Is a Half-Truth a Whole Lie?

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It is recognized that objectivity is difficult to foster in an environment where conflicts of interest exist. Because individuals may find it difficult to recognize factors that may affect objectivity, special care is used to ensure impartiality in many situations. We diligently try to exclude conflicts of interest in our judicial system and in contracting for government services, and scarce resources are allocated by lottery.

The health care environment is also one that has attempted to limit conflicts of interest in many ways.¹ Physicians and bench researchers alike are expected to disclose conflicts of interest to numerous parties. These include to their home institutions, to granting agencies, and, of course, to the editorial review staff when manuscripts are submitted to journals. Our professional societies (American Society of Clinical Oncology [ASCO], American Society for Radiation Oncology [ASTRO], etc) also demand objectivity from our leaders. In fact, we recognize the pernicious influence of the business of health care through our attempts to protect some of the best and brightest of our society—our medical students and residents—from exposure to sales and industry representatives.²

It is both remarkable, and sadly, not at all surprising, that individuals and institutions may stray across a line of professionalism as regards conflicts of interest that may arise relative to the provision of oncology services. The crossing of this line can be regarded as an attempt to influence individuals less capable than medical students and residents of recognizing conflicts of interest or intellectually dissecting complex conflicting claims presented by competing information sources about arcane health care subjects. Interestingly, the disclosure of conflicts of interest to patients may not provide a clean slate for subsequent objective evaluation of information conveyed in the health care setting.³ Patients are reluctant to believe that their physicians would not be completely honest with them.⁴

Narang et al, in this issue of *Journal of Oncology Practice*,⁵ evaluated on-line, provider-generated advertising claims for two radiosurgery devices that can perform stereotactic body radiation therapy (SBRT), a technology that must still be described as promising, because there are only scant data of questionable quality to support its use for most possible clinical applications. Narang et al identified many claims of dubious veracity in direct-to-consumer advertising on provider Web sites, and identified industrial support in the form of links to manufacturer Web sites (26%) or provision of prominently displayed manufacturer-provided images or information in 50% or more of sites. This form of direct-to-consumer advertising goes against well-recognized profes-

sional standards of conduct promulgated by the American Medical Association.⁶

There is a rising concern that novel technological approaches to the delivery of health care are being adopted without adequate documentation of superior outcomes and that direct-to-consumer advertising by providers is becoming a vehicle for economic competition.⁷⁻⁹ Regulatory supervision of direct-to-consumer advertising in the United States is usually applied only in situations where egregious claims are being made. US Food and Drug Administration (FDA) regulations do not govern the content of direct-to-consumer advertising for prescribers or users of restricted medical devices, though they do govern advertising by the manufacturers and distributors of such equipment.¹⁰ Although the Federal Trade Commission (FTC) has aegis over provider direct-to-consumer advertising, it cannot adequately monitor all such advertising across the country to ensure the veracity of all claims made.

This is not an isolated problem in the marketing of oncologic services. Cancer creates unique vulnerabilities that are exploitable. Patients and even community nonspecialist caregivers may be deceived by hyperbolic advertising campaigns that make unsupportable, though catchy, claims about the cancer services provided. These deceptive campaigns should stop; for most curative or palliative cases, the available evidence-based treatment guidelines establish management parameters that all oncologists may follow.

ASTRO and ASCO do not have ethics policies to govern direct-to-consumer advertising, and this is a shortcoming that should be addressed. It is necessary for professional societies to take on this responsibility, as the FDA and FTC have not shown themselves to be willing to take on this role. Professional society practice certification could certainly incorporate a review of institutional Web sites to assure that the information being presented is accurate and objective.^{11,12} External validation of content is also feasible.¹³ Consideration of principles to guide Web site content include only authoritative data, a defined purpose for the Web site, a statement on confidentiality, referencing of all data, a justification of claims, full disclosure of funding sources, and lack of anecdotes or testimonials.

Excellence in health care services is fostered, in part, by competition. Competition may occur on the basis of convenient parking, pricing of services, external validation or reputation, and a host of other criteria. Deceptive information presentation to patients should not be part of competition.

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