Advertising by doctors and the public interest

Buyers beware

Advertising seeks to gain advantage over competitors by drawing the public’s attention to the superiority of the product marketed by the advertiser. In today’s political climate it was fairly predictable that the Monopolies and Mergers Commission would decide that certain restrictions on the advertising of medical services were anti-competitive and against the public interest.1 But treating medical services as a commodity raises interesting questions, which the commission has sadly failed to answer. The relationship between doctor and patient is one of trust and is quite different from that in a commercial transaction.

The salesman of an advertised commercial product—say, a washing machine—is under certain constraints, such as an obligation not to make false claims. But beyond these constraints he incurs no further responsibilities. If in the course of the transaction it becomes apparent that a machine marketed by a competitor would suit his customer much better or that his customer does not really need a washing machine at all he is under no obligation to say so.

The commission clearly failed to understand the nature of the doctor-patient relationship, in the course of which the doctor may frequently have to disclose information that the patient would much rather not receive. Self promotional advertising is inconsistent with the philosophy of a caring profession. It leads to the introduction of caveat emptor (let the buyer beware) into the relationship to a degree that the existing rules have been most careful to avoid.

The sanction of touting and canvassing by general practitioners is a fundamental departure from the principles of medical ethics. As such it should have been shown beyond any doubt that it would be in the best public interest to permit it, given the opportunities it affords for exploitation, of which the commission admits it was aware. In fact, the report goes no further than to state that “the balance of advantage lies in allowing general practitioners to advertise” and then subject only to certain constraints.

The suggested constraints are that advertising should not be of a character that could reasonably be regarded as likely to bring the profession into disrepute and should not abuse the trust of patients or exploit their lack of knowledge. As examples we are told that advertising should not disparage other doctors, claim superiority over them, or include explicit claims to cure particular complaints. “Cold calling” on patients and too frequent advertising should not be allowed. Nor should advertising place patients under any pressure.

Unfortunately, as anyone experienced in trying to enforce ethical guidelines will immediately recognise, policing these conditions will be impossible other than in the most flagrant cases of abuse. The commission will have succeeded in its aims of allowing touting and canvassing of medical services while the profession will be blamed for having failed to enforce the conditions needed to safeguard patients.

The integrity of the report is also suspect in its review of the effects of lifting restrictions on advertising professional services in Britain and other countries. It lists various countries where this has occurred with consequential price reductions, but only the careful reader will detect that for medical services no evidence is given of any beneficial effects. Indeed, there is no reference at all to the American experience, where there was an increase in the cost of medical services and a deterioration in quality.2

In the National Health Service the taxpayer will pay the bill for advertising as costs will form part of the practice expenses pool. The commission tries to get over this difficulty by pointing out that the “practitioner who spends more than the average will not be compensated for the difference” and warns that “if unreasonable expenditure took place, either by the profession as a whole or by particular groups of doctors such as larger practices, the basis of reimbursement [of practice expenses] would need to be re-examined.”3

Mr Clarke is, of course, very keen on general practitioners advertising. But advertising to the public by consultants is entirely another matter, as it might lead to a substantial increase in the referral rate of patients by general practitioners, which would not please the Treasury at all. Accordingly the commission accepted the evidence it received from the Department of Health that it would not be against the public interest to continue restrictions on such advertising, subject to specialist societies being allowed to respond to direct requests from the public for lists of their members and their qualifications.

The commission rejected warnings by the General Medical Council of the dangers of advertising by plastic surgery “clinics,” suggesting that the Department of Health and the Advertising Standards Authority should examine the case for additional controls over such advertisements. In its evidence to the commission the British Medical Association went to considerable lengths to explain that the British Code of Advertising Practice was unsuited to deal with such questions. The commission has, however, accepted the evidence of the Advertising Standards Authority to the contrary. In fact the code is difficult to interpret, is aimed primarily at traditional
Obstructive sleep apnoea and driving

Sufferers need medical advice

Doctors in Britain have been slow to recognise obstructive sleep apnoea, but now their awareness has increased and more respiratory physicians are investigating and treating this disorder. In obstructive sleep apnoea recurrent collapse and closure of the pharyngeal airway during sleep leads to loud snoring and repeated episodes of hypoxia and arousal of which the patient is unaware. As there may be more than 300 such arousals every night the dominant symptom is daytime sleepiness with poor concentration and frequent "micro-sleeps," particularly during boring activities.1

Although such sleepiness may be personally disastrous (for example, resulting in loss of a job, marital strife, and a reduced quality of life), it may also hazard both patients and others if they fall asleep while driving. These patients often report loss of concentration while driving, particularly on motorways in the dark, when incoming sensory information and activity is low, though more exciting activities will still maintain arousal. Truthful answers about sleepiness during driving may be difficult to obtain owing to patients' fears about losing their driving licence. Thus, as regards fitness to drive, obstructive sleep apnoea should be classified with epilepsy, hypoglycaemia, and Adams-Stokes attacks.

Many long distance lorry drivers have obstructive sleep apnoea2 as they commonly have the major risk factor, obesity. In their survey of truck accidents in which the driver is killed, the American National Transportation Safety Board is now asking relatives routinely about features of obstructive sleep apnoea, given that three recent reports have shown that the road traffic accident rate of patients with this condition is up to seven times greater than that of normal drivers.3 The proportion of crashes in which the driver was at fault and the number of traffic violations were both appreciably higher in patients with obstructive sleep apnoea than in other drivers; moreover, about one third of the patients had had car crashes in the previous five years.4

The prevalence of sleep apnoea and excessive daytime sleepiness is not known, but estimates vary between 0.01% and 5% of men, depending on the exact definition used.5,6 Obstructive sleep apnoea resembles hypertension in that there is a continuum from normality to severe abnormality, and the importance of the less severe forms is not clear. In a survey of over 500 men drawn randomly from a general practice about 5% had some evidence of obstructive sleep apnoea on overnight oximetry (J Crosby et al, paper to the British Thoracic Society, December 1988). "Do you have to pull off the road while driving due to sleepiness" was the only question about sleepiness admitted to more often by this 5% compared to the rest, a small but significant difference (unpublished data).

Excessive sleepiness can be investigated either with tests of sleep latency7 (the time taken to fall asleep, measured during several deliberate attempts to do so) or, perhaps more appropriately, with long and boring vigilance tests.8 The difficulty of simulating the low sensory input of long motorway journeys explains the paucity of laboratory work on this problem. Nevertheless, in most subjects9,10 the mean of 120 measurements of the reaction time following the random presentation of a visual stimulus, over 10-15 minutes, is a sensitive index of one night's sleep deprivation, and almost as good as the one hour Wilkinson vigilance test.11 Lapss of concentration produce excessively long reaction times; in our laboratory normal subjects have a response time of 308 (SD 33) ms whereas over half our patients with obstructive sleep apnoea and other causes of sleepiness (such as the narcolepsy syndrome) have reaction times more than 2 standard deviations (374 ms) above the mean (unpublished data).

How should a doctor advise a patient who drives, has obstructive sleep apnoea, and complains of sleepiness? If there is a history of recurrent sleepiness while driving the patient should certainly be advised to stop driving and also to inform the Driving and Vehicle Licensing Centre in Swansea if treatment is not expected to cure the condition within three months. Patients have a responsibility to do this and doctors are responsible for advising them. With lesser degrees of sleepiness, such as anyone might have after a few nights of broken sleep, the answer is not clear. Nevertheless, patients should be told that this condition can impair driving and that it is common sense not to drive if feeling at all sleepy. An insurance company might well resist a claim if a client was found to have been driving against medical advice. In cases of doubt the medical department at the Driving and Vehicle Licensing Centre should be consulted. All patients with obstructive sleep apnoea who hold public service vehicle licences or heavy goods vehicle licences should be advised to stop driving until effective treatment has been arranged. At present there is no justification for being more stringent than this, given that we do not know the relative risk of a patient with obstructive sleep apnoea having a car accident, compared with patients with other medical disorders that are currently regarded as compatible with continued driving.

Effective treatment for obstructive sleep apnoea is available and dramatically reduces the symptoms due to fragmentation of sleep. The treatment depends on the severity of the condition, ranging from simple advice to lose weight and stop