

Week 14: Popular Articles

Both of the two pieces for this week deal with ethics in medicine – one about Big Pharma and doctors; the second about doctors and the decisions made by their patients.

a) Whose Body is it, Anyway?, Atul Gawande
(*New Yorker*, October 4, 1999)

This piece you have in your readings is a redacted version of this original article.

It is about the ethics of choice, e.g., not doing extraordinary things and being allowed to die at home

Also, what doctors should (and shouldn't) do when patients make bad decisions (in their view, at least)

How about Angelina Jolie?

b) Drug Companies & Doctors: A Story of Corruption, Marcia Angell (*New York Review of Books*, January 15, 2009)

Marcia Angell was the first female Editor ever for the New England Journal of Medicine

This piece is one hell of an indictment of Big Pharma and the collusion of doctors

There is some further discussion of this in your required readings on Experimental Design

“disease-mongering” – promoting diseases to fit the drugs

Some Wikipedia comments on this:

Disease mongering is a pejorative term for the practice of widening the diagnostic boundaries of illnesses, and promoting public awareness of such, in order to expand the markets for those who sell and deliver treatments, which may include pharmaceutical companies, physicians, and other professional or consumer organizations. Examples include male pattern baldness and certain social phobias.

The term “disease mongering” was first used in 1992 by health writer Lynn Payer when she applied it to the Listerine mouthwash campaign against the disease halitosis. Payer defined disease mongering as a treatment which includes the following practices:

stating that normal human experiences are abnormal and in need of treatment

recognizing suffering which is not present

defining a disease such that a large number of people have it

defining a disease's cause as some ambiguous deficiency or hormonal imbalance

associating a disease with a public relations spin campaign

directing the framing of public discussion of a disease

intentionally misusing statistics to exaggerate treatment benefits

setting a dubious clinical endpoint in research

advertising a treatment as without side effect

advertising a common symptom as a serious disease

There is a great quote on p. 361: “a desire to eliminate the smell of corruption while keeping the money”

Physicians may prescribe drugs “off-label” – for purposes other than for the use originally approved by the FDA

KOLs (Key Opinion Leaders) are important to Big Pharma

Medical schools are also in cahoots with Big Pharma

There is a great quote on p. 356 on designs that are chosen to do drug trials:

Clinical trials are also biased through designs for research that are chosen to yield favorable

results for sponsors. For example, the sponsor's drug may be compared with another drug administered at a dose so low that the sponsor's drug looks more powerful. Or a drug that is likely to be used by older people will be tested in young people, so that side effects are less likely to emerge. A common form of bias stems from the standard practice of comparing a new drug with a placebo, when the relevant question is how it compares with an existing drug. In short, it is often possible to make clinical trials come out pretty much any way you want, which is why it's so important that investigators be truly disinterested in the outcome of their work.