

Target Article

# The Ethics of Advertising for Health Care Services

Yael Schenker, University of Pittsburgh

Robert M. Arnold, University of Pittsburgh

Alex John London, Carnegie Mellon University

Advertising by health care institutions has increased steadily in recent years. While direct-to-consumer prescription drug advertising is subject to unique oversight by the Federal Drug Administration, advertisements for health care services are regulated by the Federal Trade Commission and treated no differently from advertisements for consumer goods. In this article, we argue that decisions about pursuing health care services are distinguished by informational asymmetries, high stakes, and patient vulnerabilities, grounding fiduciary responsibilities on the part of health care providers and health care institutions. Using examples, we illustrate how common advertising techniques may mislead patients and compromise fiduciary relationships, thereby posing ethical risks to patients, providers, health care institutions, and society. We conclude by proposing that these risks justify new standards for advertising when considered as part of the moral obligation of health care institutions and suggest that mechanisms currently in place to regulate advertising for prescription pharmaceuticals should be applied to advertising for health care services more broadly.

**Keywords:** media, organizational ethics, professional–patient relationship, cultural studies

In its original 1847 Code of Ethics, the American Medical Association (AMA) banned advertising for health care services. “It is derogatory to the dignity of the profession to resort to public advertisements or private cards of handbills inviting the attention of individuals affected with particular disease,” the Code of Ethics states. “These are the ordinary practices of empirics, and are highly reprehensible in a regular physician” (American Medical Association 1847). Subsequent advertising prohibitions persisted through the AMA’s 1957 “Principles of Medical Ethics,” which judged the practice of soliciting patients to be unethical (American Medical Association 1958). In 1980, these prohibitions were reversed when a Second Circuit appellate court ordered the AMA to cease and desist from enforcing restraints on advertising, ruling that such restraints violated Section 5 of the Federal Trade Commission Act prohibiting “unfair or deceptive acts or practices in or affecting commerce” (638 F.2d 443: *American Medical Association, Petitioner, v. Federal Trade Commission* 1980). Since that time, advertising for health care services, while viewed with skepticism by some commentators (Tomycz 2006; Yarborough 1989), has nevertheless increased steadily. In the first 6 months of 2011, advertising by American hospitals, clinics, and medical centers totaled \$717.2 million, an increase of 20% over spending in 2010 according to a recent report in the *New York Times* (Newman 2011). The majority of these advertisements are designed to attract patients and promote specific clinical services, such

as therapeutic interventions or diagnostic tests (Larson et al. 2005).

The rise in advertising by health care institutions parallels an increase in direct-to-consumer advertising of prescription drugs (Donohue et al. 2007). In the United States, direct-to-consumer pharmaceutical advertisements are subject to unique oversight by the Federal Drug Administration (FDA) and required to present a “fair balance of risks and benefits” (U.S. Department of Health and Human Services, Food and Drug Administration 2009). Stricter regulations are informed, in part, by recognition that uninformed patients may request and receive inappropriate medications, thereby negatively impacting their own welfare and unnecessarily burdening the health care system. Long-standing concerns about the risks of direct-to-consumer pharmaceutical advertising have led to continued scrutiny of prescription drug advertising trends and effects (Donohue et al. 2007; Frosch et al. 2010; Kravitz et al. 2005; Rosenthal et al. 2002). Advertisements for clinical services at health care institutions, in contrast, do not undergo unique oversight and have been subject to far less examination, despite well-recognized risks of pursuing inappropriate clinical tests and procedures (Volpp et al. 2012).

In this article, we advocate the need to reevaluate the ethics of clinical advertising by health care institutions. We argue that informational asymmetries, combined with high stakes and patient vulnerabilities, establish a fiduciary

Address correspondence to Yael Schenker, MD, MAS, University of Pittsburgh, 230 McKee Place, Suite 600, Pittsburgh, PA 15213, USA. E-mail: schenkery@upmc.edu

obligation to patients on the part of not only health care providers but also health care institutions. We further argue that the advertising practices of health care institutions form part of this fiduciary responsibility to patients and must therefore be considered differently from the advertising practices of companies that do not share these obligations. We illustrate how common advertising techniques that may not be problematic when applied to consumer goods or services pose unique ethical risks when used by health care institutions to advertise clinical services. We conclude by proposing that these risks justify new standards for advertising by health care institutions and suggest that mechanisms similar to those currently in place to regulate advertisements for prescription drugs should be developed for and applied to health care advertising more broadly.

## DEFINITIONS AND A BRIEF HISTORY OF PROFESSIONAL ADVERTISING REGULATIONS IN THE UNITED STATES

For the purpose of this article, we define health care institutions as organizations providing clinical care. These may include hospitals or hospital systems, academic medical centers, cancer centers, provider groups, or clinics. We draw comparisons to pharmaceutical advertising to frame the debate, as well as advertising for health-related products and services—such as industry-marketed direct-to-consumer screening tests and weight-loss services—that have been subject to special scrutiny. We do not directly examine advertising for medical research participants (Fisher 2009; Petryna 2009), which involves unique ethical and regulatory issues beyond the scope of this discussion.

Historically, advertising for professional services—including medical services, dental services, social work services, and legal services—has been regulated by professional codes of conduct (Kwoka 2005). The justifications for such regulation include the need to maintain high ethical standards and prevent deceptive marketing practices that may undermine the public's trust in the profession or harm consumers (Federal Trade Commission 1994). For example, the AMA's 1957 "Principle of Medical Ethics" states that "the medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence" (American Medical Association 1958).

The landmark 1980 *AMA vs. Federal Trade Commission* (FTC) case determined that this code of conduct violated free-trade principles. Subsequently, the courts have scrutinized codes of conduct governing multiple professions' advertising practices and frequently determined that advertisements for professional services should be treated similarly to advertisements for other types of goods (Kwoka 2005). Thus, under current laws, clinical advertisements placed by for-profit health care institutions are monitored by the Federal Trade Commission (FTC) under the same "reasonable standards" for fairness and nondeception applied to advertisements for common consumer purchases, while clinical advertisements placed

by nonprofit health care institutions are subject to even less oversight, as nonprofit corporations are exempt from provisions of the Federal Trade Commission Act (*Community Blood Bank of the Kansas City Area, Inc. vs Federal Trade Commission* 1969; Federal Trade Commission Act 1914).

## HEALTH CARE DECISIONS INVOLVE INFORMATIONAL ASYMMETRIES

Legal frameworks treat advertising for clinical services no differently from advertising for any other consumer goods or service. However, when applied to health care services, common advertising techniques can be ethically problematic. In particular, health care decisions have special characteristics that ground important moral obligations on the part of health care institutions to patients. Although some of these characteristics may be present in decisions about other types of goods and services, they arise routinely in the health care context, with significant consequences for patient welfare and the health care system.

### Understanding Needs

Advertising for food and clothing may shape consumer desires and create preconceived needs. For example, a successful commercial for breakfast cereal leads shoppers who had previously been satisfied with oatmeal to desire and purchase the advertised cereal brand. For other kinds of purchases, consumers may have an independent sense of what their needs are. For example, a college student may need a computer that is portable, lightweight, and has at least 6 hours of battery life. These needs can be established without consulting a computer salesman and can be used as criteria for deciding which laptop to buy. By comparison, patients often do not have an independent sense of what their medical needs are. If the same student visits her doctor with a persistent cough, she may know that she wants to feel better but she is unlikely to independently understand whether she needs a blood test or an x-ray, an inhaler or an antibiotic. An adequate understanding of health care needs requires medical knowledge and experience in the prevention, diagnosis, and treatment of disease. Such understanding therefore depends, in most cases, upon individualized consultation with a clinician. Advertising practices that generate the perception of a health care need may induce patients to seek unnecessary services.

### Evaluating Quality

It is also easier to evaluate the quality of consumer goods upon purchase than it is to discern the quality of health care services. A detergent that leaves spots on clothes is most likely of poor quality, while a detergent that gets clothes clean is a better quality product. The ability to make this distinction allows consumers to punish poor-quality products and reward high-quality products by altering their consumption behavior. By contrast, health care services are credence goods, an economic term referring to a type of good whose quality is more difficult for a consumer to

evaluate. Consider a patient with cancer who is started on a chemotherapy regimen and subsequently feels nauseous and fatigued. To evaluate treatment quality requires medical expertise to contextualize her experience. Has her tumor shrunk? Are her symptoms associated with her chemotherapy? Are these symptoms likely to persist or resolve? Would a different treatment modality such as radiation therapy have been more effective or have resulted in fewer side effects? Patients may know what their desired health outcomes are, but most lack the medical expertise needed to contextualize and fully evaluate the quality of care they receive. In some cases, patients may alter their use of health care services based on a marker of quality that is more easily evaluated—such as clinic wait times or the friendliness of a provider. However, such markers do not fully reflect the quality of medical care.

Informational asymmetries with respect to needs and quality operate in other professional services as well. For example, legal clients rely on their attorneys to accurately assess their legal needs and provide effective legal services. However, health care decisions involve asymmetries that are particularly pronounced and often more consequential. As the complexity of medical care increases, independent patient assessment of health care needs and quality becomes increasingly difficult. Consumer vulnerabilities may also complicate these assessments, as difficult health care decisions frequently arise when patients are already sick. The stakes are often higher for health care decisions than for decisions about other types of goods and services. Poor choices can more easily lead to poor outcomes—including disability or even death—thereby necessitating additional care. Furthermore, the consequences of poor quality medical care may not be immediately obvious. For example, medical imaging tests may cause cancer related to radiation exposure decades after the tests were performed.

### Assessing Price

Because consumers can punish and reward producers of consumer goods, there are competitive pressures that help to align price with quality. In order to segment the market, producers will seek a niche (e.g., by producing high-quality computers and charging a premium, or by producing computers that may reflect lower quality but that come with a substantially lower price). For most professional services, prices are also clearly displayed and linked to quality. Legal clients receive an itemized bill for legal services and may choose to work with a higher priced senior partner or a less expensive junior attorney. Using information about price and quality, consumers in competitive markets can thus make their own judgments about value. In contrast, patients cannot rely on price as a quality marker because health care costs lack transparency and reflect an array of other influences. Most patients are shielded from direct costs by virtue of their insurance coverage, meaning they do not pay out-of-pocket for medical services. Frequently, actual costs are disclosed only after treatment has been rendered, and even patients who lack insurance have difficulty getting

information about costs up front (California HealthCare Foundation 2005). Wide variations in health care costs have also been observed, reflecting different charges that have been negotiated between hospitals and third-party payers (private insurance companies and the Center for Medicare and Medicaid Services). For example, a recent analysis of hospital charges for acute appendicitis in California hospitals found a 119-fold difference between the lowest and highest observed charge, with nearly one-third of this variation unexplained by patient or hospital-level factors (Hsia et al. 2012), suggesting that price variations bear little relation to quality differences for this standard operation. Thus, while advertising exerts procompetitive effects by increasing demand for lower costs goods and services in markets where price and quality are transparent, advertising for health care services is unlikely to exert similar effects because patients lack information about both quality and costs.

### INFORMATIONAL ASYMMETRIES GROUND FIDUCIARY HEALTH CARE RELATIONSHIPS

Informational asymmetries limit patients' abilities to independently evaluate health care services. Thus, patients will likely not have the information they need to decide whether an advertised diagnostic test or specialized clinical service best meets their needs. Informational asymmetries in health care, combined with the potential for health care decisions to result in significant harms, have long been recognized as grounding special fiduciary duties on the part of health care providers to patients.

Fiduciary derives from the Latin *fiduciarius*, meaning "holding in trust." The fiduciary nature of the patient-physician relationship means that physicians have a primary obligation to act in their patients' best interests and patients trust them to do so. This codification of physicians' primary responsibility to patients over economic or other interests dates back to the origins of the medical profession (London 2000; Relman 1992). Graduating medical students recite a modern version of the Hippocratic Oath, pledging to practice medicine "for the benefit of the sick" (Kao and Parsi 2004), and the American Medical Association's Code of Ethics states that as a member of the profession, "physicians must recognize responsibility to patients first and foremost" (American Medical Association 2001). This responsibility includes helping patients to navigate difficult health care choices, for which "uncertainty is very different on the two sides of the transaction" (Arrow 2004) because physicians possess the knowledge that patients need in order to make informed decisions that reflect patients' needs and values.

Modern medicine is increasingly an institutional effort in which patient-physician interactions are mediated in significant ways by health care systems (Lin et al. 2006). These systems determine which services are available and which clinicians a patient can see, develop treatment and screening algorithms, and recommend specific tests and interventions. As a result, health care institutions perform more than

merely business, financial, or administrative roles; they are intimately involved in shaping patient care and the delivery of clinical services. Similar informational asymmetries exist between health care institutions and patients as exist between clinicians and patients, and the performance of these institutions can also have significant consequences for patient health. While pharmaceutical companies have traditionally operated one step removed from the clinical care of patients, prioritizing profits while relying on physicians to ensure that advertised drugs are used appropriately, health care systems cannot claim to operate at a mere arm's length from patients. These institutions share fiduciary duties that differ from the missions of companies that produce other types of goods.

Health care institutions recognize these special moral obligations. A review of mission statements suggests that both for-profit and nonprofit institutions view the practice of medicine as their primary role and would agree with Michael Sandel's view that "a purely profit-driven [hospital . . .] falls short of what hospitals are properly for" (Aitkenhead 2012). The motto of Cancer Treatment Centers of America, a widely advertised for-profit cancer center, reads: "You and your healing are at the center of our hearts, minds and actions, every day" (Cancer Treatment Centers of America 2013). The "vision" of the University of Pittsburgh Medical Center, an academic, nonprofit medical center, begins: "Putting our patients at the center of everything we do and creating a model that assures that every patient gets the right care, in the right way, at the right time, every time" (University of Pittsburgh Medical Center 2013). Such promises are more closely aligned with the oaths sworn by individual physicians than with the mission statements of many businesses, in which motives are more obviously profit driven and "caveat emptor" or "consumer beware" is the assumed rule.

Health care institutions have additional obligations beyond patient care: Nonprofit institutions share a duty to further the health of the community; research institutions have a responsibility to advance medical science and protect research subjects; for-profit institutions are accountable to stockholders; and academic institutions help to train clinicians. However, problems may arise when additional obligations conflict with a fiduciary responsibility to patients. As an example, consider a health system that sends a letter to all female patients recommending an annual pap smear to screen for cervical cancer in an effort to increase patient volume at its gynecology clinics. Evidence-based consensus guidelines have recently been revised to recommend cervical cancer screening every 3 to 5 years. Clinicians at this institution whose patients request an annual pap smear have the option of initiating a discussion about why this may not be in their best interest, but this takes time and may leave patients dissatisfied or mistrustful (of clinicians, the health care institution, or both). The alternate course of action—to provide the test without further discussion—may be easier and more satisfying to patients but does not prioritize their best interests. Thus, conflicting norms within an institution may not only compromise the fiduciary mission of

the institution, but also compromise the ethical behaviors of individual clinicians.

Recognition that the ethical behavior of health care institutions extends beyond the traditional scope of clinical ethics has led to recent increased interest in the field of organizational ethics in health care (Zoubul 2009). Organizational ethics focuses on the moral responsibilities of the institution as a whole (McDonald et al. 2008; Ozar et al. 2000; Thompson et al. 1992). In 1995, the Joint Commission on Accreditation of Healthcare Organizations introduced a new standard requiring hospitals to have a code of ethical behavior (Zoubul 2009), and in 2008 the Veterans Health Administration established and implemented an Integrated Ethics Model designed to be a "comprehensive, systematic, integrated approach to ethics in healthcare organizations" (Foglia et al. 2012).

### THE MORAL RESPONSIBILITIES OF HEALTH CARE INSTITUTIONS EXTEND TO CLINICAL ADVERTISING PRACTICES

Since the 1980 appellate court decision, advertising has assumed a more significant role for many health care institutions (Newman 2011). Defined as any communication that is paid for, including radio and television commercials, print advertisements, Internet advertisements, and billboards, advertising is one component of the "marketing mix" employed by health care institutions to "create or expand demand for services" by encouraging patients to form preferences for a particular hospital, provider group, diagnostic test, or therapeutic approach (Borden 1984; Gershon 2003). Advertising drives patient requests for care and may lead to the provision of care that is either unnecessary or harmful (in one analysis, direct-to-consumer pharmaceutical advertising had led one-third of the general public to ask their physicians for drug information and one-fifth to request a prescription) (Bell et al. 1999; Kravitz et al. 2005). Thus, part of the fiduciary responsibility of health care institutions extends to the way they advertise or promote their services. This responsibility distinguishes advertisements for health care institutions providing clinical care from advertisements placed by pharmaceutical companies, which have traditionally co-opted the physician-patient relationship (urging consumers to "ask your doctor" if this medication is right for you) to ensure protection of patient well-being.

The Joint Commission, dedicated to improving quality and safety in health care organizations, recommends an ethics framework that includes "marketing and advertising plans" (Joint Commission 2013). Yet to date, advertising practices have received little attention in the larger debate about organizational ethics in health care, which has instead focused broadly on institutional obligations to the community, resource allocation, and workplace ethics. A recently conducted systematic review of the empiric literature on health care organizational ethics did not identify advertising as a topic of study (Suhonen et al. 2011).

## TECHNIQUES USED IN CLINICAL ADVERTISING BY HEALTH CARE INSTITUTIONS

An examination of three common techniques used in advertisements for health care services reveals how these advertisements may pose ethical risks by persuading patients without facilitating informed health care decisions. We have included examples from actual advertisements to illustrate these advertising techniques. We have not conducted a systematic review of the content of clinical advertising by health care institutions, and in this article we do not make claims about the prevalence of these techniques. These examples merely provide context and highlight the ethical concerns at stake. We have selected examples from magazine advertisements because these are among the most widely viewed by patients (Abel et al. 2009) and easily accessed by interested readers.

### Positive Associations and the Suggestion of Indirect Benefits

Associating advertised products with indirect benefits through the use of likeable images, celebrity endorsements, or references to wealth, beauty, popularity, or happiness is a common and persuasive advertising technique (Armstrong 2010). “Remember, nobody smiles doing housework but those ladies you see on TV,” Carol Channing croons in “Free to Be You and Me.” Because “scouring a skillet or two” does not make most people happy, advertisements for household products have been successful by suggesting benefits beyond clean dishes, ranging from youthful skin to stylish living (Elliott 2010).

Health care advertisements similarly make claims about indirect benefits in addition to, or instead of, focusing on the quality of medical care. For example, many health care advertisements suggest that patients will receive luxury or V.I.P. treatment. Famous patients (advertisements for Memorial Sloan-Kettering Cancer Center featured former New York Yankees manager Joe Torre with a sign that reads “Cancer, you’re benched”) and pictures of gleaming lobbies that resemble five-star hotels focus our attention on the benefits of wealth and celebrity rather than on being sick. “Out-patient surgery in Beverly Hills? No . . . right here, in Pittsburgh!” proclaims one such advertisement for Radiance, a private outpatient surgery center. “World-Class Comfort and Care” promises an advertisement for the Brown Hand Center, describing its clinics across the United States as the destinations of choice for patients from around the world who expect “service as it should be.” An advertisement for Lenox Hill Hospital in Manhattan proclaimed, “We can’t help you with playoff tickets. We can’t help you with co-op board approval or getting your child into a preschool. But if it’s really a matter of life and death—we can help” (Newman 2011). The association between this hospital and the lives of wealthy New Yorkers is both memorable and appealing to consumers. Part of the appeal is the impression that interacting with the institution itself conveys a desirable status; another part of the appeal stems from the idea that celebrity and wealth are indicators of the best medical

care. However, V.I.P. treatment is not associated with health care quality, and some physicians have suggested that being treated like a celebrity or high-profile patient may be associated with inferior quality care (Block 1993; Klitzman 2009).

Other indirect benefits suggested by health care advertisements include improved personal relationships and athletic prowess. In advertisements for the Texas Heart Institute at St. Luke’s Episcopal Hospital, “the bionic bride,” a young woman who received a heart transplant, discusses how she married her college sweetheart and is now enjoying the dream of her new life, in a new house, with a new husband. Debakey Heart and Vascular Center advertisements feature a runner describing how he was able to complete a marathon soon after receiving a catheter ablation treatment for atrial fibrillation. Such lifestyle benefits may stem from improved health, but they are several steps removed from the medical interventions being promoted. The suggestion of indirect benefits increases the influence of an advertisement’s message in part by distracting attention from consideration of the indications, quality, or costs of advertised services (Armstrong 2010; Bishop 2000; Cialdini 1984).

### Focus on Salient Cases Without Attending to Background Probabilities

Medicine is filled with stories of personal triumph and survival in the face of poor odds. Focusing on an individual narrative is more persuasive than recounting survival statistics and may lead the listener to overestimate the chance of a low-probability event. A woman with cervical cancer is told she will never be able to have children but gives birth to a healthy baby girl after receiving fertility-sparing surgery. A woman with metastatic pancreatic cancer is alive and well 10 years after being told that she has 2 months to live. A man nearly dies after having a heart attack in his car but is saved after successful resuscitation and implantation of a percutaneous ventricular assist device. These first-person accounts—all featured in recent advertisements, for Memorial Sloan Kettering Cancer Center, Cancer Treatment Centers of America, and West Penn Allegheny Health System, respectively—are persuasive because they are memorable and emotionally appealing. Consumers identify and empathize with real people—frequently shown at home or with their families—who have overcome adversity. Salient personal stories incite hope and fear, both powerful motivating forces that may influence how patients assess information and make choices. For example, fear of death may lead patients to ignore the likelihood of desired outcomes when considering prevention or treatment options (Loewenstein and Lerner 2003; Witte and Allen 2000; Zeckhauser and Sunstein 2008).

What most advertisements do not emphasize is the degree to which featured personal stories exemplify the experiences of most patients or the probability of achieving similar results. Unusual successes are sometimes touted without mentioning eligibility criteria or risks for

procedures that may be novel or experimental. Details about cure rates and comparative performance data are often absent or found only in supplemental online material (Singer 2009). Some advertisements include mandatory disclaimers. For example, all personal vignettes in Cancer Treatment Center of America advertisements are subtitled, "No case is typical. You should not expect to experience these results." Yet evidence indicates that such disclaimers may not have the intended effect of promoting accurate understanding and in some cases may increase acceptance or belief in an advertiser's message because consumers assume that a disclaimer means that the advertisement has been properly reviewed and vetted (Ben-Shahar and Schneider 2010; Loewenstein et al. 2012).

### "Uncooperative Communication"

In *Studies in the Way of Words*, the philosopher of language H. P. Grice argued that communication is made possible by a shared assumption that he called the Cooperative Principle (Grice 1989). As defined by Grice, the Cooperative Principle is the assumption that what is said will be as informative as (but not more informative than) is required, true and supported by adequate evidence, relevant, and perspicuous (orderly, brief, and neither ambiguous nor obscure). Grice calls these assumptions "maxims" of quantity, quality, relation, and manner. When a maxim is not followed, what is said may differ from what is understood or implicated. A maxim may be purposefully violated in order to mislead without the speaker uttering a sentence that is literally false. Take, for example, a variation on a two-person exchange discussed by Grice: A man says, "I am out of milk." His friend replies, "There is a store around the corner." It is assumed that the friend's statement is relevant (i.e., that the store is open and stocks milk) and informative (i.e., that it is possible to find the store in question simply by turning the corner). If the friend knows that the store is closed or carries only soda, she violates the maxim of relevance. If she knows that the store cannot be easily located upon turning the corner, as it is also on the opposite side of the street and several blocks away, she violates the maxim of quantity. In either case, she may mislead the man, though what she has said is factually true.

Violations of the cooperative principle occur commonly in advertising, constituting what we term "uncooperative communication." Two recent examples from cancer center advertisements illustrate this practice and how it may be used to imply significant differences in health care quality or benefits that are larger than truly exist. Advertisement for Memorial Sloan-Kettering Cancer Center read, "Where you're treated can make all the difference." This statement may be factually true (where you are treated is likely to make a difference in something) but differs from what is understood: Where you are treated will make a difference in whether or not you survive and if you are treated here you have a better chance of survival. Survival, while not explicitly mentioned in the advertisement, is assumed to be the relevant outcome. By expressing this claim, the

organization also implies that it offers a survival advantage over competitors. Unless mortality rates are actually lower at the advertised cancer center, the claim violates the maxim of relation, and the proposition that this statement winds up communicating to the listener is false.

In advertisements for M.D. Anderson Cancer center, the name of the center is written with the word "cancer" crossed out and followed by the tag line "Making Cancer History." The phrase is ambiguous. Does it mean that the cancer center is making historic advances in cancer detection and treatment? This seems likely to be the case, as it is a well-known research institution, though evidence of this claim is not included in the advertisement. Or does it mean that the cancer center is making cancer a thing of the past, as is suggested by the line through the word cancer in their name? The same ad features a personal story of a man who faced leukemia with the word "leukemia" crossed out. The implied meaning, that the cancer center cures cancer and saves lives, is what most patients want to hear. This will be true in select cases but not universally. Through violation of the maxim of manner, the ad plays on the double meaning of the phrase, hinting at improbable benefits without misstating any facts.

### WHAT ARE THE ETHICAL CONCERNS RAISED BY THESE ADVERTISING TECHNIQUES WHEN APPLIED TO CLINICAL ADVERTISING BY HEALTH CARE INSTITUTIONS?

The techniques we have described are persuasive advertising principles. They encourage patients to form preferences for a health care institution or clinical service based on positive associations with advertising slogans or images, the suggestion of lifestyle benefits, and emotionally salient success stories. Simplified messages imply meaningful benefits and significant differences between health care options. Patients are encouraged to act like consumers in a free marketplace, to form preferences and desires for specific services, and to choose a new health care institution or request a specific intervention in much the same way they select a new detergent or computer. Many health care advertisements encourage immediate and direct contact, providing 1-800 numbers for potential patients and families to call. Yet as outlined earlier in this essay, we necessarily approach decisions about health care armed with very different tools and expectations than when we buy other consumer products. Examining health care advertisements through the lens of these differences, we highlight potential ethical risks to patients, providers, health care institutions, and society inherent in current advertising approaches.

### Risks for Patients

Patients who form attachments to a particular health care institution, its providers, or specific treatments based on the persuasive advertising principles we have described may pursue health care services that are either unnecessary or harmful. A similar claim may be made about consumers

who purchase a new laundry detergent or computer based on a persuasive advertisement, only to discover that the new product does not live up to their expectations. However, patients face unique risks for the following reasons.

First, because it is more difficult to independently assess whether a medical service is necessary or valuable, advertising by health care institutions may more easily lead patients to believe that a particular service meets their needs when in fact it does not. All health care services entail risks. Pursuit of unnecessary services therefore creates a situation in which risks are likely to outweigh benefits and patients may suffer harm. This argument has been used to support stricter restrictions on direct-to-consumer pharmaceutical advertising and industry marketing of screening tests, for which the Federal Drug Administration regulates how risks and benefits are presented (Hasman and Holm 2006; Lovett and Liang 2011; Lovett et al. 2012), as well as advertising for services that can have adverse health consequences but are not provided by health care practitioners, such as diet products or medical spa services (Federal Trade Commission 2002; O'Brien 2013). The argument for advertisements by health care institutions is even stronger because, as we have argued, these institutions share a primary fiduciary responsibility to ensure that they provide care in patients' best interests.

Second, because health care is a credence good, patient satisfaction may depend on aspects of care that patients can directly assess (such as provision of V.I.P. services) even though those aspects of care do not track the quality of health care that they receive. In a nationally representative sample of more than 50,000 U.S. adults, higher patient satisfaction was associated with greater total health care expenditures, greater prescriptions drugs expenditures, and increased mortality (Fenton et al. 2012). One suggested explanation for this finding was that satisfied patients may request and receive more care that is harmful to them. Because what conveys satisfaction to patients may not be what is in their medical best interests, catering to patient preferences through advertising may be in conflict with providing judicious, evidence-based care (Kupfer and Bond 2012). To the extent that organizations charge a premium for such services, individual health care costs may increase without a corresponding improvement in patient outcomes.

Third, health care is based on fiduciary relationships designed to protect patients' best interests. Changing health care providers or institutions based on advertising promises may lead to the loss of previously established beneficial relationships. And finally, because patients have real medical needs and a limited amount of time to spend on their own health, advertisements that encourage pursuit of desired services may mean patients devote less time to the pursuit of less appealing but more beneficial medical interventions. A similar argument has been made in support of stricter oversight of weight-loss advertising, as pursuit of unproven products may lead the public to neglect evidence-based interventions, such as improving diet and increasing exercise (Federal Trade Commission 2002).

### Risks for Physicians and Health Care Institutions

While health care advertisements may be viewed as benefiting physicians and health care institutions by attracting new patients and increasing revenues, the techniques we have described involve risks to physicians and health care institutions as well. For example, advertising may alter patient expectations in a way that threatens the fiduciary relationships on which health care depends. Patients who form a preference for a particular intervention based on an advertisement's promise may be less interested in alternative therapies and disappointed if the advertised intervention is not an option for them. Physicians may spend valuable time realigning patient expectations. Alternatively, just as many physicians describe feeling pressured to prescribe medication they would not otherwise use in response to patient requests triggered by direct-to-consumer drug advertising (Frosch et al. 2010), physicians may be tempted to provide an intervention "as advertised" or pursue a diagnostic workup that they do not feel is in a patient's best interest in response to requests triggered by advertising for these health care services. Conflicting norms may arise within health care institutions if physicians do not agree with the recommendations in institutional ads, posing a threat to provider and institutional integrity.

Advertisements viewed as inappropriate or uninformative may also erode patients' trust in providers and health care institutions. Trust distinguishes health care from business transactions and retains an essential role in enabling physicians to provide high-quality patient care. As the economist Kenneth Arrow noted in his seminal 1963 article on health economics, "the very word 'profit' is a signal that denies the trust relations" (Arrow 2004). Institutions that profess to act on commitments to the welfare of stakeholders, but are viewed as prioritizing profits, may be censored in the media and by the public for a lack of transparency regarding competing interests and a disregard for the fundamental ethical obligation to further patient well-being.

### Risks for Society

Society places a high value on medical care while struggling to devise ways to pay for it. While debate continues about the means, widely accepted goals include improving quality and decreasing costs. As we have suggested, health care advertisements may pose risks to quality if patients are persuaded to pursue care that is either unnecessary or harmful. The costs associated with advertising-driven demands—from which patients are largely shielded—may consume scarce health care resources and reduce the pool of funds, drawn from public health plans or private insurance pools, that are available to pay for needed services. Furthermore, the escalating costs of these promotions may mean less funding is available to provide high-quality care.

### Conclusion

It is possible to view the current state of health care advertising as contributing to an incoherent status quo.

While society works to create and preserve a high-quality medical system in which patients make decisions in consultation with expert clinicians that reflect an integrated assessment of the medical evidence and their personal values, in reality patient expectations may be fundamentally shaped by frequent exposure to medical advertising before deliberations with clinicians take place. Because informational asymmetries and the medical market do not allow patients to reliably evaluate health care products, the influence of medical advertising on patient preferences is largely unchecked by countervailing forces. This influence may mislead patients and encourage utilization practices that work against the goals of improving quality and decreasing costs.

We argue that fundamental differences between health care and consumer goods necessitate unique criteria for evaluating health care advertising. While the primary virtue of advertisements for detergents and computers is persuasiveness, as measured by revenue generated, health care advertisements must be considered as part of the fiduciary responsibility of health care institutions to patients. Current FTC regulations prohibiting deceptive advertising practices may therefore be inadequate, as patients can easily be misled by subtle advertising techniques that do not involve misstated facts or blatant deception. New standards for health care advertising should be designed to promote informed health care decisions, in keeping with the responsibility of health care institutions to protect patient well-being. As such, these standards might adapt aspects of FDA regulations for pharmaceutical advertisements, such as the guidelines for risk disclosure designed not merely to avoid deception, but to provide consumers with a “fair balance” of information about benefits and harms (Greene et al. 2012; U.S. Department of Health and Human Services, Food and Drug Administration 2009). While we do not make any claims about the effectiveness of FDA guidelines, they are an additional layer of oversight that have helped to focus attention on the potential risks of advertising prescription drugs directly to patients.

Given conflicting values among multiple stakeholders in an evolving and highly competitive system, developing and enforcing new standards for health care advertising will not be easy. We have explored why aspects of health care advertising may be ethically problematic. Empiric examination of the content and effects of health care advertising is also needed. Regulatory efforts would be strengthened by evidence demonstrating that specific advertising trends or techniques mislead patients in clinically significant ways that may be expected to negatively impact health care quality or costs. Legal and ethical analysis of the options for balancing public health and information dissemination, how to censure advertising campaigns without simply shifting the problem elsewhere, and how larger changes to the health care system may affect this dynamic must also be a focus of interdisciplinary investigation. We believe that the potential risks and paradoxes inherent in our current system, coupled with the escalation of clinical advertising by health care institutions, signal the necessity for broader scrutiny of health

care advertising beyond direct-to-consumer advertising for pharmaceuticals. ■

## REFERENCES

- 638 F.2d 443: *American Medical Association, Petitioner, v. Federal Trade Commission, Respondent. Connecticut State Medical Society and New Haven County Medical Association, Inc., Petitioners, v. Federal Trade Commission, Respondent.* 1980. U.S. Court of Appeals SC-Fd, ed; 1980.
- Abel, G. A., H. J. Burstein, et al. 2009. Cancer-related direct-to-consumer advertising: Awareness, perceptions, and reported impact among patients undergoing active cancer treatment. *Journal of Clinical Oncology* 27(25): 4182–4187.
- Aitkenhead, D. 2012. Michael Sandel: ‘We need to reason about how to value our bodies, human dignity, teaching and learning.’ *The Guardian*, May 27. Available at: <http://www.guardian.co.uk/books/2012/may/27/michael-sandel-reason-values-bodies>
- American Medical Association. 1847. Code of medical ethics of the American Medical Association. Available at: <http://www.ama-assn.org/ama/pub/about-ama/our-history/history-ama-ethics.page>
- American Medical Association. 1958. Principles of medical ethics. Available at: [www.ama-assn.org/resources/doc/ethics/1957-principles.pdf](http://www.ama-assn.org/resources/doc/ethics/1957-principles.pdf).
- American Medical Association. 2001. Principles of medical ethics. Revised June. Available at: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page>
- Armstrong, J. S. 2010. *Persuasive advertising: Evidence-based principles.* New York, NY: Palgrave Macmillan.
- Arrow, K. J. 2004. Uncertainty and the welfare economics of medical care. 1963. *Bulletin of the World Health Organization* 82(2): 141–149.
- Bell, R. A., R. L. Kravitz, et al. 1999. Direct-to-consumer prescription drug advertising and the public. *Journal of General Internal Medicine* 14(11): 651–657.
- Ben-Shahar, O., and C. E. Schneider. 2010. The failure of mandated disclosure. Michigan Law Empirical Legal Studies, Working Paper No. 10-008. Available at: <https://www.law.umich.edu/centersandprograms/lawandconomics/abstracts/2010/Documents/10-008/benshahar.pdf> (accessed January 24, 2014).
- Bishop, J. D. 2000. Is self-identity image advertising ethical? *Business Ethics Quarterly* 10(2): 371–398.
- Block, A. J. 1993. Beware of the VIP syndrome. *Chest* 104(4): 989.
- Borden, N. H. 1984. Concept of the marketing mix. *Journal of Advertising Research* 4(2): 2–7.
- California HealthCare Foundation. 2005. Price check: The mystery of hospital pricing. Available at <http://www.chcf.org/publications/2005/12/price-check-the-mystery-of-hospital-pricing>
- Cancer Treatment Centers of America. 2013. Mission and promise. Available at: <http://www.cancercenter.com/western-hospital/about-western/mission-promise.cfm> (accessed May 21, 2013).



- Cialdini, R. B. 1984. *Influence: The psychology of persuasion*. New York, NY: William Morrow and Company.
- Community Blood Bank of the Kansas City Area, Inc. vs Federal Trade Commission. 1969. United States Court of Appeals Eighth Circuit. Available at: <https://bulk.resource.org/courts.gov/c/F2/405/405.F2d.1011.18645.1.html>
- Donohue, J. M., M. Cevasco, et al. 2007. A decade of direct-to-consumer advertising of prescription drugs. *New England Journal of Medicine* 357(7): 673–681.
- Elliott, S. 2010. A campaign linking clean clothes with stylish living. *New York Times*, January 7. Available at: [http://www.nytimes.com/2010/01/08/business/media/08adco.html?\\_r=0](http://www.nytimes.com/2010/01/08/business/media/08adco.html?_r=0) (accessed January 24, 2014).
- Federal Trade Commission Act. 1914. (15 U.S.C §§ 41–58, as amended). Available at: <http://www.law.cornell.edu/uscode/text/15/chapter-2/subchapter-1>
- Federal Trade Commission. 1994. *Submission of the staff of the Federal Trade Commission to the American Bar Association Commission on Advertising*. Washington, DC. Available at: <http://www.ftc.gov/be/v020023.pdf>
- Federal Trade Commission. 2002. Weight loss advertising: An analysis of current trends. Available at: <http://www.ftc.gov/bcp/reports/weightloss.pdf>
- Fenton, J. J., A. F. Jerant, et al. 2012. The cost of satisfaction: A national study of patient satisfaction, health care utilization, expenditures, and mortality. *Archives of Internal Medicine* 172(5): 405–411.
- Fisher, J. A. 2009. *Medical research for hire: The political economy of pharmaceutical clinical trials*. New Brunswick, NJ: Rutgers University Press.
- Foglia, M. B., E. Fox, et al. 2012. Preventive ethics: Addressing ethics quality gaps on a systems level. *Joint Commission Journal Quality Patient Safety* 38(3): 103–111.
- Frosch, D. L., D. Grande, et al. 2010. A decade of controversy: Balancing policy with evidence in the regulation of prescription drug advertising. *American Journal of Public Health* 100(1): 24–32.
- Gershon, H. J. 2003. The E in marketing: Ethics in the age of misbehavior. *Journal of Healthcare Management* 48(5): 292–294.
- Greene, J. A., N. K. Choudhry, et al. 2012. Changes in direct-to-consumer pharmaceutical advertising following shifts from prescription-only to over-the-counter status. *Journal of the American Medical Association* 308(10): 973–975.
- Grice, H. P. 1989. *Studies in the way of words*. Cambridge, MA: Harvard University Press.
- Hasman, A., and S. Holm. 2006. Direct-to-consumer advertising: Should there be a free market in healthcare information? *Cambridge Quarterly Healthcare Ethics* 15(1): 42–49.
- Hsia, R. Y., A. H. Kothari, et al. 2012. Health care as a “market good”? Appendicitis as a case study. *Archives Internal Medicine* 172(10): 818–819.
- Joint Commission. 2013. Joint Commission resources: Ethics framework. Available at: <http://www.jcrinc.com/Chapter-1-Defining-Main-Components/Developing-and-Implementing-an-Ethical-Infras/Ethics-Framework>
- Kao, A. C., and K. P. Parsi. 2004. Content analyses of oaths administered at U.S. medical schools in 2000. *Academic Medicine* 79(9): 882–887.
- Klitzman, R. 2009. When the patient is a V.I.P. *New York Times*, August 27. Available at: <http://well.blogs.nytimes.com/2009/08/27/when-the-patient-is-a-vip/> (accessed January 24, 2014).
- Kravitz, R. L., R. M. Epstein, et al. 2005. Influence of patients’ requests for direct-to-consumer advertised antidepressants: a randomized controlled trial. *Journal of the American Medical Association* 293(16): 1995–2002.
- Kupfer, J. M., and E. U. Bond. 2012. Patient satisfaction and patient-centered care: Necessary but not equal. *Journal of the American Medical Association* 308(2): 139–140.
- Kwoka, J. E. 2005. The Federal Trade Commission and the professions: A quarter century of accomplishment and some new challenges. *Antitrust Law Journal* 72(3): 997–1012.
- Larson, R. J., L. M. Schwartz, et al. 2005. Advertising by academic medical centers. *Archives Internal Medicine* 165(6): 645–651.
- Lin, H. C., C. S. Chen, et al. 2006. Differences in practice income between solo and group practice physicians. *Health Policy* 79(2–3): 296–305.
- Loewenstein, G., and J. S. Lerner. 2003. The role of affect in decision making. In *Handbook of affective sciences*, ed. R. J. Davidson, 619–624. New York, NY: Oxford University Press.
- Loewenstein, G., S. Sah, et al. 2012. The unintended consequences of conflict of interest disclosure. *Journal of the American Medical Association* 307(7): 669–670.
- London, A. 2000. Thrasymachus and managed care: How not to think about the craft of medicine. In *Bioethics: Ancient themes in contemporary issues*, ed. R. Polansky and M. Kuczewski, 131–154. Cambridge, MA: MIT Press.
- Lovett, K. M., and B. A. Liang. 2011. Direct-to-consumer cardiac screening and suspect risk evaluation. *Journal of the American Medical Association* 305(24): 2567–2568.
- Lovett, K. M., B. A. Liang, et al. 2012. Risks of online direct-to-consumer tumor markers for cancer screening. *Journal Clinical Oncology* 30(13): 1411–1414.
- McDonald, F., C. Simpson, et al. 2008. Including organizational ethics in policy review processes in healthcare institutions: a view from Canada. *HEC Forum* 20(2): 137–153.
- Newman, A. A. 2011. A healing touch from hospitals. *New York Times*, September 12. Available at: <http://www.nytimes.com/2011/09/13/business/health-care-ad-spending-rises-advertising.html> (accessed January 24, 2014).
- O’Brien, E. 2013. 10 Things medical spas won’t tell you. Market Watch: *The Wall Street Journal*, January 4. Available at: <http://www.marketwatch.com/story/10-things-medical-spas-wont-tell-you-2013-01-04> (accessed January 24, 2014).
- Ozar, D., J. Berg, P. H., et al. 2000. Organizational ethics in health care: Toward a model for ethical decision making

- by provider organizations. *American Medical Association*. Available at <http://www.ama-assn.org/resources/doc/ethics/organizational-ethics-2000.pdf>
- Petryna, A. 2009. *When experiments travel: Clinical trials and the global search for human subjects*. Princeton, NJ: Princeton University Press.
- Relman, A. S. 1992. What market values are doing to medicine. *Atlantic* 269(3): 98–102, 105–106.
- Rosenthal, M. B., E. R. Berndt, et al. 2002. Promotion of prescription drugs to consumers. *New England Journal Medicine* 346(7): 498–505.
- Singer, N. 2009. Cancer center ads use emotion more than facts. *New York Times*, December 18. Available at: <http://www.nytimes.com/2009/12/19/health/19cancerads.html?pagewanted=all> (accessed January 24, 2014).
- Suhonen, R., M. Stolt, et al. 2011. Organizational ethics: a literature review. *Nursing Ethics* 18(3): 285–303.
- Thompson, D. F., P. B. Hofmann, et al. 1992. Hospitals and moral imperatives: hospital ethics. *Cambridge Quarterly Healthcare Ethics* 1(3): 203–215.
- Tomycz, N. D. 2006. A profession selling out: Lamenting the paradigm shift in physician advertising. *Journal of Medical Ethics* 32(1): 26–28.
- University of Pittsburgh Medical Center. 2013. Our mission, vision, and values. Available at: <http://www.upmc.com/about/why-upmc/mission/Pages/default.aspx> (accessed May 21, 2013).
- U.S. Department of Health and Human Services, Food and Drug Administration. 2009. Guidance for industry presenting risk information in prescription drug and medical device promotion. Rockville, MD. Available at: <http://www.fda.gov/cber/guidelines.htm>
- Volpp, K. G., G. Loewenstein, et al. 2012. Choosing wisely: Low-value services, utilization, and patient cost sharing. *Journal of the American Medical Association* 308(16): 1635–1636.
- Witte, K., and M. Allen 2000. A meta-analysis of fear appeals: Implications for effective public health campaigns. *Health Education Behavior* 27(5): 591–615.
- Yarborough, M. 1989. Physician advertising: Some reasons for caution. *Southern Medical Journal* 82(12): 1538–1544.
- Zeckhauser, R., and C. R. Sunstein. 2008. *Overreaction to fearsome risks*. Cambridge, MA: Harvard University.
- Zoubul, C. S. 2009. Health care institutional ethics: Broader than clinical ethics. In *Health care ethics: Critical issues for the 21st century*, ed. E. E. Morrison, 237–250. Sudbury, MA: Jones and Bartlett.

Copyright of American Journal of Bioethics is the property of Routledge and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.