

Of hospital advertising truths, half truths, and the academic medical center



Spyros Andreopoulos

The author is director emeritus of the Office of Communication and Public Affairs at Stanford University School of Medicine. He is the author of numerous books and articles about health care, and has previously contributed to *The Pharos*.

Rival nonprofit and for-profit hospitals spend millions of dollars on aggressive direct-to-consumer (DTC) advertising to lure coveted patients. The trend infects top-flight academic medical centers (AMCs) and causes their marketing departments to become increasingly creative in their pitches to patients, using the kind of subtle, manipulative techniques associated more with pharmaceutical companies than health care institutions. Until recently, the competitive efforts of AMCs were limited to persuading private-practice physicians to refer patients to their hospitals and clinics. Patients were not directly urged to choose their own hospitals except through their physicians. While no one disputes that academic centers have an obligation to succeed financially, aiming advertisements at healthy consumers to increase business for hospitals is new and may entail risks.

For the past two years I have tracked advertising by AMCs to determine its appropriateness and effectiveness. Because the trend is new, the available literature on the subject is inadequate, but it permits some tentative conclusions. The public education value and effectiveness of DTC advertising by AMCs seem marginal at best. Advertising uses money I believe could be better spent in providing good health care and setting an example, and it tarnishes AMCs' well-earned reputations. In competing for patients, AMCs must address

the longstanding generic issues that make their clinical services less than desirable.

Consumers put AMC on sacred ground

The current trend toward technological solutions to clinical problems and the potential of their premature application to satisfy competitive pressures could have a distorting influence on the missions of AMCs and their pursuit of scholarship. Although consumers are generally wary of advertising, AMCs and academic physicians arguably inhabit a sort of sacred ground in the eyes of many Americans, who may not view their ads with the same level of skepticism. Thus unquestioning consumers could be attracted to medical services that are unnecessary, or worse, harmful.

Conflict of interest can occur when physicians who provide risk counseling to patients are at the same time promoting procedures and therapies in which they have personal or financial stakes. Such conflicts erode the covenant of trust AMCs need to carry out their missions. Some academicians who criticize the pharmaceutical industry's advertising practices as leading to wrong prescribing and inflated health care costs are curiously silent when their own institutions unabashedly hawk medical services that have potentially the same result.

Advertising by hospitals and physicians has a checkered past.¹ During the Gold Rush era in California it was common practice for physicians to make known their skills through the newspaper. The American Medical Association (AMA) was founded in 1847 for the purpose of improving medical education. It did so rapidly and to a degree beyond the dreams of its founders, resulting in equal advances in the quality and ethics

of doctors. The AMA and the American Hospital Association (AHA) explicitly banned advertising for their members. The AMA's code of ethics of 1847 called advertising a "highly reprehensible practice,"² while physicians believed it to be damaging to their reputations.³

The professional value system of physicians, rooted in the Hippocratic oath, is based on providing the best quality of care and service. Hospitals were primarily created to improve access to care for the poor, indigent, elderly, and vulnerable.⁴ These values served to constrain questionable practices. A sense of decorum in the relationship between doctor and patient was firmly established and maintained by the discipline of physicians themselves. A U.S. Federal Trade Commission suit against the AMA in 1975, accusing the organization of "restraint of trade" for its ban on advertising, was concluded in 1982 and medical advertising was legalized. Thus this progressive era came to an end.

The 1990s—AMCs need new money

The introduction of managed care insurance and Medicare cuts in the 1990s forced AMCs to seek new revenue sources through marketing and advertising. How much AMCs are spending for this purpose is anybody's guess, since marketing and advertising expenditure figures are not available in Medicare cost reports because these functions are lumped together with the overall expenditures for administration. The most recent estimates available, however, indicate that, between 1991 and 1998, DTC advertising by all hospitals went up fifty-six percent, hitting \$3.1 billion in 1998,⁵ with California experiencing a dramatic six-fold increase over the period.⁶ Large nonprofit teaching hospitals are by far the most active advertisers compared to for-profit hospitals, for which marketing expenditures are leveling off. Today it is nearly impossible to open a newspaper or turn on television and radio without being barraged by AMC hospital ads touting their programs, skilled doctors, and procedures.

In the first study ever conducted to analyze this trend, researchers from the Veterans Affairs Medical Center at White River Junction, Vermont, and Dartmouth Medical School examined marketing practices by seventeen of the nation's top academic medical centers from the esteemed *U.S. News & World Report* honor roll of 2002.⁷ Researchers interviewed each center's marketing staffs and obtained all nonresearch-related print advertisements distributed by the honor roll centers.

They found that of the 122 ads aimed at attracting patients, the most common marketing strategy involved an emotional appeal to evoke feelings of fear, hope, or anxiety about a health risk. Many of the ads promoted individual departments and conditions such as cardiovascular, cancer, and orthopedic issues, but also tests or services of unclear health value to the public, such as full-body CT scans. Other ads promoted cosmetic procedures. In some cases, the ads seemed to place the

financial interests of the medical centers before the interests of patients. One-third of the ads used slogans focusing on technology, fostering a misperception that high-tech procedures are always better, but neglected to mention the procedures' costs or potential harms. The ads tended to create a need in the minds of medical consumers where one might not have existed, thus increasing the likelihood of services being used inappropriately and exposing patients to unnecessary risks. While AMCs have institutional boards to exercise oversight for clinical research, the study found that none of them had a formal process to ensure that ads presented fair, balanced, and straightforward information on what therapeutic interventions entail.

The Dartmouth study does not draw conclusions about the effectiveness of hospital advertising. The AHA and ten state hospital associations, however, have looked at consumer responses to various advertising approaches—radio, TV, and print—as part of a public opinion survey.⁸ The data are suggestive only. Consumers in focus groups tended to be skeptical of ads by academic medical centers that emphasized their prize-winning researchers, and they questioned whether such high-end organizations would care for them. The ads that registered best showed real health care professionals going into the community to care for patients.

VIP programs, co-marketing . . . legal, but will the public object?

While reports on advertising practices are instructive, they merely expose the tip of the iceberg. Some major AMCs use equally disingenuous "soft-sell" marketing strategies to generate patient referrals and maintain their elite status. The strategies include questionable VIP programs to attract wealthy patients, and the entry into co-marketing efforts with commercial airlines and other corporate sponsors that may have nothing to do with health care.⁹ Although such practices are legal, adopting them puts academic centers at risk of losing public support, possibly even the privileges they have enjoyed as nonprofit institutions.¹⁰

Professional organizations such as the Society of Thoracic Surgeons are concerned about the use of physician endorsements appearing on web sites and in paid advertising that are often prepared by lay publicists without physician verification of accuracy. Examples cited are unwarranted claims of success of new surgical technologies, denigration of "gold standard" procedures previously validated in peer-reviewed journals, and undocumented claims of short hospital stays and low costs. The society's policy does not restrict advertising by physicians, but it warns that certain types of communication have a significant potential for deception and should receive special attention.¹¹ Similarly, the AMA warns its members of advertising's potential to deceive the public, and the AHA's guidelines state that content should be measured primarily by its truthfulness, fairness, and sensitivity to public needs.

Although surveys show that consumers approve of hospital advertising, it is not a major factor in patients choosing a hospital.¹² This finding is not surprising because, with the exception of patients on straight Medicare and those covered by indemnity insurance, most patients have little say in selecting a hospital. It is generally a patient's health plan (ordinarily chosen by his or her employer), the location of hospital, and the preferences and staff affiliations of his or her personal physician that determine the hospital to which a patient is admitted. Prospective patients seeing ads for hospitals may infer something of the quality of care they are likely to receive at a given hospital,¹³ but they may also reach the opposite conclusion. Since advertising to boost sagging revenues may signal financial difficulties, it could cause consumers to suspect that the hospital is poorly managed and quality is low.

Hospital advertising is frequently purported to have an educational purpose, informing prospective patients about the quality of the hospital being touted. But data on hospital quality are available from "neutral" sources—news media, friends, consumer organizations, and the Internet. Thus, hospital advertising is not only superfluous, but it may crowd out other information about an institution that could be disseminated factually and effectively by its communication department.

Patients rely on their physicians, not ads ... or do they?

Even if most consumers were free to select their own hospitals, marketing experts believe that advertising to influence that choice is not the answer.¹⁴ Getting sick is beyond the control of the best marketing and advertising efforts. Given a choice and unable to directly assess health care quality, most consumers rely on the advice of their physicians and on proxy measures to determine where they will go for their hospital care.¹⁵ An example given by one marketing expert is the airline industry. How do passengers know the engines are well maintained on the plane in which they are about to take off? Since they cannot inspect the engines themselves, passengers subconsciously consider cleanliness a proxy for maintenance because cleanliness is immediately accessible and understandable to them. Similarly, if a patient finds himself in a broken hospital bed or a dirty room, he can logically wonder about the state of the anesthesia equipment or respirator.

Studies examining the hospitalization experiences of patients at our AMCs reveal serious shortcomings. While the expertise and quality of medical care provided by faculty physicians are rated very high, patients' experiences are often marked by inexcusable inefficiencies, inconveniences, and events that reveal fundamental problems associated with organization and teamwork.¹⁶

Some of the identified problems include poorly coordinated health care, poor organization and admitting procedures, staff not knowing which physician is in charge of the care, tests not being done on time, and staff providing conflicting

information. Having an early morning clinic appointment, for example, and waiting several hours to see a physician may not have a negative outcome on a patient's care, but is this experience necessary? Is it acceptable to have a patient wait in the emergency department for six hours because no one can find a phlebotomist to draw blood for a test the resident ordered? Is it excusable when patients encounter delays in finding a hospital room or have dirty linen and uncleaned rooms?

Fixing these problems should be given the highest priority. Evidence suggests that reorganization of patient care functions by some AMCs can strengthen both the quality of care and educational functions.¹⁷ In addition, patients can become the most powerful marketing tool AMCs possess. If patients are treated right, their recommendations to family and friends will do more to build success than any form of paid advertising.

The value of AMCs to society in terms of medical innovation, training of physicians, and provision of indigent care needs no advertising. It is well recognized by the generous support they receive from taxpayers and private philanthropy. The ability of AMCs to deliver medical care efficiently and economically depends on organization and new, possibly painful, adaptations rather than pushing procedures. Cosmetic surgery and some concierge services aside, consumers are not actively seeking out a hospital's TV commercials to help them choose the place for their next medical procedures, nor do they care to know which hospitals are the corporate sponsors of the local radio news or baseball team.

For most consumers, getting the children to school, juggling careers, taking care of aging parents, and staying healthy and out of the hospital are the real priorities. If an AMC wants to make an impact, it must use its limited resources to intersect with those priorities and build relationships so that people will choose its facility when needed. DTC advertising is the wrong prescription for what ails AMCs or for their survival.

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The author's address is:

Office of Communication and Public Affairs
Stanford University School of Medicine
701 Welch Road, Suite 2207
Palo Alto, California 94304-1711
E-mail: masga@stanford.edu

Commentary

Of truths, half truths, and less than half truths on the road to health

Michael M. E. Johns, MD

The author (AΩA, University of Michigan, 1968) is the CEO of the Robert Woodruff Health Sciences Center at Emory University.



The issues concerning hospital advertising are quite interesting, complex, and urgent, and deserve careful and informed review and consideration. Hyperbole and outdated or unsupported assumptions should be avoided. Advertising, whether by for-profit or not-for-profit (NFP) health care entities and providers, is part of a larger universe of effort that falls under the general category of marketing and the closely related functions of public relations and communications. Virtually all NFP organizations with a service mission and a significant public to serve—including academic health centers (AHCs)—engage in marketing, public relations, and communication. Advertising by AHCs has been around almost as long as open-heart surgery, and has evolved at least as much. It is most often carried out as part of an overall marketing and communications strategy. Because its timing and content can be controlled, it can take many forms, target many different audiences, and be designed to achieve a variety of goals. While it certainly can be designed and employed for nefarious and otherwise unethical purposes, it is not helpful to characterize all advertising as unethical. And it is misleading to characterize advertising by AHCs as “aggressive direct-to-consumer advertising” that is “infecting” AHCs. Communicating clearly and directly with “consumers,” whatever the medium, is often the preferred way to promote understanding of health issues and resources.

The recent dynamic for AHCs: Managed care penetration

Mr. Andreopoulos cites some recent studies on hospital and AHC advertising, but fails to mention some of their most important findings. Barro and Chu, for instance found not simply that large NFP teaching hospitals experienced the largest increases in advertising spending from 1995 to 1998. Testing a number of hypotheses to explain this increase, they concluded that the most likely explanation is that the upsurge in managed care penetration introduced a new dynamic into local and regional markets for health services. AHC teaching hospitals, needing leverage to negotiate so as not to be left out of HMO networks and to receive premium payments in reimbursement contracts, apparently undertook increased advertising as a means to “create a sense of necessity for a hospital,”^{1p14} For other hospitals, they explain, “HMOs are simply a financial shock, and advertising expenditures should fall.”^{1p14} Ignoring this conclusion, Mr. Andreopoulos cites this report to bolster his hypothesis that “the introduction of managed care insurance and Medicare cuts in the 1990s forced AHCs to seek new revenue sources through marketing and advertising.”²

Another of Mr. Andreopoulos's assertions is that the value of AHCs is obvious and transparent to society. I believe he would be hard pressed to find many marketing or communications professionals, department chairs, health professionals, or administrators within our nation's AHCs who would agree with him. Our own marketing surveys show that the general public has a hard time understanding what an AHC is—What is our mission? What services do we provide? What kind of research and education do we pursue, and why? What distinguishes us from local or regional for-profit or community providers?³ AHCs are extraordinarily complex and diverse institutions. Educating the public about our abilities, missions, and resources remains a significant priority. And there is no question that most AHCs do work hard to be the very best sources for health care in their communities and believe that they have an affirmative obligation to make that known to the public.

Robin Larson and colleagues raise fundamental questions about particular marketing strategies employed by AHCs in advertising to the public: Do certain ads or marketing strategies put the interests of the AHC or provider ahead of those of the public or patients? Is the messaging appropriate and properly targeted? Do certain approaches mislead? If services or products are advertised, are they known to be safe, appropriate, and effective? Does the messaging provide adequate information concerning the risks of the relevant test, procedure or therapeutic? Should AHCs subject certain or all types of marketing to oversight and review similar to that which we routinely require for clinical research?⁴

Needed: Careful ethical analysis of all ads put out by AHCs

All of these, and many more, are important questions

that all AHCs, professional societies and organizations, and providers should be taking seriously. Increasingly, public and private sectors must both cooperate and compete to translate discovery and innovation into advances in health and healing. All parties must be vigilant to recognize and manage any real or apparent conflicts of interest that may erode the trust of the public or reflect on the integrity of our work. Advertising practices of AHCs should therefore receive careful scrutiny. Most AHCs have review processes for advertising that include, at a minimum, administrative, legal, and ad agency reviews. If there is no such process, review for potential conflict of interest and related ethical guidelines should be put in place.

Advertising: Part of the communications tool kit

I sympathize with the view that it would be preferable to spend scarce resources directly on health care, research, and education, rather than on advertising. But you won't go very far forward looking in the rear-view mirror. The decision in 1982 that legalized medical advertising can be looked at two ways. Mr. Andreopoulos asserts that a “progressive” era came to an end. The counter view is that, in an evolving, competitive health care marketplace, advertising is part of the basic communications tool kit. Increasingly sophisticated consumers rightfully expect the information and educational resources to enable them to be full participants in understanding and managing their health and care. We must provide them the knowledge about our institutions' capabilities and limitations. And we must bring our professional dedication to the best interests of the public we serve, including our patients, our research subjects, and our students. If we keep our eyes focused on the quality and integrity of everything we do—from research to care to education to communication—we will continue to make progress on the road to health.

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The author's address is:

Emory University
1440 Clifton Road, Suite 400
Atlanta, Georgia 30322
E-mail: mmejohns@emory.edu