-based doctors. *See id.* The Industry Profile reported that companies employ more than 86,000 in marketing but less than 52,000 in research and development. *See* JERRY AVORN, *POWERFUL MEDICINES: THE BENEFITS, RISKS AND COSTS OF PRESCRIPTION DRUGS* 305 (Knopf 2004).

<sup>110</sup> *See, e.g.,* Weissman et al., *supra* note 107.

<sup>111</sup> Rory Watson, *EU Health Ministers Reject Proposal for Limited Direct to Consumer Advertising*, 326 *BRIT. MED. J.* 1284 (2003); Francis B. Palumbo & C. Daniel Mullins, *The Development of Direct-to-Consumer Prescription Drug Advertising Regulation*, 57 *FOOD & DRUG L.J.* 423, 431-32 (2002).

<sup>112</sup> Pat Kelly, *DTC Advertising's Benefits Far Outweigh Its Imperfections: A Drug Industry Executive Supports this Growing Practice*, *HEALTH AFF.-WEB EXCLUSIVE* W4-246-47 (2004), <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.246v1> (last visited Oct. 7, 2005).

<sup>113</sup> *See* Angell, *supra* note 26, at 123-26; Avorn, *supra* note 110, at 288-91; Wendy L. Bonifazi, *Hard Sell: Drug Makers are Spending Billions on 'Direct-to-Consumer' Ads; But Just How Effective are the Products?*, *WALL ST. J.*, Mar. 25, 2002, at R8.

ing the drug.<sup>114</sup> In a 2001 survey, physicians reported that 63% of patients talked to them “very” or “somewhat” often about specific diseases or treatments that they had heard about from advertisements.<sup>115</sup> A similar percentage of patients were said by physicians to respond similarly after seeing information on the Internet.<sup>116</sup> A more recent survey of 643 physicians<sup>117</sup> found that while they believed that direct-to-consumer advertising led patients to seek unnecessary treatments, the physicians prescribed the advertised drug in 39% of such visits, but also used such occasions to suggest other treatments and lifestyle changes.<sup>118</sup> In general, when physicians prescribed the requested drug, they reported it was the most effective drug for their patients in almost half the cases.<sup>119</sup> However, 20% of the physicians surveyed believed that the requested drug would have no overall health effect.<sup>120</sup> In these situations, the physicians reported that a desire to accommodate patient requests influenced their prescribing behavior.<sup>121</sup>

Plausible arguments exist on both sides of the direct-to-consumer marketing issue; it continues to be hotly debated. Proponents point to cases where conditions are under-treated relative to need, such as in the treatment of depression.<sup>122</sup> They note that direct advertising alerts people to treatment possibilities of which they were previously unaware, and may help bring them into treatment.<sup>123</sup> Critics, however, note that in some cases the advertising

<sup>114</sup> HENRY J. KAISER FAM. FOUND., UNDERSTANDING THE EFFECTS OF DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING 3 (Nov. 2001), <http://www.kff.org/rxdrugs/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13876> (last visited Oct. 7, 2005).

<sup>115</sup> HENRY J. KAISER FAM. FOUND., NATIONAL SURVEY OF PHYSICIANS PART II: DOCTORS AND PRESCRIPTION DRUGS, Chart 4, (Mar. 2002), <http://www.kff.org/rxdrugs/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13965> (last visited Aug. 8, 2005).

<sup>116</sup> *Id.*

<sup>117</sup> *See, e.g.,* Weissman et al., *supra* note 107.

<sup>118</sup> *See, e.g., id.*

<sup>119</sup> *See, e.g., id.*

<sup>120</sup> *See, e.g., id.*

<sup>121</sup> *See, e.g., id.*

<sup>122</sup> Peter J. Pitts, *Turning Point or Tipping Point: New FDA Draft Guidances and the Future of DTC Advertising*, HEALTH AFF.-WEB EXCLUSIVE W4-259 (Apr. 2004), <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.259v1/DC1> (last visited Aug. 8, 2005).

<sup>123</sup> One recent study found that more than two-fifths of persons with a twelve-month major depressive disorder received no treatment. Of all those with depression, only 22% received treatment that met standards of minimally adequate care. Ronald C. Kessler et al., *The Epidemiology of Major Depressive Disorder: Results from the National Comorbidity Survey Replication (NCS-R)*, 289 JAMA 3095, 3102-03 (2003).

may encourage unnecessary and even dangerous medication use.<sup>124</sup> Both theory and the research literature make quite clear what can reasonably be expected, irrespective of which side wins the debate.

Theory and research clearly demonstrate that removing barriers increases the demand for medical care, while financial and other barriers reduce demand.<sup>125</sup> Barriers take many forms including lack of awareness regarding appropriate information, financial costs, geographic distance to services, and social distance between providers and patients.<sup>126</sup> Evidence from the Health Insurance Experiment and other studies show that eliminating financial barriers increases demand not only for unnecessary and ineffective services, but also for effective services.<sup>127</sup> In contrast, creating financial and other barriers makes care access more difficult and reduces requests for both trivial and needed services. Barriers serve as crude gateways. Additionally, no organizational mechanism will be sensitive enough to differentiate appropriately as to what constitutes a desirable level of service. This is where medical professionalism comes in.

## V. THE ROLE OF MEDICAL PROFESSIONALISM

One value of an open democratic system is transparency and public access to information that enhances opportunities for choice. Open and free media, whether intended to inform or to influence, contributes to an awareness of options. It also contributes to political, social and commercial choices. The public is not unsophisticated about the motives behind much advertising and even media news coverage. Studies consistently show that the media, as a source of objective and reliable information about health, have low credibility with the public.<sup>128</sup> Nevertheless, media information, whether in the form of advertising or other content, generates further consideration and discussion. Prescription advertising may bring people to doctors, however, it remains doctors' responsibility to appropriately assess, inform and collaborate with the patient in

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<sup>124</sup> Angell, *supra* note 26, at 123-26; Avorn, *supra* note 109, at 313-20; Deyo & Patrick, *supra* note 61, at 71-82.

<sup>125</sup> See JOSEPH P. NEWHOUSE, *FREE FOR ALL?: LESSONS FROM THE RAND HEALTH INS. EXPERIMENT* 162, 338 (1993).

<sup>126</sup> See DAVID MECHANIC, *MEDICAL SOCIOLOGY* 268-89 (2nd ed. 1978) (reviewing determinants of help-seeking).

<sup>127</sup> NEWHOUSE, *supra* note 125.

<sup>128</sup> HENRY J. KAISER FAM. FOUND., *supra* note 6, at 3, 5.

making appropriate treatment decisions. Indeed, if this was not the case, why require prescription drugs at all?

In one of the most important health economics papers, Nobel Prize recipient Kenneth Arrow noted that unlike other markets where patients have reasonable opportunities to prejudge their purchase, this was less realistic in medicine.<sup>129</sup> Indeed, he argued, what the patient usually purchases is not a discrete service but rather the physician's judgment and the outcome of this process cannot be ascertained in advance.<sup>130</sup> In Arrow's sense, what the patient purchased in medical encounters was medical professionalism.<sup>131</sup>

The world always offers greater complexities than theory allows. Physicians are busy, feel time-pressured and must see enough patients to meet their income objectives.<sup>132</sup> Moreover, the nature of interpersonal relationships and physicians' understandable desire to retain patients rather than lose them to competitors makes physicians reluctant to refuse services that their patients demand.<sup>133</sup> Changing patients' views often requires time and patience. However, both these resources may be stretched under usual and economically viable medical practice conditions.<sup>134</sup> Both patients and doctors complain about lack of sufficient time.<sup>135</sup> Such complaints are inevitable and hardly new.<sup>136</sup> In fact, for as long as we have surveyed such issues, both physicians and patients have complained that their encounters are too short.<sup>137</sup> Often, a busy doctor's easiest course in responding to a demanding patient is giving that

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<sup>129</sup> Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 946, 949 (1963) [hereinafter Arrow, *Uncertainty*]. In 2002, a special issue of the *Journal of Health Politics, Policy and Law* was devoted to a symposium on "Kenneth Arrow and the Changing Economics of Health Care." Symposium, *Kenneth Arrow and the Changing Economics of Health Care*, 3 J. HEALTH POL., POL'Y & L. (2002), available at [http://www.ihhpar.rutgers.edu/rwjf/downloads/research\\_in\\_profiles\\_iss03\\_apr2002.pdf](http://www.ihhpar.rutgers.edu/rwjf/downloads/research_in_profiles_iss03_apr2002.pdf) (last visited Oct. 7, 2005).

<sup>130</sup> Arrow, *Uncertainty*, *supra* note 129, at 946, 949.

<sup>131</sup> *Id.* at 946.

<sup>132</sup> David Mechanic, *Physician Discontent: Challenges and Opportunities*, 290 JAMA 941 (2003) [hereinafter Mechanic, *Discontent*].

<sup>133</sup> *Id.* at 943.

<sup>134</sup> *Id.* at 942-44.

<sup>135</sup> *Id.*

<sup>136</sup> Mechanic, *Discontent*, *supra* note 132, at 942.

<sup>137</sup> *Id.*

patient what he requests, particularly when no obvious harm will result.<sup>138</sup>

Many advocates want to protect individuals from what the advocates believe are efforts to misinform and mislead. We might agree that it is desirable for pharmaceutical companies to join a consortium and contribute to increasing public awareness of evidence-based practice,<sup>139</sup> thus improving public knowledge about conditions and available treatments, but without emphasizing the brand or maker of a particular treatment. However, these changes are unlikely to happen. Advocates have urged brand-neutral drug retailing for decades with little response from pharmaceutical companies.<sup>140</sup> Understandably, pharmaceutical companies are motivated by the desire to market and distinguish their own product, rather than promoting an entire drug class. Their unwillingness to relay messages about treatment in a more brand neutral environment, however, does not justify banning media use for drug advertising. The paternalistic idea of protecting the consumer from misleading advertising may be well intentioned but if we really believe that the consumer is sovereign, justification for doing so is weak.

Direct-to-consumer pharmaceutical advertising differs from the advertising that is incorporated without public awareness into entertainment, celebrity talk shows, and even into what purports to be news reporting.<sup>141</sup> Direct-to-consumer pharmaceutical advertising is explicit and allows an informed intermediary to amplify and correct manufacturers' claims. Physicians may feel hassled and rushed, but maintaining an effective doctor-patient partnership requires time for dialogue and information exchange.<sup>142</sup> An increasing number of tools are becoming available that enable doctors to better manage complex chronic disease and patients' educational

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<sup>138</sup> *Id.* at 943.

<sup>139</sup> David Sackett, the "father" of evidence-based medicine, and his colleagues define it "as the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients." David L. Sackett et al., *Evidence Based Medicine: What it is and What it Isn't*, 312 BRIT. MED. J. 71 (1996). See also David M. Eddy, *Evidence-Based Medicine: A Unified Approach*, 24 HEALTH AFF. 9 (2005).

<sup>140</sup> Neutral marketing, commonly referred to as academic detailing, has been advocated for decades. Studies demonstrated the effectiveness of such objective detailing. See Avorn, *supra* note 109, at 325-26, and more generally, at 314-38.

<sup>141</sup> Kassirer, *supra* note 38, at 184, cites several examples of the use of celebrities paid by pharmaceutical companies to mention drugs or drug treatments in ostensibly spontaneous interviews.

<sup>142</sup> Mechanic, *Discontent*, *supra* note 132, at 943.

needs.<sup>143</sup> These tools can contribute meaningfully to building a more viable medical professionalism for the twenty-first century.

## VI. MEDIA AS BATTLEGROUND

In the last thirty years, media use for health promotion has evolved. In the early 1970s awareness grew regarding the important effects of health behavior on disease risk.<sup>144</sup> At the same time, major foundations began taking interest in using the media to change behavior. By then it was widely recognized that messages about health behavior and disease competed with many other types of communication and that often those who most needed the messages were not reached. Several national foundations launched a major effort to develop entertaining health programming drawing on the participation of various celebrities. In the 1980s, the concept of social marketing of health developed, and these efforts are still much in vogue.<sup>145</sup> Ling and colleagues describe social marketing as follows:

Social marketing uses marketing's conceptual framework of the 4 Ps: Product, Price, Place, and Promotion. Social marketers adopted several methods of commercial marketing: audience analysis and segmentation; consumer research; product conceptualization and development; message development and testing; directed communication; facilitation; exchange theory; and the use of paid agents, volunteers and incentives.<sup>146</sup>

However, the resources available for social marketing pale in comparison to the vast investments made to promote products and practices that may harm health.

All types of advertising, whether for commercial or health motives, face the challenges of a public exposed to an overabundance of information, who lack trust in efforts to influence them, and who prefer entertainment.<sup>147</sup> Thus, increasing efforts are being made to influence the entertainment media's content.<sup>148</sup> For example, commercial marketers pay to have their products visible in movies and

<sup>143</sup> *Id.* at 944.

<sup>144</sup> John Knowles, *The Responsibility of the Individual*, 106 *DAEDALUS* 57, 57–80 (1977). For an overall perspective, see DAVID MECHANIC, *FUTURE ISSUES IN HEALTH CARE: SOCIAL POLICY AND THE RATIONING OF MEDICAL SERVICES* 25–37 (1979).

<sup>145</sup> See, e.g., Ling et al., *supra* note 2, at 341.

<sup>146</sup> *Id.* at 342.

<sup>147</sup> *Id.*

<sup>148</sup> See generally HENRY J. KAISER FAM. FOUND., *Issue Brief: Entertainment Education and Health in the United States*, <http://www.kff.org/entmedia/7047.cfm> (last visited Aug. 8, 2005) [hereinafter KAISER FAM. FOUND., *Entertainment Education and Health*].

drama; celebrities appearing on talk shows are paid to endorse products in contexts that are not presented as advertisements; and general programming is developed to promote practices and points of view.<sup>149</sup>

Professionals promoting health have also entered this arena and sponsor health entertainment education.<sup>150</sup> In 2003 and 2004, the Robert Wood Johnson Foundation sponsored various events to improve public awareness of the uninsured population.<sup>151</sup> This effort included encouraging story lines about the uninsured in day-time and prime time programs.<sup>152</sup> In 1988, the Harvard Alcohol Project worked with the communications industry to build “designated drivers” into scripts of top rated television programs including such shows as *L.A. Law*, *The Cosby Show*, and *Cheers*.<sup>153</sup> They report that over a four-year period more than 160 prime time programs “incorporated subplots, scenes and dialogue on the subject” and that all three major networks aired frequent public service announcements during prime time.<sup>154</sup> Further, they report success in enlisting many prominent supporters, from George Bush and Bill Clinton to Major League Baseball and the National Basketball Association.<sup>155</sup> The Project makes strong claims about contributing to reducing alcohol-related fatalities,<sup>156</sup> but the evidence remains circumstantial. In any case, the Project established an approach for reaching the public that others in the health fields emulate.

## CONCLUSION

In the final analysis, the media simply serve as the ropes in a “tug of war” among many ideas and interests. While some interests clearly have more money, power and influence, the heterogeneity of interests and the abundance of communication channels provide outlets for almost any view. Media is, of course, a business, and will

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<sup>149</sup> *Id.*

<sup>150</sup> KAISER FAM. FOUND., *Entertainment Education and Health*, *supra* note 148, at 3–4.

<sup>151</sup> *Id.*

<sup>152</sup> *Id.*

<sup>153</sup> *Id.* at 2.

<sup>154</sup> HARV. SCH. PUB. HEALTH, CTR. FOR HEALTH COMM., *The Harvard Alcohol Project's Designated Drive Campaign*, available at <http://www.hsph.harvard.edu/chc/alcohol.html> (last visited Aug. 8, 2005).

<sup>155</sup> *Id.*

<sup>156</sup> Jay A. Winsten, *Designated Drivers: The Harvard Alcohol Project*, 10 AM. J. PREVENTIVE MED. 11, 12–13 (1991).



market almost anything that will sell. The challenge for health promoters is accepting that they are bit players, relatively speaking. Thus, establishing their credibility and reaching broad audiences continues as a significant problem.

