



## Selling Sickness: How Drug Companies Are Turning Us All Into Patients

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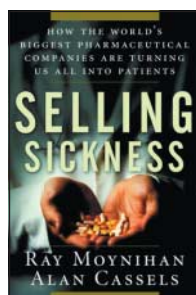
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## Selling Sickness: How Drug Companies Are Turning Us All Into Patients

Ray Moynihan, Alan Cassels



Allen and Unwin, \$A26.95,  
pp 272  
ISBN 1 74114 579 1  
[www.allenandunwin.com](http://www.allenandunwin.com)

Rating: ★★★

I remember as a medical student being appalled at the spectre of well paid hospital doctors climbing over one another to get their hands on the free food and branded knick-knacks on offer at supposedly educational lunchtime meetings sponsored by drug companies. I found the blandishments of the company representatives preposterous—a view confirmed when I briefly joined their ranks in a subsequent career break. Ever since I have avoided such meetings and contacts with the world of pharmaceuticals—and I am sympathetic towards the approach of the No Free Lunch campaign (endorsed by Moynihan and Cassels), which recommends that doctors “just say no to drug reps” and send back their advertising paraphernalia.

*Selling Sickness* is a spirited journalistic exposure of the methods used by the pharmaceutical industry to expand the market for its products. These include the redefinition of risk factors—such as raised cholesterol and blood pressure, or reduced bone mineral density—as diseases afflicting substantial sections of society and requiring treatment with medication. Another strata-gem is to persuade both doctors and patients that conditions such as anxiety and depression, hitherto reckoned to afflict only a small minority, should be diagnosed—and treated—much more widely. Yet another trick is the naming of new disorders; Moynihan and Cassels focus on attention

deficit disorder (in adults as well as children), premenstrual dysphoric disorder, and social anxiety disorder, each of which is linked to a specific drug treatment.

The pharmaceutical companies promote all these conditions through their cultivation of “thought leaders” in the relevant fields and through the presence of recipients of substantial financial favours on elite medical bodies concerned with defining diseases and promulgating guidelines on diagnosis and treatment. They also provide lavish hospitality at events ranging from prestigious specialist conventions to golf weekends for general practitioners.

*Selling Sickness* describes how “awareness raising” campaigns seek to transform the worried well into the worried sick. Whereas in the United States the direct advertising of drugs to consumers is possible, in Britain, where this is prohibited, campaigns promote awareness of conditions such as erectile dysfunction, prompting requests for prescriptions. The technique of “astro-turfing”—the formation by drug company public relations professionals of fake grass roots advocacy groups, often featuring celebrities—has helped to popularise new disorders and increase demand for treatments.

Moynihan and Cassels show how the diverse processes of “disease mongering” have helped to turn pharmaceuticals into a global \$500bn (£271bn; €401bn) industry, one of the most profitable spheres of capitalist enterprise. Yet their narrow focus on the drug companies neglects the wider forces that have encouraged the medicalisation of the lives of individuals and society.

Whereas 20 or 30 years ago the medical profession was the main target of critics of medicalisation, today doctors appear more the victim of pressures from above and below, from government and from the public—and the drug companies have become the new demons.

On the one hand, politicians faced by a loss of prestige and authority have turned to health as a sphere in which they can forge points of contact with a remote and fragmented electorate. In the United Kingdom scarcely a week goes by without a government initiative seeking to raise

popular awareness of some condition or other, exhorting people to modify their behaviour or lifestyle in some way in the cause of health, and encouraging them to seek medical advice and treatment. On the other hand, these initiatives find a ready

response in an increasingly atomised society, in which individuals experience a heightened sense of frailty and vulnerability, which is often expressed in a preoccupation with health and the measures deemed necessary to achieve and sustain it.

Moynihan and Cassels quote approvingly a Canadian health advocate who claims that the demand for

new medical technologies is “driven by opportunistic investors seeking new products and profits—not patients seeking new diagnosis and treatments.” This one-sided analysis misses the drive arising from people who seek out and embrace new diagnoses (often, like fibromyalgia or myalgic encephalopathy (ME), not linked to any specific drug treatment) and form organisations to demand that doctors recognise, diagnose, and treat them. Undoubtedly the drug companies have skilfully exploited these trends and have benefited handsomely from them, but they did not create them.

How can we break the cycle of dependency between the medical profession and the pharmaceutical industry? We must first recognise that the convergence between doctors and drug companies cannot be understood as merely the result of the corrupting effects of corporate largesse, however distasteful we may find these links. What is required is a wider challenge to the processes of medicalisation, one that redraws the boundaries between health and disease and between, on the one hand, medical practice involving the diagnosis and treatment of disease and, on the other, the worlds of lifestyle regulation and “recreational” drug use (including preventive treatments of dubious merit as well as medications of unproven therapeutic value).

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Competing interest: MF is the author of *The Tyranny of Health: Doctors and the Regulation of Lifestyle* (review *BMJ* 2001;322:305).

The pharmaceutical companies promote all these conditions through their cultivation of “thought leaders”

Yet another trick is the naming of new disorders

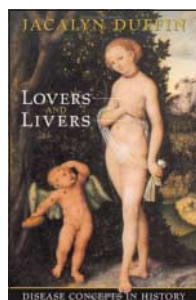
Items reviewed are rated on a 4 star scale  
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See [bmj.com](http://bmj.com) for review of BBC Radio 4's 'Architecture of Health'.

## Lovers and Livers: Disease Concepts in History

Jacalyn Duffin



University of Toronto Press,  
£29.95/\$27.50, pp 229  
ISBN 0 8020 3805 0

Rating: ★★☆☆

Conventionally, medicine deals with those troubles that we agree to define as diseases. However, the selection of diseases from the range of problems that afflict us is neither inevitable nor straightforward, as illustrated by the much debated candidate cases of those alphabet disorders of modernity such as RSI (repetitive strain injury) and ME (myalgic encephalopathy). Given the large body of work that explores the emergence, construction, and negotiation of diseases, Duffin perhaps makes heavy weather of convincing readers that diseases are not merely biological categories, but emerge when social demand and medical possibility coalesce.

Her first case study is lovesickness. Drawing on a wide range of classical

literature and medical writing, Duffin describes how the dysfunctions of love have been, since classical times, not only metaphorically considered as illness, but at times also literally medicalised as disease.

Does lovesickness really exist? Duffin is ambivalent on the status of underlying biological realities. Some “symptoms” seem stable over the centuries, she suggests, but not its credibility as a medical problem. She draws on phenomena as diverse as adultery, nymphomania, venereal disease, sex manuals, and masturbation to argue that “love was once a card-carrying disease” (p 65) but appeared to disappear in the 20th century. However, overtones of disease persist in concepts such as transference, crimes of passion, co-dependency, and brain scans suggesting that love is similar to obsessive compulsive disorder.

These lists are fascinating in their passing details, but raise the question about the legitimacy of tracing such equivalences through time. How can we know that there is a real underlying illness if we recognise it only from its endlessly varied manifestations, sometimes medicalised, sometimes not? How can we read historical writings on love from anything other than a 21st century understanding of what that means?

Duffin's arguments suffer a real tension between the relativism of a historian recognising that biology has been a rather different object through the centuries, and the fastidiousness of a clinician anxious to correct a few wrong assumptions on the way, such as

the “gender bias” in the management of heart disease. More generally, though, from what privileged vantage point can we assess what is a bias, responsible for incorrectly framing a disease concept, and what are the social forces that create diseases?

The story of the emergence of hepatitis C is one of litigation and cultural mores about deserving and undeserving sufferers. Political needs had their part in shaping medical research that constructed a new disease from what was essentially a left over category of liver disorder, and dividing it into two diseases with different meanings depending on how it was contracted, through blood transfusion, or through lifestyle. But Duffin has already implied that it could not be otherwise: we cannot have a pure disease, untainted by the unpleasantness of politics and morality, for illnesses cannot become diseases without a social network to make them possible.

Both stories end with a plea for a more population based approach to disease, in which problems (whether they are those of women reluctant to leave violent husbands, or injecting drug users at risk of hepatitis) are seen as residing in the social order, rather than within a medical model. Again, hardly a new idea, but one well worth reiterating. Not all troubles are, or should be, the province of medicine.

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## EXIT—le droit de mourir

Directed by Fernand Melgar

French speaking Switzerland release date:  
September 2005

German speaking Switzerland release date:  
February 2006  
[www.climage.ch](http://www.climage.ch)

Rating: ★★★★★

Switzerland is known not only for its snow covered mountains and for its chocolate but also for its liberal legislation with regard to assisted suicide. If no selfish motive is involved, suicide assistance—for example, by providing the necessary drugs—is legal even by non-doctors. Active euthanasia, however, remains illegal under all circumstances.

Suicide assistance is largely offered by three organisations in Switzerland: EXIT for German speaking Switzerland; EXIT for French speaking Switzerland, also known as EXIT ADM; and Dignitas. Unlike Dignitas,

which also caters for non-residents and has prompted much debate about suicide tourism, both EXIT associations offer their services to Swiss residents only.

Filmmaker Fernand Melgar was first confronted with an incidence of assisted suicide while watching a news report a few years ago. “The report did somewhat shake me up, although I never questioned the choice of the suicide candidate,” he recalls. “It was more the suicide assistant's perspective that bewildered me—what would motivate someone to take on such a responsibility?”

Melgar contacted EXIT ADM with the idea of making a documentary film. In view of the delicacy of the subject, the society's president, Dr Jérôme Sobel, initially hesitated to agree to the project. “Then again, we had nothing to hide,” he says. Melgar was eventually given the opportunity film virtually all of the society's activities over a year.



The result of this experiment is astounding. *EXIT*, as the film has been named, is basically a compilation of typical scenes from the society's daily life. Perhaps in an attempt to let the viewer make their own decisions, Melgar does not impose his own interpretation—Melgar merely takes the role of the passive observer. There is no narrative to guide you nor is there a journalist interviewing anyone and summarising things for you. Instead the film builds on the intimate conversations between its characters, including suicide candidates, other members of EXIT, relatives, friends, accompanying volunteer workers, secretaries, and others.

Little by little, the viewer learns about the motivations of candidates for suicide, their ups and downs, and about their feelings for their loved ones. We learn how difficult it is to be an accompanying volunteer worker. “This is not something you can do as regularly as clockwork. It's an exceptional act every single time. I'm exhausted after every assisted suicide,” Dr Sobel says.

Ultimately, the film shows how peaceful the process of an assisted suicide can be. They simply drink a glass of “magic potion” and fade in the company of their loved ones.

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## PERSONAL VIEW

## Unlearning

Senior clinicians are often castigated for being out of date. Rapid developments in technology and frequent alterations in evidence based guidelines make it difficult to ensure constant modernity. But does neuronal loss incapacitate the senior clinician? Are young people inherently more receptive to new ideas? Or are other mechanisms at work? Dame Janet Smith suggests that revalidation should require doctors to pass regular summative knowledge tests. No doubt educationalists will seek to develop fair, validated, and defensible examinations, and we will face some form of multiple selection questionnaire, probably linked to a visit to a simulator to resuscitate a plastic doll. An industry will establish itself around such tests, and—given time, a few courses, and plenty of practice—I might hope to surmount the hurdle.

But my fear is that, as a senior adult learner, I will be expected to conform to methods of teaching, learning, and testing that alienate me. I suspect that younger doctors will find it easier to pass the tests than I shall, not (I hope) because I am on the path to senility but because they have less to unlearn. My 1960s education consisted of didactic discourses linked to ritual humiliation and the threat of violence from masters or peers. A safe learning strategy was to keep your head down and your mouth shut and avoid attracting attention. And I became very good at this. My daughter's schooling has produced few basic science problems that I cannot solve, even though I have not thought about physical chemistry or the physics of light for 30 years. But I loathe being forced into artificial situations in simulators or mouldages; I cannot suspend reality.

Medical school was a joyous apprenticeship. I listened carefully to experts, made notes, and formed my ideas by comparing the opinions of others. Nowadays, of course, interactive groups, facilitated learning, and plenary report-back sessions have replaced such direct methods of learning. We sit debating inefficiently for 40 minutes, argue about who reports back, and watch politely while a guru covers a whiteboard in random scrawl. There is nothing for me to latch on to, note down, and remember. I return home clutching a continuing medical education certificate, feeling cheated that I have paid money that no one has earned.

It's not just learning techniques that must be unlearned: clinical protocols too change with time. But unlike a computer hard drive my mind does not replace old information with new; the original remains intact to confuse. My retentive mind can still

visualise the guidelines on cardiopulmonary resuscitation I learnt at medical school. I was taught well—a process reinforced by years of attending arrests. In the 1970s the compression to breath ratio was 5:1, with 60 sternal compressions a minute. Imprinted on my mind are the specified doses of bicarbonate, calcium, and "lignocaine." But nowadays this imprinted knowledge could potentially fail me during advanced life support testing.

Theoretically I know that the arrest box now contains adrenaline, atropine, and amiodarone, that biphasic defibrillators require 100 joules not 360, and that 5:1 evolved to 10:2, to continuous, and ended up, at least for now, at 15:2. But this knowledge only overlays the old, and I feel uncomfortable recalling it, knowing that although the theory is evidence based, ward survival after cardiac arrest has actually altered little since my days as a preregistration house officer, and knowing that the resuscitation guidelines will shortly be re-revised, so the entire workforce will again be rendered out of date.

Unlearning is becoming fashionable. An internet search for "unlearn" reveals sites in which people are challenged to alter their fundamental beliefs regarding religion, sexuality, or business prowess. Learning something new is easy; unlearning something old is difficult. Unlearning is not the same as forgetting. Forgetting enables you to start again without the problem of trying to resolve conflicting information. Unlearning is far more challenging, because you have to alter information, and in so doing you have to challenge your beliefs. Unlearning a fact implies that all the time spent learning it originally was wasted. Unlearning a method of learning requires fundamental alteration of your mental processes, even though the original way worked perfectly well for you. The dividends of unlearning are negligible: after much effort you still possess the same amount of valid knowledge. Maybe that's why we become grumpy old people.

So, to all those management consultants and psychologists who make a living out of facilitating our thought processes, I offer this: think about unlearning and teach us all how to do it. I predict a great future for unlearning. But in the meantime, if you wish to revalidate me using guidelines on advanced life support bear in mind that I know five sets of guidelines not one, and that errors I may make in following the current fashion reflect a retentive memory, not approaching senility.

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## SOUNDINGS

*Risk management for academics*

I was recently sent a PhD thesis to mark. As well as the smartly bound thesis, the parcel included an eight page glossy leaflet entitled "Safety—everyone's responsibility." On my forthcoming visit to viva the candidate, I was informed, I should take reasonable measures to stay out of danger and not to harm others. I should place my used batteries only in bins labelled "toxic waste" and avoid blocking fire escape routes.

On the basis of my previous experiences with PhDs, I think I'll return a full risk assessment checklist:

1. Personal injury. I once dedicated an entire Soundings column to the injuries I had sustained by falling over my own half written thesis, which, along with continuous feed printouts of two years' worth of data, had taken up residence in a large wooden box in my hallway. The risk of broken bones applies mainly to the candidate, but over-attentive supervisors who keep multiple drafts of their pupil's past work should ensure that the container is stowed securely under a desk.

2. Déjà vu. This phenomenon is most commonly experienced in the Literature Review, but on some occasions can occur throughout the work. My husband, a fellow academic, once passed me a thesis he was marking. I scanned several paragraphs and confirmed that I had written every word myself.

3. Inability to swallow. This is a near universal peril encountered in the Discussion section. The candidate, after summarising (more or less accurately) the findings from a humble and parochial empirical study, and desperate by this time to reach a fitting conclusion to his or her story, presents a series of sweeping and grandiose recommendations for changes to practice and policy. Examiners should ensure that this section is approached from a sitting position with a cup of peppermint tea to hand.

4. Nausea and vomiting on reading the Acknowledgments. This section has generally been written last, in a flood of relief and remorse, when the candidate, emerging bleakly from their garret after six months' writing up, realises that their partner is not only still around but has been coping single handedly with washing up, small children, in laws, etc. In the interests of health and safety, supervisors should routinely remove this section with a clean razor blade before the thesis is posted, and send directly to the appropriate Significant Other.

**Trisha Greenhalgh** professor of primary health care, University College London