Perspective: The Paradox of Men's Health

YUL D. EJNES, MD

Men's health is a booming business. Global sales of testosterone replacement therapy (TRT) were estimated at $1.6 billion in 2018.[1] The figures for erectile dysfunction (ED) drugs were significantly higher, at approximately $4.8 billion in sales worldwide in 2017.[2] By comparison, global sales of acetaminophen were estimated at $9.4 billion in 2021.[3] It even appears that sales were helped by COVID-19; there was a 67% increase in PDE-5 inhibitor prescriptions in the United States between February 2020 and December 2020.[4]

A significant portion of these transactions occurs outside the traditional relationship between a patient and a primary care physician. Some of the care is delivered in other conventional settings, such as subspecialty offices or academic men's health centers, but not always with the involvement of the primary care physician. Online providers comprise a growing source of TRT and ED treatment.[5] Even when care is delivered in the primary care office, it is often driven by marketing beyond the office.

One would expect a primary care physician in practice for over 30 years to be concerned and strongly object to what is happening in men's health. However, while it worries me, I also see it as an opportunity to reflect on it within the bigger context of changes in how we deliver care, how people access medical information, and the evolving preferences of American society.

Disintermediation, medicalization, consumerization, and democratization of technology and knowledge – what some refer to as the "participatory web"[6] – have changed the dynamic between patients and physicians.

Defined as "cutting out the middleperson," disintermediation challenges the physician's historic role in filtering and distilling knowledge about diseases, diagnostics, and treatments for patients. Before the Internet, there was direct-to-consumer (DTC) advertising, perhaps the first salvo to displace physicians from their role as "the" source of information for patients.[7]

With the explosion of DTC advertising, relatively minor common conditions became major threats to the health of the population. In some instances, this process of medicalization introduced catchy names – "ED" and "Low-T," among them.[8] A lost erection following a double work shift, a few beers, and the distraction of a crying baby in the next room became a medical problem in need of a drug. Decreases in hormone production related to normal aging were reframed as abnormalities that needed to be detected and corrected.

The business model didn't stop at creating a product and a demand for that product. New ways of delivering the treatment or test were developed, aided by the widening availability of online access. While most of us became telemedicine users recently because of the pandemic, industry was years ahead of the profession in utilizing technology to connect willing patients with willing providers.

Coinciding with these market forces, healthcare delivery became increasingly transactional and less relational.[9] Preceded by the spread of urgent care centers in the 1970s,[10] the emergence of retail clinics brought the disintermediation and fragmentation to new physical locations, meeting the needs of patients who did not have physicians or patients who had physicians but could not get in to see them.

Some might attribute the growth of retail clinics (some of which promote themselves as "men's health" centers) and online options to the difficulty of getting an appointment with one's regular doctor, but it's more than that. It also meets a need created by everchanging preferences. A growing number of people favor the convenience (and cost, in some cases) of transactional care over the whole patient orientation and longitudinal features of relational care. Moreover, in settings where traditional relationships with a primary care physician exist, patients may self-refer to other specialists, sometimes without the knowledge of the primary.

Many in primary care believe that if we expand availability, increase access options, and market ourselves better, this will all go away. As helpful as that may be, it may not go far enough. Ask yourself why you don't have a personal banker or don't go to the local bookstore as often as you used to and use an ATM or shop online at Amazon instead.

Keeping all of the above in mind, the question of whether men's health care outside the traditional model is a good thing or a bad thing has to be asked with qualifiers: for whom – the patient, physicians, others – and through which lens – a business lens or a patient care lens?

Online, specialty-based, and non-traditional sources of men's health care offer some advantages. For men who don't have a primary care physician, they offer access. Even for men who have a medical home, the alternatives may be more convenient, less expensive, and, for those who are embarrassed by their problem, more comfortable. When science conflicts with consumerism – for example, a man

for whom hormone replacement is not indicated based on a proper medical evaluation but still is convinced that he has "Low-T" – it serves as a path to getting what one thinks they need based on marketing or their own research.[11] This would seem to be all good from the consumer perspective.

The primary care viewpoint is less straightforward. Fragmentation of care is anathema to the core principles of primary care.[12] However, even though we complain about fragmentation, we've played a role in it as well, with the division of inpatient and outpatient care and gaps in after-hours access for our patients. Ironically, while fragmentation often raises barriers to patients' getting care, in the case of men's health, it may lower them.

Fragmentation has implications at the macro level on cost and resource utilization, and at the individual patient level, it introduces risk. Information sharing that would help avoid redundant testing or drug interactions usually doesn't occur when a patient seeks care from an online provider or outside clinic. The treating physician or provider does not have access to the patient's full medical record and must rely on information provided by the patient to identify features that would affect the diagnosis or choice of treatment.

There are potential harms when receiving care outside the practice, especially from a source that is separated from the usual referral network or community. Did the prescriber get a complete history to ensure that there were no alternate diagnoses or treatments or contraindications to specific drugs? Were there missed diagnoses or misdiagnoses?

For instance, if the erectile dysfunction is a sign of marital discord, undiagnosed sleep apnea, or vascular disease, will the patient get appropriate counseling, workup, and referral by the dot.com provider, or a prescription for a PDE-5 inhibitor regardless? If a patient is getting androgen therapy, is the prescriber monitoring for adverse effects with regular follow-up and appropriate lab monitoring?

Additionally, as physicians are held more accountable for quality and cost of care, treatment received outside of the practice poses new challenges. Not only are we ethically responsible for keeping patients healthy and safe, but also we're on the financial hook for what they do, much of which we can't control.

There are bureaucratic and administrative hassles that come with the outsourcing of men's health care. Patients who need refills and can't access their subspecialist or online provider may approach the primary care physician, who lacks access to the outside record to inform the refill, or even worse, the prior authorization process that might be required for some of the drugs. When there are adverse reactions or things do not go smoothly, guess who often ends up getting the call?

Are biases and conflicts of interest at play? Two old sayings come to mind: Maslow's – "If the only tool you have is a hammer, you tend to see every problem as a nail," and the uncredited – "When you go to Midas, you get a muffler." How many men who go to outside providers or a website for an ED medication or TRT walk away with a treatment, compared to those who are treated by their primary care physician or referred to an academic center of excellence? Does the heavy marketing of TRT contribute to overtesting, overdiagnosis, and overtreatment? A 2017 review suggested that it does.11

What are the financial relationships between the provider, lab, and pharmacy in the outside practices? A 2015 review of testosterone replacement websites reported that a small minority disclosed financial conflicts and only 27% described side effects, while 95% promoted the benefits of treatment.[13]

That is not to say that physicians in traditional practice settings are free of dualities, but there's a difference between doing something to help patients that might also be profitable and doing something that is profitable that might also help patients.

We should also ask if all of this exacerbates health inequities, especially given the reliance on technology that may not be accessible to all and the "cash or credit" nature of many of the providers of men's health care.

The explosion of options for treatment of ED and testosterone deficiency are symptoms of a broader dysfunction in the healthcare system. Like it or not, some of our patients are "voting with their feet," or in the case of online care, with their fingers. Rather than fight the inevitable, as primary care physicians we must find ways to respect our patients' preferences while minimizing the dangers of their seeking care outside our offices. It is the patient-centered thing to do.

References

1. Testosterone Replacement Therapy Market [Internet]. Transparency Market Research. [accessed 2022 Mar 12]. Available from: https://www.transparencymarketresearch.com/testosterone-replacement-therapy.html
2. Global Erectile Dysfunction Drugs Market Will Reach USD 7.10 Billion by 2024 [Internet]. Zion Market Research. [accessed 2022 Mar 12]. Available from: https://www.globenewswire.com/news-release/2018/10/05/1617442/0/en/Global-Erectile-Dysfunction-Drugs-Market-Will-Reach-USD-7-10-Billion-by-2024-Zion-Market-Research.html
3. Acetaminophen Market [Internet]. Future Market Insights. [accessed 2022 Mar 12]. Available from: https://www.futuremarketinsights.com/reports/acetaminophen-market
4. Hernandez I, Gul Z, Gellad W, et al. Marked Increase in Sales of Erectile Dysfunction Medication During COVID-19. J Gen Intern Med. 2021;36(9):2912-14.
5. Wackerbarth JJ, Fantus RJ, Darves-Bornoz A, et al. Examining Online Traffic Patterns to Popular Direct-To-Consumer Websites for Evaluation and Treatment of Erectile Dysfunction. Sex Med. 2021;9:100289.
6. Balasubramanian A, Yu J, Srivatsav A, et al. A review of the evolving landscape between the consumer Internet and men's health. Transl Androl Urol. 2020;9(Suppl 2): S123-S134.
7. Mogull S. Chronology of Direct-to-Consumer Advertising Regulation in the United States. AMWA Journal. 2008;23(3); 106-109.

8. Maturo A. Medicalization: Current Concept and Future Directions in a Bionic Society. Mens Sana Monogr. 2012;10:122-133.
9. Hoff T. Next in line. New York: Oxford University Press; 2018.
10. Gray B, Janiak B. Urgent Care Centres. Arch Emerg Med. 1985 Dec; 2(4):197–199.
11. Bandari J, Ayyash OM, Emery SL, et al. Marketing and Testosterone Treatment in the USA: A Systematic Review. Eur Urol Focus. 2017 Oct;3(4-5):395-402.
12. Shared Principles of Primary Care [Internet]. Primary Care Collaborative. [accessed 2022 Mar 12]. Available from: https://www.pcpcc.org/about/shared-principles
13. Oberlin D, Masson P, Brannigan R. Testosterone Replacement Therapy and the Internet: An Assessment of Providers' Health-related Web Site Information Content. Urology. 2015; 85:814e818.

Author
Yul D. Ejnes, MD, MACP, Clinical Associate Professor of Medicine, The Alpert Medical School of Brown University; Chair, Board of Directors, American Board of Internal Medicine; Chair-Emeritus, ACP Board of Regents.

Correspondence
Yul_Ejnes@brown.edu