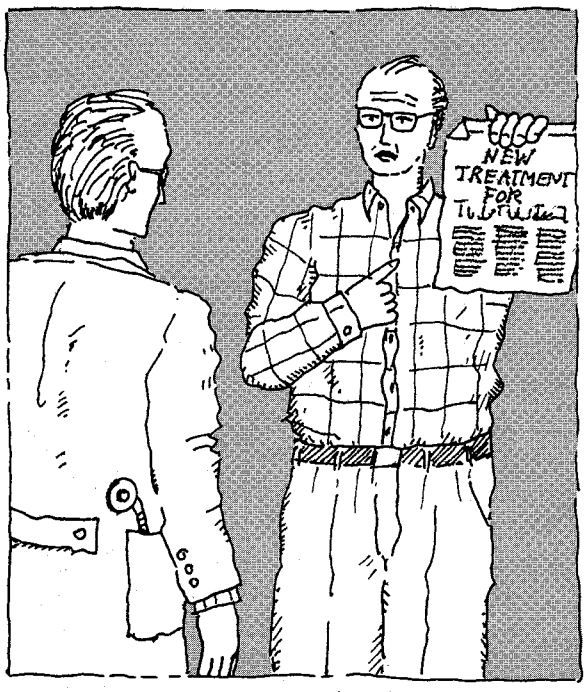
Are Machines Driving Public Demand?

News Media Coverage of Medical Technology

GARY J. SCHWITZER



I've often felt that the years during which I covered medical news for Cable News Network (1984-1991) were some of the most revolutionary. Not only did the advent of CNN increase the public's awareness of medical news, but the way the subject was covered also changed drastically. It was an era that gave us round-the-clock coverage of artificial heart experiments (including sometimes-hourly reports of patient urine output), transplants (heart, lung, heart-lung, liver, pancreas, kidney, islet cell and caudate nucleus), the National Cancer Institute's exuberance for its Interleukin-2 cancer trials, and many claims for AIDS, Alzheimer's disease and other headline conditions.

Many times during that period, I felt the most important role I could play was actually as a news gatekeeper—guarding against an overload of needless, useless medical news—rather than as a news disseminator. It became clear to me that the daily bombardment of stories concerning "newer, cheaper, safer" treatments and diagnostic tests offered no context to our viewers. Our daily messages ran the risk of doing more harm than good. At the very least, they established unrealistic expectations in the viewers' minds, building a growing perception that there was always a cure or a miracle or a breakthrough just around the corner, maybe in tomorrow's medical news report. I argued for a daring, different approach: "Let's wait until we're sure we got it right."

But network management strove to be "competitive," taking the stance that if anyone, anywhere reported a new medical story, then CNN owed its audience at least a brief mention of that news item. This reasoning always puzzled me, as it appeared to assume that a sizable portion of our audience was keeping a scorecard next to the TV set at home, watching other networks or comparing our coverage with newspapers across the country, and monitoring vigilantly to see who had which medical story first. It was applying Gulf War coverage strategy to medical news coverage . . . and something broke down in the translation.

Finally, my conscience steered me toward a career change when I had to admit that I was more interested in getting it right than in getting it first. That is not a mentality that is universally applauded in television journalism, so I took my conscience elsewhere.

DEMAND FOR TECHNOLOGY

The managing editor of *The Internist: Health Policy in Practice* recently asked me to write an article, exploring the following questions:

- To what extent does the media affect patient demand for services by reporting on new technology?
- Do patients put too much pressure on physicians to try a technology of uncertain benefit?
- How does public demand for technology affect the spread of technology?
- To what extent do marketing and competition among hospitals motivate the demand to acquire new technology?

In the absence of any clearinghouse of infor-

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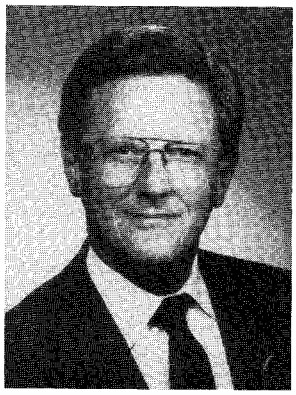
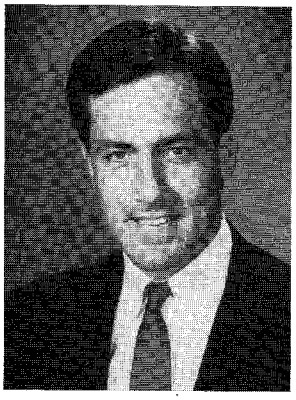


Duvall: *'Try not to have a defensive attitude'*



Hornbake: *Need for a 'balanced view' in media*

mation on such questions, and with only scattered anecdotal reports by physicians complaining at medical meetings, it's clear that these questions cannot be answered convincingly. But in interviews with several ASIM leaders, it became equally clear that this is not just another exercise in generalized media-bashing. These clinicians work "where the rubber meets the road" in private practice settings like New Bern, N.C., and Decatur, Ill. By no means is this a scientific sampling, and perhaps it isn't even representative of the national experience. But this spot-check uncovered several recurring themes:

- Elderly patients, many of whom have critical health problems to worry about, are preoccupied with their blood cholesterol levels.
- Many men feel they need the prostate-specific antigen (PSA) test as a general screening test to detect prostate cancer.
- It is becoming increasingly difficult to convince some of the women who have breast cancer that they are not good candidates for autologous bone marrow transplants.
- "Chest Pain Centers" and "Cancer Institutes" are the new "hot buttons" of hospital marketing.

I spoke with ASIM Trustee E. Rodney Hornbake III, MD, of New Bern, N.C.; Past President Charles P. Duvall, MD, of Washington, D.C.; Trustee Ronald L. Ruecker, MD, of Decatur, Ill.; and Trustee J. Leonard Lichtenfeld, MD, of Baltimore. The physicians made isolated observations about other media-driven issues (concern over coverage of animal studies, such as one that suggested soy diets reduce breast cancer in laboratory animals; unrealistic public expectations posing clinical dilemmas regarding end-of-life technology; and patients' perceptions that computed tomography and magnetic resonance imagery [CT/MRI] scans are easy, one-step, do-it-all diagnostic tests). Because I can't adequately cover all of these issues, I will summarize those that were raised by two or more of the physicians interviewed.

CHOLESTEROL

Surely, the media coverage of cholesterol and its potential health risks, including coverage of the government's National Cholesterol Education Program, helped plant the fear of high cholesterol levels in the minds of octogenarians, without emphasizing, as Dr. Hornbake said, "that there is no data to suggest that treating hypercholesterolemia" affects an older person's health. At their insistence, Dr. Hornbake often finds himself counseling his older patients—most recently, an 85-year-old man—about cholesterol testing, generally steering such patients away from the test. Accordingly, he believes that "physicians must bear part of the responsibility for that [cholesterol testing] phenomenon because it's easy to encourage that kind of activity. It can be a very low-stress practice to do the test, just as the patient requested."

Dr. Ruecker concurs. "You have no idea how difficult it is when a 90-year-old man comes in worrying about his cholesterol. I've had them come in innumerable times when a cholesterol screening in a shopping mall has shown their cholesterol to be over 200. They've already exceeded their life expectancy, making it to 90, and now they're going to worry about a total cholesterol of 230!

"We're spending a lot of resources tracking cholesterol in people for whom it'll make no difference in the long run. The media have done the story well, but the target audience should have been younger," Dr. Ruecker said.

Dr. Lichtenfeld said that even his younger patients are becoming obsessed with their cholesterol levels, noting that many people with cholesterol levels at 205 or 210 develop an unnecessary "disease mentality." He wishes the news media, in covering cholesterol, would remind people that "the facts aren't known for women, or for older people, who were not represented adequately in the large-scale trials that are the subject of most news coverage." He also wishes reporters would broaden their view "to include the perspectives of the British or the Canadians who say we're overtreating cholesterol."

PROSTATE CANCER TESTING

A good example of media hype for the prostate-specific antigen test appeared recently in a business column in the *Boston Globe,* under the headline, "A Perk That's Good Enough for Bush Should Be Available to Everyone." The article detailed several insurers' reluctance to pay for the test under some circumstances. The column's summary: "Health insurers and Congress, concerned about Medicare recipients, must find methods to fund the PSA test as a routine screening for all males over age 50. It is, after all, a perk President Bush enjoys."

If presidents received MRI scans during routine physician exams, would the columnist suggest that the $1,000 scans become part of routine screening for all Americans?

Dr. Lichtenfeld said the PSA test is an example of a technology for which people have "gone crazy." He said that although the test's developers have shown it to be a good marker for early prostate cancer, "now they've gone out and captured the eye of the media, leaving the impression that every man should have screening PSAs. Hospitals are climbing on board, using the test as a marketing gimmick."

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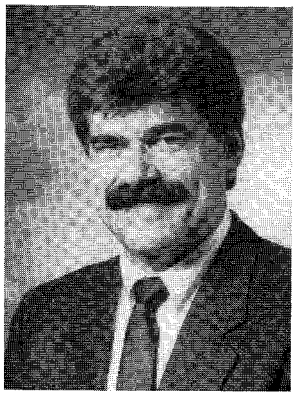
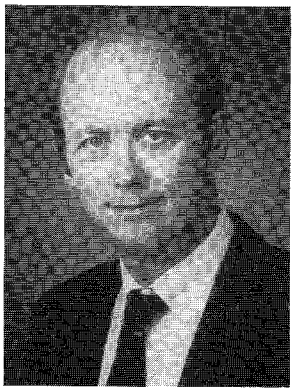


Lichtenfeld: *Technology becoming a 'marketing gimmick'*



Ruecker: *'Report the consensus'*

Dr. Lichtenfeld received several calls from patients who had received the PSA test, but no urologic exam. He recalls scenarios in which patients "get the PSA, then a transrectal ultrasound, then a biopsy, then a diagnosis of cancer, then surgery or radiation—all in a situation where there may not have even been a diagnosis in the past. The common wisdom is, 'Isn't this wonderful? We can find it early, with a better chance of cure!'"

What isn't reported, and what doesn't make it into the marketing messages is that "many men diagnosed with early-stage prostate cancer may have no change in the quantity or quality of their lives—even without treatment," said Dr. Lichtenfeld.

This raises the issue of so-called "lead-time bias"—where people identified during general screenings may have a slower-growing cancer, and may not require intensive treatment, Dr. Lichtenfeld said. The news media, he said, have failed on that issue. "I've diagnosed more prostate cancer in the last several months than I have in the previous several years, but I'm not sure I've provided benefit to that many more patients. These 'discriminator' facts are not being put out into the public arena."

Dr. Hornbake has experienced similar situations. He said that patients in their 40s and 50s are coming in for blood pressure follow-ups and asking, "While I'm here, why not do that prostate cancer test?" When he responds, "We did that . . . that's what the digital rectal exam was for," the patient often retorts, "No, I mean that new blood test."

Still other patients tell Dr. Hornbake that because they've had benign prostatic hyperplasia (BPH), he should check them for cancer. In a similar situation, a doctor may do the test just to avoid a confrontation with the patient. "The more competitive market you're in, the more difficult it is to say 'No,'" Dr. Hornbake said. "The path of least resistance is to agree. To argue or suggest it's unnecessary is to invite the patient to leave the practice. That's one reason I chose to set up practice in a part of the country where my services are in demand. I'd hate to have my office in suburban Virginia, outside Washington, D.C."

Dr. Duvall, who practices in Washington, D.C., chuckled upon hearing Dr. Hornbake's comment. "Twenty-five percent of my practice is lawyers and their families, and I'd guess 90 percent are college graduates." With such an educated clientele, it's not unusual for Dr. Duvall to receive a call like the one he got recently. Said Dr. Duvall: "An elderly dentist called, asking for Proscar (finasteride), the recently FDA-approved drug for BPH. I told him I'd had no experience with the drug whatsoever. The man said, 'I've been calling around and I found a drug store that will order it if you prescribe it.' After checking on background information, I wrote the prescription. I saw the man in a social setting three days later and he beamed, 'God, this stuff works great!' I doubt seriously it could have worked that quickly."

Indeed, literature on Proscar suggests it may take up to a year to determine if the drug has any beneficial effects, because the prostate shrinks slowly in response to the drug. (Sounds like grounds for a new study: "The press-powered placebo effect.")

BONE MARROW TRANSPLANTS

There also are frequent "miracle" claims about untried therapies in the field of oncology, reports Dr. Lichtenfeld, a trained oncologist. The current example is the autologous bone marrow transplant (ABMT) for women with metastatic breast cancer.

"When a woman goes on television, appealing for funds, or goes to court, to force this kind of therapy, all I can think of is that some of my patients have not done well with this treatment and have relapsed shortly after autologous bone marrow transplant," said Dr. Lichtenfeld. "Is it right to spend our health care dollars this way, when [with the same money] we could immunize all the kids in Baltimore?"

In addition, as far as prolonged survival is concerned, the transplant may be "therapy" for only 5 percent of the women who undergo the procedure, said Dr. Hornbake. "Yet it costs $50,000 to $80,000 [or as much as $150,000 in some areas] and is promoted as 'state-of-the-art treatment' outside clinical trials," he said.

However, medical terminologies may be major obstacles to the public's comprehension of ABMT and other complex therapies. "The public doesn't understand the concept of 'statistically significant' in the medical sense, particularly in the field of oncology," said Dr. Ruecker. "To an oncologist, 'response rate' means a tumor regression of at least 50 percent. But to the public, 'response rate' means 'cure.' The difference is lost in news articles."

For example, Dr. Ruecker said, if the Associated Press picks up a story about a new therapy that was tested on only 10 or 15 patients, and which may have gone unreported in the medical journals and unvalidated by other investigators, the story can give patients unsubstantiated hope.

"Patients with terminal illnesses, who are grasping at straws, may tell their physicians, 'I need this therapy!'" explained Dr. Ruecker.

Steered by imprecise, fuzzy reporting, patients may lose track of the different applications for the same technology. "Bone marrow transplantation for lymphoma is clearly established therapy," said Dr. Duvall. "Just as clearly, it is experimental for breast cancer. We don't know in

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which stages of [breast] cancer it makes a meaningful difference, nor which subsets of patients for whom it's most appropriate.

"Yet the decision of whether it's experimental or 'Damn it, you gotta pay for it' is being made not by researchers or by the government, but by singular judges with singular cases in front of them. And the 'you' that's gotta pay for it is you and me, when you get right down to it," he said.

DEMANDING PATIENTS

Dr. Duvall told the story of a man with prostate cancer who was not responding well to his drug regimen. As Dr. Duvall was about to propose a new approach, the patient revealed he'd done his own literature search—and proceeded to propose his own scheme.

"An educated clientele still needs a doctor," Dr. Duvall said. "You just try not to have a defensive attitude. There can be a built-in tendency to go for new technology in these folks.

"It's hard to disagree with a patient who pleads, 'Hey, doc, what do you think about doing a treadmill test on me? You know, one of my law partners had a heart attack last week,'" he explained.

Dr. Ruecker puts his own spin on the "magic bullet," vaccine-for-all-ailments mentality he often sees in patients today. "I'm 48 years old," he said, "and I can remember when the polio vaccine wasn't around. People made real changes in their lifestyles in the summertime. Pools closed. You didn't go outside at night. Now, the mind-set is: 'Let's invent a vaccine, but don't ask me to do anything different in my lifestyle. If we just spend enough money, somebody will come out with a cure and I won't have to change.'"

When faced with a patient who demands an unwarranted new drug, procedure or test, Dr. Ruecker has one fall-back position when all else fails. "I ask them, 'Do you realize by telling you that you don't need this, that's $500 I'm not going to make?' It often makes the patient stop and think, 'Maybe I don't need this.'"

QUESTIONABLE MARKETING

The four physicians interviewed also discussed the recent, misleading marketing practices of some of the hospitals in their vicinities, including the following:

- A radio ad for a neonatal intensive care unit, bragging, "We routinely save babies who weigh less than one pound." When a listener complained, the ad was yanked from the airwaves.
- A radio ad for laparoscopic hernia repair. As you may suspect, the ad did not mention that the procedure was not for everyone; neither did it mention that the procedure is still in the learning curve.
- The creation of a Cancer Care Institute by a hospital trying to get a linear accelerator to compete with another hospital's hardware four miles down the road.
- The creation of a Chest Pain Center, with the only change being the posting of plastic signs with arrows pointing to the hospital's emergency room.
- The "Cancer Treatment Centers of America" television ads, which particularly perturb Dr. Lichtenfeld. "They sound like lawyers advertising in Baltimore!"

MEDIA ADVICE

Dr. Hornbake said he's seen some outstanding examples of media coverage of health care issues, although more in print than on television. His outlook on network news coverage is pessimistic: "If there's medical news on the network news, it's not going to be well done. The same thing that has happened to political reporting has happened to medical reporting: no perspective," he said.

He cautions that medical reporters should avoid being so easily manipulated by the medical community. "Get a balanced view, and don't listen to every promoter who merely sounds reasonable. Realize that some so-called new breakthroughs are really old information. Anyone who's been around this business for any length of time knows where the problems are, has seen things come and go, and knows that what's held out today as a breakthrough may not be around tomorrow."

In addition, Dr. Hornbake said reporters need to verify the information they receive from physicians. "Don't suffer from a 'deity complex,' making a false assumption that everything a physician or scientist said is automatically more honest, above-board, or even peer-reviewed."

"Document and then re-document." That's Dr. Ruecker's advice to journalists covering medical news. "Make sure you're reporting the consensus in health care and not isolated, sensational events. You're doing a disservice to your audience if you create false expectations."

From the perspective of one who worked in television news for 17 years, that's some of the best advice I've ever heard a doctor give. ◀

GARY J. SCHWITZER, *who was a medical reporter at Cable News Network for seven years, is employed by the Foundation for Informed Medical Decision Making in Hanover, N.H., a group that produces videos to guide patient decision making. The opinions expressed in this article are those of the author or the physicians who are quoted, and do not represent the foundation's policy.*