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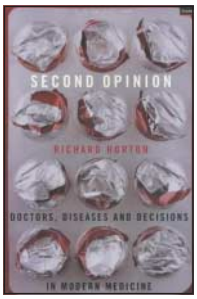
Second Opinion: Doctors, Diseases and Decisions in Modern Medicine

Richard Horton



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Rating: ★

Second Opinion paints a depressing view of the world. One section begins with an invitation to imagine a virus wiping out humanity. Later author Richard Horton, editor of the *Lancet*, talks of "huge population pressure" producing "our own global hot zone." Cities are "the graveyards of mankind" and society is "responsible for the accelerated evolution of infectious diseases."

In the battle with the mosquito, "the outlook for human beings is far from encouraging." Bioterrorism "conjures up the prospect of imminent human self annihilation from technologically adept terrorists," although ecological disaster or the tobacco or sugar industries might kill us first. In the middle of this we are facing an epidemic of HIV, yellow fever, severe acute respiratory syndrome (SARS), and West Nile disease, with the threat of Ebola looming large.

This appalling situation is being met "recklessly" by governments that are sometimes apathetic and at other times zealous. Horton is clearly motivated to have health organisations pick up the slack, but he is despondent. Until recently, "the US public health system had been slowly and quietly falling apart" and doctors everywhere have been prostituting themselves for the pharmaceutical industry, or for outdated sentimental attachment to techniques, while also abusing research subjects and killing their patients in the pursuit of personal glory. Surgery is in "crisis" and the World Health Organization is cowardly and fairly useless.

Horton is following what has become a fashionable prejudice of condemning humanity for a variety of sins against nature, the planet, and fellow beings. Redemption will come about, suggests Horton, when doctors render their financial sources transparent and generally act in a spirit of openness, honesty, and humility.

Now there is much to be said for doctors being independent of financial pressure from the pharmaceutical industry as well as political pressure from governments, and an infusion of honesty might considerably benefit research journals. But there are many problems with Horton's manifesto, such that it is.

Placing doctors on trial and finding them pretty much guilty of everything misses the real problem by some distance. A more reasonable observation might be that most doctors are being honest most of the time, but this is a difficult task when so many of the major concerns facing the population are based on essential falsehoods. The current scare about the measles, mumps, and rubella (MMR) vaccine is an excellent example, but hype and misrepresentation have also followed HIV, Creutzfeldt-Jakob disease and SARS, to name but a few.

Furthermore, Horton fails to recognise the implications of what "being honest" really means. Full disclosure to the patient through informed consent may seem a reasonable goal but in practice this can mean an unwieldy and increasingly impossible burden for the patient. Patients tend to be bombarded with too much rather than too little information and, consequently, the burden of responsibility for clinical decisions is perversely placed on the patient.

Horton has the world standing on its head

Feverishly trying to ensure that patients are happy and secure also inadvertently undermines trust that the physician knows what he or she is doing. Remarkably, Horton thinks this situation is not even a little unfortunate: "Less trust is a good thing, for it suggests a greater transparency regarding the reality of medical practice."

Transparency is unattainable, however, because of the gulf in knowledge and experience between patient and doctor. When submitting to the surgeon's knife or even taking a prescribed medication the patient has to engage in a leap of faith. Trust is what makes this leap possible, but doctors who gleefully provide details on every possible negative outcome undermine this trust. They also deftly evade responsibility for any adverse event.

Then there is humility. Horton wants more of it when there is already far too much. Today's doctors are diffident and afflicted by insecurity and self doubt. By contrast with the arrogant caricature that talks of "the appendix in bed three" doctors

Lancet editor Richard Horton

are constantly stressed about their communication skills and often question their own competence. Doctors require continuous ("life-long") formal instruction and regulation, mentoring and monitoring, support and counselling. It is nice if my doctor can relate to me as a human being but an aloof arrogance born of confidence is far preferable to an angst born of insecurity.

Surprisingly, having promoted great dollops of humility for the surgery, Horton seems to require none at all in the social and international arena. At one point he complains that many American cities are not properly prepared for terrorism; just what is it about editing the *Lancet* that makes one able to judge the security needs of Cincinnati better, say, than the locally elected officials?

Despite Horton's misgivings here and there, the promotion of better health is to allow intervention in developing world development programmes, conflicts of all kinds, and previously private behavioural decisions. No matter how well meaning, when an unelected and often foreign body tells a people how to rotate their crops, berates those at war, and castigates the consumer for eating too much saturated fat, the result is interventionist, imperialist and dictatorial.

Horton has the world standing on its head; I hope that having now got *Second Opinion* off his chest he will be able to find his feet.

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A hot flush for Big Pharma

How HRT studies have got drug firms rallying the troops

So the headlines have dealt another blow to the image of hormone replacement therapy (HRT). Will the drug companies be able to revive the fortunes of one of their most lucrative products? Will the big guns of the pharmaceutical industry be blazing, eager to counteract the latest volley of bad publicity? Or will the industry construct its defences more subtly?

Certainly, if the history of HRT promotion is anything to go by, the pharmaceutical public relations machine will be doing all it can to limit the fallout from studies published last week in the *New England Journal of Medicine* (2003;349:523-34) and the *Lancet* (2003;362:419-27), just as it has been since the first damning results from long term HRT studies were released last year. After all, billions in global sales are at stake. The two latest studies confirm that postmenopausal women taking combined HRT have an increased risk of heart disease and a twofold greater chance of developing breast cancer. These support the negative findings released in July 2002 after the huge US Women's Health Initiative (WHI) study was prematurely halted by its safety monitoring board.

But what exactly can the PR machine do in the face of evidence that now says long term HRT use increases women's risk of blood clots, strokes, heart attacks, breast cancer, and dementia, and has no quality of life benefits? Probably what it has always been doing—promoting the idea of HRT both as a cure for a medicalised menopause and an elixir even in the absence of scientific data.

HRT has been touted for decades as a panacea not just for the symptoms of menopause (hot flushes, vaginal dryness) but also for heart disease, dementia, osteoporosis, sexual function, mood, and overall vitality. Its tireless promotion by manufacturers is often held up as the ultimate case study in pharmaceutical marketing. Not content to mass market its benefits for the short term relief of menopausal symptoms, the industry set its sights on a bigger goal: the widespread acceptance of HRT as a long term preventive medicine for the massive (and growing) number of postmenopausal women. So far it seems that that strategy has worked. Science journalist Barbara Seaman, who has written extensively about the medicalisation of the menopause, says that American pharmaceuticals giant Wyeth's HRT products have been in the top 50 selling drugs in the US for almost four decades.

More than 100 million women worldwide—1.5 million in Britain—took HRT in 2001 and global sales amounted to $3.8bn (£2.4bn; €3.4bn). But after the first wave of publications from the WHI study, Wyeth, which accounts for more than 70%

of the global market, saw its share price plummet. The stock, which traded as high as $58.48 (£36.48; €51.66) in May 2002, fell by almost half to a low of $28.25 in July.

HRT promotion has depended heavily, although covertly, on industry involvement with scientists. In the 1960s American physician Robert Wilson wrote the influential *Forever Feminine*, extolling the virtues of HRT as a virtual fountain of youth for the "dull and unattractive" ageing woman. In an article in the *New York Times* last year (10 July 2002), Wilson's son conceded that Wyeth paid for his father's book and promotion of HRT.

In 2002 the powerful New York based Society for Women's Health Research, whose "sole mission is to improve the health of women through research," held a celebrity gala ostensibly celebrating women's "coming of age." It was entirely underwritten by Wyeth. In a *Washington Monthly* article entitled "Hot Flash, Cold Cash," journalist Alicia Mundy reported that only a few days after the Wyeth themed gala the company donated a quarter of a million dollars to the society.

Several weeks later, the WHI study results were made public. Wyeth was in a tailspin. They found support from the society, whose high profile chief executive, Phyllis Greenberger, and her staff went on national radio and television talk shows attacking the findings of the WHI study and its authors. "Instead of taking the side of its constituents," Mundy observed, "the society seemingly took the side of its donors—and of Wyeth in particular." As they fervently downplayed the negative findings of the WHI study and urged women not to abandon their HRT, the society's staff failed to disclose their substantial links to Wyeth and other drug companies. Similar activities and non disclosures are under investigation in Australia, after a complaint about the involvement of a well known doctor, Susan Davis, in HRT promotion.

HRT industry tactics play out not only in the ivory tower, but also in the corridors of big public relations firms. A group called

What will the drug companies do now?

HRT Aware hired London based PR firm the RED Consultancy to create an initiative that would "secure positive news coverage about HRT, target 45+ women with positive HRT messages, and link HRT to an aspirational life style" (www.pmlive.com/awards). The Choices Campaign, as it was called, launched in February 2000 to wide media coverage. It reached masses of "ordinary" women by touring bingo halls with local celebrities, using a former soap star and female doctor as spokeswomen, and forging relationships with charities such as the Menopause Amarant Trust. What is not so well known is that HRT Aware was an industry group comprised of oestrogen product manufacturers Janssen-Cilag, Wyeth, Solvay, Servier, Organon, and Novo Nordisk.

HRT Aware also commissioned the Social Issues Research Centre to produce a Jubilee Report (named to coincide with the Queen's Jubilee celebrations), which last month won a Communiqué award from the magazine *Pharmaceutical Marketing* in the public relations and medical education category. SIRC's research linked the improved lives of modern day postmenopausal women to HRT. It introduced a new elite group of 50+ women, dubbed the "HRHs" (hormone-rich and happy), who were said to have better careers, relationships, health, wellbeing, and sex lives than those not taking HRT. The Jubilee Report received widespread—and supportive—media coverage in the UK, virtually none of which mentioned that the pharmaceutical industry fashioned the campaign.

This year Novo Nordisk hired German PR firm Haas & Health Partner, which sent out to doctors letters downplaying the WHI results. The letters emphasised that the "absolute risk for women is quite minimal" and were signed by Dr Irene Haas (a historian, according to her company's website). A subsequent letter from Dr Haas states "amazingly, a glass of wine per day and obesity have higher breast cancer risks."

That pharmaceutical companies devise clever ways to market their products is hardly surprising. But let us hope that any counter attack that they make to the latest damaging research is subjected to the same kind of scrutiny that HRT itself is now under.

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PERSONAL VIEW

Listen to the patient

The patient was a 79 year old woman with a history of ischaemic heart disease: two acute myocardial infarcts 10 years ago, followed by longstanding atrial fibrillation and worsening angina. Coronary artery bypass surgery six years ago had fully relieved the angina, and she had been free of symptoms (although still with atrial fibrillation) while taking digoxin, β blockers, and warfarin, among other drugs. Now she reported two days of progressive shortness of breath with intermittent pain in the centre of her chest. She had obvious dyspnoea at rest, slight cyanosis, readily audible bilateral crepitations, a raised jugular venous pulse, marked dependent oedema of her arms and legs, and (I was pretty sure) a palpable tender liver.

It didn't seem the most difficult clinical problem—even for a public health physician without paid clinical responsibilities these last 20 years. I was not the patient's doctor, however, but her son. She had been discharged from an emergency assessment unit in the local teaching hospital the day before, with a reduced dose of digoxin after tests had excluded another myocardial infarct. This made me uneasy, but I was more upset that she remained so breathless that she could barely speak. Telephoning the assessment unit proved ineffective (except in raising my own blood pressure). The anonymous voice at the other end maintained that it was not policy to discuss or review patients even one day after discharge and suggested the accident and emergency department of the hospital on the other side of town.

Half an hour later we were there. Some time later a pleasant and helpful junior doctor kindly let me stay while she conducted a brief history and examination. She was even nice enough to pretend not to mind when I tried discreetly to point out the clinical signs. This approach was clearly not a success, however, as the working diagnosis was pneumonia, pending chest radiography. Two hours after our arrival, the film showed marked bilateral pulmonary oedema. My mother's shortness of breath, eased a little by oxygen, resolved fully after she was treated with intravenous furosemide (it seemed a long lost friend from my own days as a house officer). The expected dramatic consequences on urinary output added a further dimension to the discomfort and chill of the accident and emergency department, but on balance she was glad. In the early hours, after she had spent more than four hours at the hospital, an ambulance arrived to take her back to the assessment unit that had so recently discharged her. She arrived already restored to her usual condition and was discharged again the next day, with daily furosemide added to the drug cocktail.

Sadly, this probably sounds a mundane tale, likely to be repeated daily across the NHS. If so, my concern over some features is not lessened. Clinical assessments at the first admission and the first discharge clearly missed the point. The assessment unit's policy of refusing all contact concerning a recently discharged patient seems needlessly inflexible and led to an unnecessary, distressing, and prolonged stay in an accident and emergency department. Over a series of consultations with clinicians at all levels very little weight was placed on history and examination, in comparison with the results of investigations.

> We have lost something of the art of medicine in a headlong rush to embrace the science

I was taught the dictum attributed to William Osler: listen to the patient—he or she is telling you the diagnosis. My mother was too breathless to tell us in her own words, but the physical signs more than made up for her enforced reticence. If radiography is needed to diagnose pulmonary oedema, somebody needs to order it, which did not happen during the first admission. I am grateful that somebody did so at the second attempt, but the pathophysiology was clear throughout. The doctor in the accident and emergency department observed that it was the first time she had known the patient's son make the diagnosis, but the unspoken element of surprise seemed to be that I had done so without radiological examination.

I can't help feeling that we have lost something of the art of medicine in a headlong rush to embrace the science. Perhaps this view makes me the kind of dinosaur that I used to scoff at in the days when qualification was still nearer than retirement. But quality of care in this instance could so easily have been improved significantly at no cost—in fact with a clear saving of time and money. If this tale really is commonplace across the NHS the implications must be considerable. I hope that it is not too late to listen to this particular patient.

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SOUNDINGS

Medical thaumaturgy

It is by no means easy to perform miracles on this earth, in this age of scepticism and of evidence based incredulity.

But things are different at 35 000 feet, in an airplane, high up above the clouds. Here a qualified miracle worker may notice the red spots of Dr Henry Koplik of New York (1858-1927) and relieve the anxiety verging on hysteria of the mother of a blotchy, sniffly, febrile, loud, brattish child. He will "cure" the "stroke suspect" with a transient ulnar palsy sustained from sitting too long in economy class. He will wake up the heavy-set businessman who briefly passed out after drinking too much whisky in first class. With impeccable skill he will manage a confusing arrhythmia by applying an electrode to the chest of a man with an impalpable pulse. He will open the miracle box and press the green button, obey the injunction not to defibrillate, and witness with relief a spontaneous return to sinus rhythm.

But on the ground Italy is the best country for miracles. Imagine, for example, the crowded train from Ferrara to Bologna: a call for *dottore;* anxious relatives gathered around a cyanosed woman foaming at the mouth. No stethoscope, rudimentary Italian only. Doctor holds up jaw, makes her sit up, then waits. Woman deeply unconscious, not sweating, *niente diabetes*, no response to painful stimuli, pinpoint pupils. Could it be a pontine haemorrhage? But lifting one leg to test plantar reflexes has miraculous effect. Behold, she moves. Pupils dilate.

In a few minutes she stands up. Mumbles. Gropes around for her handbag. In Bologna a mustachioed conductor and a comely policewoman take over; time to take one's leave and run to catch last train for Milan.

On the outskirts of the baroque town of Lecce, under the hot Apulian sun, a young nun in full habit is seen bending over an older woman on the sidewalk. Blood everywhere. Mother down from Rome to visit daughter nun; wears sandals only; steps on a piece of glass. Dramatic intervention: tiny puncture wound on sole of foot; nun's handkerchief applied for 20 minutes; bleeding stops. Then it is time to move on, to other tasks, just as San Giorgio di Lecce might have done in the days when dragons infested the countryside, elfins danced on many a green mead, and miracle men walked about the land.

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