Online marketing of medical procedures needs better regulation

The British Association of Aesthetic and Plastic Surgeons, prompted by the problems with breast implants made by Poly Implant Prothèse (PIP), has called for several changes, including a ban on all advertising of cosmetic surgery. This is understandable, perhaps, as a kneejerk reaction to protect the reputation of the industry, but with increasing globalisation how realistic is such a ban?

The recent debacle has highlighted the challenges in regulating direct to consumer advertising of medical care in the internet age. In the United Kingdom, healthcare has not traditionally been viewed as a product to be marketed and advertised. Advertising medical products, for instance, is strictly controlled by legislation and codes of practice.

Promotional material on the internet directed at a UK audience is also subject to the Association of the British Pharmaceutical Industry’s code of practice. In reality, however, enforcement is only possible against entities with a presence in the regulator’s jurisdiction. With the increase in so called medical tourism, where surgeons or providers of a medical service are based abroad and market themselves to patients in the UK, regulating and enforcing codes of practice are becoming serious problems.

The phenomenon of patients travelling outside the UK to receive medical treatment has rapidly expanded over the past 10 years. A survey by the Office for National Statistics showed that as many as 63 000 UK patients travelled abroad to access treatment in 2010. Such medical travel is driven to a considerable extent by web based resources that advertise to the patient (or, rather, consumer), provide information and market destinations, and connect them with an array of foreign healthcare providers and brokers. Research shows a burgeoning number of sites dedicated to medical tourists in recent years. A major growth area has, in particular, been advertising and marketing of cosmetic surgery that predominantly present treatment as a lifestyle choice, rather than as a serious surgical procedure with accompanying risks and potential long term health consequences.

The problem facing any call for a ban in advertising is that these foreign sites are not regulated by any UK body, and they do not have to adhere to any specific codes or standards. In the European Union, an e-commerce directive (2000/31/EC) requires companies to display ways in which the website can be contacted, but this is minimal information given the nature of services and products marketed by medical providers.

A systematic review of websites aimed at potential UK medical tourists found limited information available, for example, on care after operations, quality, or even the qualifications of surgeons. Selective information may be presented, or presented out of the wider context, such as ignoring issues of aftercare and support. There is also the possibility of unreliable products (such as PIP implants) being marketed through the internet, poor quality surgery, inadvisable treatments, and even treatments that have little clinical efficacy. Most sites are commercially driven and designed to stimulate consumer demand, especially in the case of elective procedures such as cosmetic surgery.

At a time of growth in the private medical sector, and especially with an increasing number of providers abroad marketing themselves to patients in the UK, patient safety is increasingly at risk. The case of faulty PIP implants has dramatically demonstrated this. The UK government’s inability to force private clinics in the UK who fitted PIP implants to remove them, or to provide information about the number of implants fitted, illustrates the limits of the government’s powers to demand information from or action by the domestic private sector.

We need clear and enforceable international guidelines on the content of advertising of medical services, which must include specific quality assurances for the medical products used, for the care after surgery, and for services available to patients in cases of complications. These guidelines need to have a clear basis in international law to be enforceable and hence of practical use. I am not suggesting that this will be simple and straightforward—quite the contrary—but that in an age of increasing globalisation of healthcare, it is essential for patient safety.

Richard Smith is professor of health system economics and head, Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine, London Richard.Smith@lshtm.ac.uk

Competing interests: None declared.

Provenance and peer review: Not commissioned; not externally peer reviewed.

References are in the version on bmj.com.

Cite this as: BMJ 2012;344:e1399
BETWEEN THE LINES Theodore Dalrymple

Less than immortal

How immortal is literary immortality? The members of the Académie Française, always 40 in number, are called les immortels, but it is clear that many of them are forgotten within a few years of their death, and some sooner than that. In his preface to Three Plays by Brieux, Bernard Shaw calls Eugène Brieux (1858-1932) the greatest French playwright since Molière, the equal of if not the superior to Sophocles; but, so far at least, history has not agreed with him. Though Brieux was elected to the ranks of les immortels, his plays are now never performed.

This, perhaps, is because they deal exclusively, and didactically, with the social problems of his day; it is also why they appealed to Shaw, who didn’t mind a bit of preaching himself. The idea that the kitchen sink school of drama of the 1950s was original is false; and in the preface, Shaw tells a little parable: The wife of an eminent surgeon had some talent for drawing. Her husband wrote a treatise on cancer; and she drew the illustrations. It was the first time she had used her gift for a serious purpose; and she worked hard enough at it to acquire considerable skill in depicting cancerous proliferation. The book being finished and published, she resumed her ordinary practice of sketching for pleasure. But all her work now had an uncanny look. When she drew a landscape, it was like a cancer that accidentally looked like a landscape. She had acquired a cancerous technique; and she could not get rid of it.

In other words, to a kitchen sink dramatist, all vessels are kitchen sinks; but Shaw does not see this as a limitation, rather as something to be welcomed because the true purpose of the theatre is propaganda.

Brieux’s most famous play was Damaged Goods, which the Lord Chamberlain refused to license, so that it had to be performed in private theatre clubs. But when it was published it sold by the tens of thousands; eventually it was distributed to students at Yale as a warning against the perils of syphilis.

The hero of the play is the doctor, a practitioner of a happily defunct specialty, sphyriology. His consulting rooms (according to the stage directions) are full of valuable works of art, given to him by members of the upper classes grateful for the cures he wrought.

His patient, George, is about to marry, but has been infected. The doctor tells him to delay his marriage for three or four years, until he is cured (the precise means of cure are not mentioned, but the play was written before the development of the first anti-syphilitic drug discovered since mercury, arsenic, and also known as Salvarsan). George, however, does not wait, marries, and his baby has congenital syphilis, which it then transmits to its wet nurse.

Throughout the play, the doctor sermonises at length with a moral certitude that irritates. For example, he advocates compulsory premarital testing for syphilis as if the audience were a legislature in the midst of debate:

It would soon become the custom for a man who proposed for a girl’s hand to add to the other things for which he is asked a medical statement of bodily fitness, which would make it certain that he did not bring this plague into the family with him.

Whether this be good sense or not (the state of Mississippi still requires a blood test before the granting of a marriage licence), it is not good drama. Policy proposals and plays do not consort well.

Theodore Dalrymple is a writer and retired doctor

Cite this as: BMJ 2012;344:e1429

MEDICAL CLASSICS

C: Because Cowards Get Cancer Too…

John Diamond; first published 1999

“Tell anyone that you have cancer and what they’ll hear is that you’re about to die. Why would they not? It’s what you heard when you got the diagnosis, after all.” These words are now over 10 years old, but John Diamond’s account of medicine’s most feared illness remains as fresh, insightful, and poignant as when it was first published. A British journalist and broadcaster, he was diagnosed with cancer of the throat in 1997, and used his weekly column in the Times newspaper to chronicle the course of his illness. This is the book that arose from these efforts. It is more than simply a journal: Diamond tells his story interwoven with vignettes drawn from the science and history of cancer, and from his own life experience. He hoped that writing it would be part of his cure.

In a way, this is a book with two distinct sides. Firstly, it is a vivid emotional account of what it means to be diagnosed with and treated for cancer, to join “the community which has touched death and touches it still.” Diamond eschewed many conventions surrounding the disease, in particular the warlike analogies that doctors use to describe cancer, and the idea that having cancer is synonymous with bravery. He is candid and articulate when describing the anger, fear, and frustration that he faced, and throughout the book a dark and dry sense of humour permeates the most desperate of situations. As he goes to receive the news that the cancer has relapsed, he is greeted by “my surgeon [and] two men I’d not met before . . . standing behind them, looking embarrassed, was a tallish man in hood and gown with a scythe over his shoulder.”

While sharing with his readers the emotional burden of cancer, Diamond was at the same time a rationalist, and his analytical skills as a journalist were meticulous. His appetite for knowledge and love of science are something that medical readers will identify with; he was the first ever patient at the Royal Marsden Hospital to ask to see the histopathology slides of his own cancer (something the hospital duly organised). The medical profession does not escape his critical eye, being guilty of some toe curlingly awful communication skills we will all recognise. Despite this, he chose to place his faith in the treatments that mainstream medicine had to offer, remaining fiercely outspoken against alternative therapies with no evidence base. This faith becomes all the more poignant as a succession of treatments transform him into a “wounded, honking mute,” and his graphic descriptions of the adverse effects of cancer treatment are something that every doctor should take the opportunity to consider.

Diamond was not unique among his contemporaries in bringing his illness into the public domain, so what qualifies his book in particular as a medical classic? Although he was not medical, what he did was to crystallise several truths about what it means to be a physician; essentially that patients place a huge amount of trust in us, and we have the capacity to harm as well as help them. He may have written for his own catharsis, but his legacy is to reinforce for the rest of us our sense of the privileges and weaknesses of medicine.

Peter M Ellery, foundation year 1 doctor in diabetes and endocrinology, Diabeticare, The Hillingdon Hospital, Uxbridge UB8 3NN

p.m.ellery@gmail.com

Competing interests: None declared.

Cite this as: BMJ 2012;344:e1377

VIEWS AND REVIEWS
Off the record

It wasn’t easy to find work in the 1980s, so I took what I could get. This was mainly bar work: menial, tedious, poorly paid, and sometimes dangerous in Glasgow. But the experience gave me a very valuable return. I learnt how to defuse fights and to deal with aggression and the intoxicated. Best of all, I became an amateur counsellor, imprisoned behind the bar. People poured down drinks and out poured their life stories and confessions.

I learnt not to say much, to listen, never to be shocked, and never to make any reference to the conversations in the future. These are all fundamental daily survival skills required for general practice.

And in today’s increasingly atomised and secular society, general practice has become the confessional. Those without faith, family, or friends—and, indeed, those with faith, family, and friends—turn to doctors to unburden their perceived sins. When patients trust you, the stories just come bursting out, rambling, flowing monologues of pain, hurt, and shame. Sexual issues, drugs, infidelities, grave anxieties, terrible events from long ago.

Sometimes you question the truthfulness of the stories, but with no way of corroborating what is said, you just accept it all. Bar work taught me to be calm in all situations, never surprised, unphased and unflappable. It is hard to know what to say or do. I always explain that what they have said is confidential. For confidentiality is our medical vow—we must share these stories with no one, not even colleagues, taking confessions to our graves. We must never engage in medical gossip.

But in these litigious days, what to write in the record? The medical defence unions dictate that we record everything, so entries are now an impenetrable dense Russian prose, so full of negative findings that it can be impossible to find out what is actually going on. Indeed, if we took the advice of the defence union, medicine would become paralysed by defensive practice and unnecessary investigations. You can be too careful. And if patients disclose personal issues that really have no bearing on their medical care, does this need to be documented? For comments written in records can come back to haunt patients many years later, on many different levels. A written record is, in fact, a breach of medical confidentiality.

So what do doctors do? I have a confession to make—I say, “I am not going to write any of this in your medical records, so tell me what’s going on.” You can take the boy out of the bar, but not the barman out of the man.

Des Spence is a general practitioner, Glasgow 
destwo@yahoo.co.uk

THE BEST MEDICINE Liam Farrell

It’s good not to talk

“Mr X doesn’t talk to patients,” she said.

Joe had been having some problems, but was unable to contact his consultant. So I’d rung Mr X’s secretary.

“Pardon?” I said, wondering if I had heard properly. Or was this the ultimate expression of keyhole surgery; doctor and patient shout ing through the keyhole at each other?

“Mr X doesn’t talk to patients,” she repeated, like Browning’s wise thrush, which “sings each song twice over, / Lest you think he never could recapture / The first fine careless rapture!”

“Really?” I said, increasingly fascinated by the concept; it seemed a quantum leap in the field of doctor-patient communication. Or maybe it was an alternative universe, caused by that Hadron Collider and those Higgs boson thingies, where in

Casablanca Victor Laszlo comes back out of the mist and says to Bogie, “Sod your letters of transit, I’m not flying Ryanair.”

And then, logically, there must be a reciprocal anti-universe, where not only do consultants talk to their patients, but neurologists luxuriate in an earthly paradise of headache referrals, orthopods dream of golden fields of patients with low back pain, gastroenterologists would dance till dawn with irritable bowel syndrome, the heart of a rheumatologist goes all a-flutter at the very thought of fibromyalgia, and gynaecologists shudder with a visceral delight at the prospect of yet another prolapsed vaginal wall.

“Mr X doesn’t talk to patients.” That closed the deal; as the Bellman said, “What I tell you three times is true.”

I like to keep an open mind, so I could see Mr X’s point. When you don’t talk, you can’t say the wrong thing. And patients are selfish; all they want to do is talk about themselves. Hey buddy, you feel like saying, it’s a big world out there, it doesn’t all have to revolve around you. The history is over-rated; context is just as important. Called to the ‘hood, with pimps and crack hoes jumping on the bonnet, the experienced clinician will have a fair idea that it’s not going to be a croquet injury. And at the end of the day, they need a scan anyway.

I admit I was being mischievous. I could have asked for more details; the sanction is probably limited to phone calls, and I’m sure Mr X does sometimes talk to patients, under controlled conditions.

Liam Farrell is a retired general practitioner, Crossmaglen, County Armagh drfarrell@hotmail.co.uk

Cite this as: BMJ 2012;344:e1475