New Zealand general practitioners’ views on direct-to-consumer advertising (DTCA) of prescription medicines: a qualitative analysis

Ninya Maubach, Janet Hoek

Abstract

Aim To explore the range of opinions held by a sample of New Zealand general practitioners (GPs) toward direct-to-consumer advertising (DTCA) of prescription medicines.

Method Depth interviews were conducted with 20 GPs. The interview protocol examined several aspects of the debate over DTCA, including its appropriateness, informativeness, and effect on doctors’ relationships with their patients. The interview included five sets of forced choice statements that summarised key strands of the debate; these were used as preliminary stimuli to elicit doctors’ views.

Results The results reveal a low incidence of DTCA-related queries and a wide range of views on the appropriateness of DTCA. Respondents favourably viewed DTCA’s ability to increase awareness of some health conditions, although they had serious concerns about the adequacy of the risk and contraindication information provided as well as the general absence of specific cost details. While some doctors resented having to deal with questions arising from DTCA, few considered that this advertising undermined the relationship they have with their patients.

Conclusions Overall, while the majority of respondents did not support a ban on DTCA, most of them thought that stricter regulation was necessary. These findings clarify the conclusions drawn from quantitative studies, and suggest doctors’ views of DTCA may be more complex than previously reported.

The arguments for and against direct-to-consumer advertising of prescription medicines (DTCA) have been well rehearsed. Initially, these focussed on the ethics of advertising products to lay people who may not fully understand the potentially harmful effects arising from contraindications, interactions and side effects. More recently, the empirical literature has examined stakeholders’ views of DTCA; and the results of several recently published consumer surveys suggest that consumers appreciate DTCA as an information source and do not experience more negative health effects than patients taking non-advertised medicines.

Researchers have also surveyed doctors to explore the effects of DTCA on them and their patients, and a disparate range of opinion has been uncovered. However, the debate in New Zealand (NZ) has been dominated by interest groups that advocate a particular position, and by research that has not always been disinterested. In addition, the typical self-completion surveys used to study GPs’ views offer only superficial insights into the complex and sometimes contradictory issues involved.
Therefore, to provide a richer perspective on doctors’ opinions on DTCA, we used a qualitative methodology to probe GPs’ experiences of DTCA and their views on its future.

**Research context**—Although pharmaceutical industry representatives argue that DTCA helps ‘meet the growing demand for medical information, empowering consumers by educating them about health conditions and possible treatments,’ doctors have been less sanguine about its benefits. Hollon, for example, argued that DTCA had, at best, a negligible public health value and several undesirable consequences.

Toop et al provided a comprehensive review of studies opposed to DTCA and argued that doctors had at least four serious concerns about this advertising, including:

- deterioration in doctor-patient relationships;
- increasing medicalisation of well populations;
- a lack of balance in the information provided; and
- confusion created by omission of risk, side effect and cost details.

Concern that DTCA leads patients to demand medicines from their doctors has led health lobbyists to argue that this advertising erodes the trust on which a healthy doctor-patient relationship depends. Instead of viewing doctors as dispassionate and expert advisors, Bell, Wilkes, and Kravitz found that a sizeable proportion of their respondents would not necessarily accept their doctor’s advice if it conflicted with their requests. They reported that, if denied a prescription they had sought, 25% of respondents would seek to change their doctor’s mind; the same proportion would seek the prescription elsewhere, and 15% would consider ending their relationship with that doctor.

These findings led researchers to conclude that doctors might avoid conflict by acceding to patients’ requests, even if they do not fully agree with these. As a result, patients may adopt pharmaceutical solutions to health problems instead of implementing lifestyle changes, such as losing weight. This, in turn, may place pressure on the health budget if prescribing rates of subsidised drugs increase, or if drug companies used evidence of consumer demand to support applications for product subsidies.

Some doctors have also argued that the lack of balance in DTC advertisements creates misleading impressions, which they must dispel before they can discuss a patient’s condition. Ensuring patients understand a drug’s risk profile and its compatibility with other medications can take several minutes and thus creates time pressures as doctors struggle to maintain their appointment schedule. More importantly, time spent in this way reduces the time available to discuss the patient’s health and the optimal way of maintaining this.

Yet, despite the forcefulness with which critics of DTCA have presented these arguments, there is surprisingly little empirical evidence of doctors’ views. A United States (US) Food and Drug Administration (FDA) survey of 500 physicians found that 68% of respondents believed DTCA had either a positive effect or no effect on their patient relationships.

In NZ, Toop et al’s research presents a sharply contrasting perspective. The results from selected statements tested in these two studies are contrasted in Table 1 and highlight the different views that exist.
Table 1. Comparison of selected FDA\textsuperscript{15} and Toop et al\textsuperscript{4} findings of GP responses to questions about DTC advertising

<table>
<thead>
<tr>
<th>FDA\textsuperscript{15} (United States)</th>
<th>Toop et al\textsuperscript{4} (New Zealand)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Statement or question</strong></td>
<td><strong>Percent agreeing\textsuperscript{*}</strong></td>
</tr>
<tr>
<td>DTC advertising causes your patients to seek treatment for potentially serious conditions.</td>
<td>44%</td>
</tr>
<tr>
<td>To what extent did you feel pressured to prescribe a drug for the patient (who had asked for a specific drug to be prescribed)?</td>
<td>28\textsuperscript{†}</td>
</tr>
<tr>
<td>Did the fact that this patient saw an advertisement create any problems for your interaction with this patient?</td>
<td>18\textsuperscript{‡}</td>
</tr>
</tbody>
</table>

FDA=Food and Drug Administration; GP=general practitioner; DTC=direct-to-consumer; *Respondents to the FDA Physician survey were asked whether they agreed a ‘great deal’ or ‘somewhat’ with the statements. The percentages reported aggregate these two categories except where noted. Respondents to the Toop survey used a five-point Likert Scale to indicate their level of agreement with the statements; the percentages reported aggregate the ‘strongly agree’ and ‘slightly agree’ categories; †The percentage aggregates those respondents who indicated they felt ‘somewhat pressured’ or ‘very pressured’ to prescribe. ‡Respondents were asked to respond ‘yes’ or ‘no’. The percentage reported is the proportion who answered ‘yes’ to the question.

The different perceptions shown in Table 1 may reflect differences in the two countries’ regulatory environments, where quite different systems are used to control DTCA. Other explanations may include the disparate nature of the health systems, the types of treatment promoted, and patients’ differing expectations of doctors. However, US and NZ consumers’ responses are generally similar, despite differences in the questions used, the rules governing DTCA, and the structure of the health care system. Methodological differences, such as variations in the question wording, and the tone and content of the covering letter used by Toop et al\textsuperscript{4}, may also have contributed to the differences noted.

Methods

A sample of New Zealand GPs was purposively selected from the ‘Registered Medical Practitioners & Medical Centres’ section of three (Telecom) telephone directories in the lower central North Island. Invitations to participate in the study were sent to one GP in each medical centre listed, and to every GP in solo practice. Women GPs were first approached to increase the proportion of female respondents; and when one GP declined, another from the practice was randomly selected. This sampling procedure complemented the research objective, which was to examine the spectrum of opinion that existed among GPs.

The cover letter stated the research objective was ‘to assess and document GPs’ views on DTCA’. The letter was neutrally framed and did not express any opinion about the merits of DTCA; it included an endorsement by the local representative of the RNZCGP. In total, 67 letters were sent out, 11 of which were returned as ‘gone no address’ or by retired doctors.

Twenty-two doctors agreed to participate (a response rate of 39%), resulting in 20 eligible interviews (one respondent was no longer in general practice, and a high workload prevented another from participating). Sixteen interviewees were male, and 16 had also practised as a GP for more than 10 years.
Interviews were conducted in GPs’ consulting rooms during clinic hours in January and February 2003, and a payment of NZ$80 was offered during recruitment in recognition of the consultation time forgone. Each interview lasted between 30 and 45 minutes, and was recorded using a dictaphone for subsequent transcription by the interviewer. The interview protocol examined several issues, and included five sets of forced choice statements that were used as preliminary stimuli to elicit doctors’ views on aspects of DTCA, which form the basis of the discussion reported here.

The interview transcripts were independently coded by two researchers: one interviewer and an independent researcher. The separate analyses were compared and there was a high degree of overlap between constructs identified, which suggests the themes extracted accurately represented the respondents’ views.

The Ministry of Health (MOH) review of DTCA highlighted three areas of concern that we explored with GPs. These were whether DTCA improved access to health information, damaged the relationship doctors have with their patients, and led to an increasingly ‘medicalised’ population.

Table 2 contains details of the forced choice statements used as preliminary stimuli, which were chosen to reflect the concerns raised by submissions to the MOH discussion paper.

**Table 2. Forced choice statements used as preliminary stimuli to elicit doctors’ views**

<table>
<thead>
<tr>
<th>Quality of Information</th>
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<tbody>
<tr>
<td>1</td>
<td>Most people probably feel confused by the information in advertisements for prescription medicines (9)</td>
<td>OR</td>
</tr>
<tr>
<td>2</td>
<td>In general, prescription medicine advertisements overemphasise the benefits of the medicine and don’t explain the risks enough (16)</td>
<td>OR</td>
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**Demand Effects of DTCA**

| 3 | Advertising for prescription medicines leads people to demand from their doctor medicines that may not be suitable for them (8) | OR | Advertising for prescription medicines leads people to have more informed discussions with their doctor about treatments that might suit them (4) |
| 4 | Advertising for prescription medicines makes people rely more on medicines to treat their health conditions (9) | OR | Advertising for prescription medicines make people more aware of the different options available to treat their health problems (7) |

**Future of DTCA**

| 5 | Continuation of DTCA under industry self-regulation (2) | Continuation of DTCA but under government regulation (6) | Banning of DTCA (8) | Other regulatory solution (4) |

Note: The number of respondents agreeing with each force-choice statement is presented inside parentheses ().

**Results**

Some respondents could not choose between the statements in each pair, either because they thought each was equally true or untrue, hence the rows do not always add to 20. Readers should note that these were initial responses, and that the level of agreement that each respondent exhibited towards the statements varied, as many qualified their responses when explaining their choices.
Quality of information—The first two sets of statements examined the quality of the information provided in DTC promotions and whether this promotes adequate consumer understanding.

Respondents were equally divided in their views on the first pair of statements. Those who believed patients would be confused by the information provided in DTC promotions cited lay consumers’ lack of knowledge and subsequent inability to judge the appropriateness of the advertised treatments. One doctor noted, ‘Advertisements present the material in a way that asks patients to request them [treatments] from their doctor, which may not always be the most appropriate for them.’

Some respondents felt that prompting patients to ask their doctors about new treatment options created confusion among those who were already being treated with another drug, particularly if this was not advertised, and thus led patients to question whether they were receiving the best treatment. Moreover, several doctors noted that the very fact drugs were advertised meant some patients viewed these as superior to non-advertised treatments: they think it’s this wonder new drug.

Doctors also commented on the adequacy of the information provided; one commented: I think the problem is more what they leave out, not what they put in. Even doctors who thought consumers did understand DTCA were concerned that the promotions did not provide sufficient detail: It’s more that the message isn’t full. These respondents felt the simple messages presented may be understood, but noted that these failed to convey the complex factors doctors consider when deciding whether, and what, to prescribe: [DTC advertisements are] not giving all the information for them to understand the complexity of the issues.

Virtually all respondents believed that DTCA does not provide balanced information, although a minority commented that, as DTC advertisements aim to persuade rather than inform, it was unrealistic to expect them to provide fully balanced information: It's not aimed at information at all, it’s aimed at persuading.

Another respondent noted that the purpose of advertising is to generate interest in a product, saying: I don’t feel it’s the job of an advertisement to actually go into side effects and risks. They’re just trying to get the product known … they do emphasise the benefits of the medicine and they don’t explain risks, but I think that’s probably appropriate. While not widely held, these comments suggest at least some GPs accept that DTCA can convey only a limited amount of information, and do not necessarily see this as being problematic.

Many of those respondents who felt DTCA was unbalanced also noted that the risk and side effect information is not displayed in an accessible format: [these details] are usually in very, very small print and it is unrealistic to think that people read it on a television screen. For these doctors, the difficulty viewers have in accessing information compounds the problems created by inadequate provision of risk and side effect details, in particular. Changes to the format and content of DTC promotions and adoption of the US FDA regulations, which require the major risks to be conveyed both visually and aurally, may alleviate these concerns and improve the accessibility of the information currently provided.

Demand effects of DTCA—Two pairs of statements were designed to tap concerns over DTCA’s effect on patients’ demand for prescription medicines and the
implications of this for doctors’ relationships with their patients. These statements elicited diverse views as although some respondents reported requests for specific drugs, which they attributed to DTCA; they also found that DTCA had promoted more informed discussions. However, they balanced these apparently competing views by noting that DTCA prompted patients to request what they considered to be unsuitable medicines.

Respondents gave several reasons for describing medicines as unsuitable. For example, they felt that the prohibitive price of some advertised drugs, the contraindications that consumers are not aware of, and the adequacy of current treatment regimes, all constituted reasons why an advertised medicine may not be appropriate.

By contrast, other respondents considered that DTCA promoted better informed discussions and were less troubled by requests for specific medications. In one doctor’s words, DTCA more often leads to a discussion [about] the pros and cons, rather than demands. Others indicated that discussions about an advertised drug opens up the discussion forum to start talking about these issues, thus suggesting that some patients might not recognise or discuss their symptoms if they had not been exposed to DTCA.

Respondents also held mixed views on the issue of whether DTCA promotes medicalisation, which paired-statement four addressed. Some felt medicalisation was not balanced by an increase in awareness, although others agreed that DTCA improved awareness of treatment options and did not foster a culture of pharmacological over-dependency.

Respondents located their views within a broader context of social change, commenting that human nature instinctively sought the easiest solution to problems and that we have become a pill oriented society. However, other respondents believed that DTCA fostered rather than simply tapped into this culture, and suggested it encouraged medicalisation of normal states. One doctor noted: I think a lot of people are taking things because we medicalise things not normally being treated … now they feel like they’ve got to have a drug for everything.

Nevertheless, respondents who considered that DTCA improved awareness of different options felt that the advertisements served a useful function by increasing patients’ knowledge, even if they did not impart much information. Concern that DTCA depicts only one treatment option was common; however, respondents recognised their own role in promoting knowledge of alternative treatments: advertising makes them come here, then I make them aware of other treatment options.

Future of DTCA—Finally, respondents were asked if they would like to see DTCA either continue in its present form (under advertising industry regulation), continue under government regulation, or whether it should be banned.

Respondents who preferred continuation of DTCA in some form and those who wished to see it banned were evenly divided; four respondents preferred an alternative regulatory structure. Those who supported continuation of DTCA recognised that consumers actively sought out health information and felt regulated advertisements could guarantee the quality of information available. Those who favoured greater
government regulation believed that DTCA is valuable, but wanted Government to
make sure that it’s correct information and safe information.

However, other respondents had doubts over the Government’s ability to create
satisfactory regulations, and expressed concern about public money being spent to
regulate DTCA. As an alternative, some respondents even suggested complete
deregulation of DTCA, stating: the free market…is more rapidly adjusting…to the
pressures of all people, including doctors, and I think the drug company advertising
will be quite sensitive to the pressure from doctors.

These respondents noted that if DTC advertisements were dishonest or misleading,
then doctors would deliberately choose to not prescribe the products, and the
offending pharmaceutical company would suffer. However, this stance is unlikely to
receive widespread endorsement from other GPs, given concern over the harm that
may arise from irresponsible promotions.

By contrast, those who supported a ban referred to the increasing demands on them
and their time that DTCA created. As one noted: you have to spend more and more
time discussing…why the medicines are not suitable for them. Others expressed
concern that pharmaceutical companies would use DTC to increase demand, and then
lobby PHARMAC to subsidise their product: it creates demands for things which the
pharmaceutical company hopes will be funded later if there is sufficient demand.
Other reasons proposed in support of banning DTCA included the fact that it is not
permissible internationally, and that our patients did pretty well before.

Discussion

Overall, although based on a small sample size, these results nevertheless suggest a
high level of ambivalence about DTCA, and it is clear that doctors have a range of
concerns about this advertising. While specific brand requests were made during
consultations, respondents indicated a low level of DTCA driven enquiry and did not
report feeling undue pressure to prescribe requested medications. Furthermore, many
respondents appreciated patients taking a more active role in managing their health in
response to DTCA.

Yet, while some respondents saw benefits arising from DTCA, it is clear that the
current format and regulation of DTCA is not optimal. In particular, advertisements
need to provide clear and balanced information about the risks, side effects, and costs
of medicines. Currently, GPs reported spending time dispelling misunderstandings
created by inadequate communications, and this caused frustration for respondents as
it increases the pressure on their already tight schedule. Indeed, those who favoured a
ban on DTCA cited the inefficient use of their time as a primary reason for their view,
rather than a philosophical or ethical opposition to the advertising of prescription
medicines.

Some critics have argued that the heightened profile of prescription medicines
(created by DTCA) increases medicalisation by depicting aspects of normal human
ageing as disease states in need of remedy. Others challenge this view, however, and
call for greater medicalisation of age-related conditions.18

Our respondents also reported divergent views on this topic. The medicalisation of
lifestyle conditions did concern some respondents, as they felt it distracted attention
away from more appropriate forms of treatment such as dietary modification and
exercise. However, many thought that DTCA could promote discussion of lifestyle conditions between patients and their doctors, particularly conditions such as obesity or joint pain, and the prevention of chronic disease.

Recent modifications to the Research Medicines Industry (RMI) Code of Practice may foster better quality DTC advertisements; however, current DTCA promotions suggest not all companies have adopted the Code’s recommendations. Indeed, the advertising and pharmaceutical industries have been disappointingly slow to adopt suggestions that would increase the informativeness of prescription medicine promotions.

Several respondents stated they would appreciate advertising that emphasised their role as prescribers. Changing the phrase—ask your doctor if X is right for you to X is one option for the treatment of condition Y; only your doctor can determine the correct treatment for you—may address concerns over patient confusion and derogation of doctors’ role, and would also recognise the existence of other treatment options. However, our research did not explore doctors’ views of this statement, and further work is required to assess whether it would ameliorate their concerns.

Although the concerns raised by doctors in this sample did not indicate trenchant opposition to DTCA, we detected strong disquiet with particular aspects of DTCA. While some doctors’ responses suggest DTCA has the potential to provide information that fosters better dialogue between doctors and their patients, it is clear that this potential is far from being realised.

Indeed, continuing failure by the pharmaceutical industry and advertisers to address doctors’ concerns in full will make a ban on DTCA inevitable.

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References


