Selling sickness

In her review of *Selling Sickness: How the World's Biggest Pharmaceutical Companies are Turning Us All into Patients*, Miriam Shuchman[1] ignores one of the central premises of the book. The authors, Ray Moynihan and Alan Cassels, argue that physicians have been conscripted into a systematic campaign by the pharmaceutical industry to broaden the boundaries of illness so that drugs can be prescribed to formerly healthy people. As they note, "a health system that allows drug companies to play a role in defining who is sick is fundamentally unhealthy."

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REFERENCE

1. Brand-name disease [book review]. *CMAJ* 2006;174:819-20.

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Another proposal for primary care

I find the rhetoric around private clinics, enrolment fees and annual dues for "gold-plated" medical services pretty amusing. As described in a recent article by Wayne Kondro,[1] clients at the Copeman clinics would get 24-hour access to physicians and as-needed house calls. But wait — isn't that what we family docs are supposed to be providing? It certainly started out that way.

Here's my proposal. I am willing to compete with the Copeman clinics, on the following terms. For the sum of $250 per year per patient, without an enrolment fee, I will provide the same core services and do health promotion and teaching; I will also set my patients up with specialists as required. I won't need to bill the provincial system, because with about 2000 patients, I will cover my overhead and have a reasonable income, without any intermediaries like Copeman (although I would probably need to employ a nurse practitioner).

With this arrangement, I'm sure other like-minded family docs would be willing to sign up, and the problem of access to primary care would be taken care of. Does this make any sense to the Canadian ministers of health?

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REFERENCE

1. Kondro W. Copeman clinics come under scrutiny. *CMAJ* 2006;174(6):753.

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Inconsistent position on SSRI ads

Dr. Wayne Goodman, Chair of the Psychopharmacologic Drugs Advisory Committee of the US Food and Drug Administration (FDA), is quoted at the beginning of Colin Meek's article[1] as saying that he thinks ads about SSRIs stating that the drugs correct a serotonin "imbalance" are not based on scientific evidence and should be prohibited. At the end of the article, however, Dr. Goodman refuses to comment on whether the FDA should ban the ads and he endorses the admittedly unsupported claim that the drugs normalize some kind of chemical imbalance. These positions are clearly inconsistent, especially given that only the FDA has the explicit power and mandate to regulate drug ads in the United States.

For the general public, ads are crucial determinants of the perceived effects of drugs. Dr. Goodman's comments illustrate that, despite a vast drug regulatory bureaucracy, profit-focused manufacturers can make whatever claims they like about their products, with no attention to scientific evidence and no real fear of consequences. A similar situation existed about 100 years ago, during the era of "patent medicines." This is just one more sign that the adman is rapidly replacing the physician as the true intermediary between patients and their drugs.

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REFERENCE

1. Meek C. SSRI ads questioned. *CMAJ* 2006;174(6):754.

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Diabetes susceptibility

The hypothesis advanced by Hertzel Gerstein and Laura Waltman,[1] explaining why the age-adjusted prevalence of diabetes ranges from about 5% among people of European ancestry to 40% or higher in newly westernized Aboriginal populations, represents virtually the same hypothesis that I first proposed in 1998,[2] corroborated in 1999[3] and further developed in 2004.[4]

The substantial difference between their hypothesis and mine is that they regard Europeans' adaptation to a diabetogenic environment as a relatively recent phenomenon, beginning 300 to 400 years ago, whereas I believe that it occurred several millennia earlier, when incipient agriculture, apiculture, sheep farming, and rudimentary technologies enabled Europeans' ancestors to produce "genetically unknown

foods,"[2,3] such as those containing sugars in concentrations exceeding 250 g/L, which is the physiologic limit imposed by evolution.[4]

If a diabetes epidemic similar to the tragic one now afflicting the Pima Indians[3] had ravaged Europe centuries ago, this scourge would have certainly been reported by historians, who did not fail to write about the numerous plagues that decimated the European population during the Middle Ages. However, no diabetes epidemic in Europe was reported by either medieval or subsequent historians. There is also no mention of a diabetes epidemic in Latin literature, despite the fact that half of the 468-odd recipes in a Roman cookery book call for honey as an ingredient.[2] The Europeans' passable adaptation to diabetogenic foods, therefore, is likely to reflect a selection that mostly occurred before their remote ancestors could leave written records.

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REFERENCES

1. Gerstein HC, Waltman L. Why don't pigs get diabetes? Explanations for variations in diabetes susceptibility in human populations living in a diabetogenic environment. *CMAJ* 2006;174(1):25-6.
2. Baschetti R. Diabetes epidemic in newly westernized populations: Is it due to thrifty genes or to genetically unknown foods? *J R Soc Med* 1998;91:622-5.
3. Baschetti R. Genetically unknown foods or thrifty genes? [letter]. *Am J Clin Nutr* 1999;70:420-1.
4. Baschetti R. Evolutionary legacy: form of ingestion, not quantity, is the key factor in producing the effects of sugar on human health. *Med Hypotheses* 2004;63:933-8.

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[One of the authors responds:]

Diabetes currently affects approximately 8% of all adults in North America.[1] However, even with 21st century biomedical technology and intense attention to this problem, the disease remains undiagnosed in more than 30% of affected individuals.[1] It is therefore quite likely that a high prevalence of diabetes in Europe in the 16th and 17th centuries might not be recognizable in a historical record that was not attuned to the measurement of chronic illness. Thus, lack of evidence of a diabetes epidemic in such a society is not evidence of an absence of such an epidemic.

In our hypothesis,[2] we state that lower rates of diabetes in some ethnic groups (e.g., Europeans) may be attributable to a longer period of exposure to a diabetogenic environment coupled with a reproductive advantage for individuals exposed to such an environment. Such an environment is not restricted to specific foods; rather, it is characterized by a stable food supply plus increasing availability of labour-saving devices. We also point out that there is no reason to attribute the current epidemic to prehistoric alternating periods of feast or famine and the emergence of "thrifty genes"; indeed, this does not readily account for ethnic heterogeneity in prevalence. Moreover, millennia are clearly not required for resistance to diabetes to emerge if such resistance confers even a modest selective advantage within a diabetogenic environment. Finally, our hypothesis can be tested directly in animal models of diabetes and indirectly in population studies of fertility in dysglycemic individuals (such studies have not yet been undertaken).

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REFERENCES

1. Harris MI, Flegal KM, Cowie CC, et al. Prevalence of diabetes, impaired fasting glucose, and impaired glucose tolerance in U.S. adults. The Third National Health and Nutrition Examination Survey, 1988–1994. *Diabetes Care* 1998;21:518-24.
2. Gerstein HC, Waltman L. Why don't pigs get diabetes? Explanations for variations in diabetes susceptibility in human populations living in a diabetogenic environment. *CMAJ* 2006;174(1):25-6.

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Medical wait lists

A recent *CMAJ* editorial argued that the development of wait-time benchmarks by the Canadian Wait Time Alliance might have been less useful than it seems.[1] Although it would be foolhardy to argue with the assertion that there is a lot more to the health-reform story, there are many valid reasons for starting to deal with access to care by examining late-stage interventions rather than primary care or prevention.

First, to demonstrate success with any initiative, measurable indicators are needed. It is easy to measure the interval from the date of a decision to perform a diagnostic test or intervention to the date when that test or procedure is performed.

Second, the concentration of diagnostic and therapeutic services in tertiary care centres makes the implementation of wait-time benchmarks much simpler from an operational perspective.

Third, our well-meaning politicians do not have the expertise to appreciate where the real bottlenecks and truly dangerous delays are in the system. However, through this current initiative, physicians have an opportunity to properly inform politicians and policymakers about a broader range of issues related to access to care.

Who can blame politicians for picking the procedures they did? In 2002, a total of 74 626 Canadians died from cardiovascular disease and 65 103 from cancer. Together, these deaths accounted for 62.4% of all deaths in Canada.[2] Although there is always a risk that these procedures will be completed at the expense of other important procedures, if you had to start somewhere, this would be the place. The Canadian Wait Time Alliance recognized this risk and brought it to the politicians' attention.[3]

Sadly, the editorial is correct in stating that there is little hard evidence for some of these benchmarks. This is the case for many services and procedures in cardiac care, although for some interventions (e.g., cardiac catheterization) there is excellent literature to support the recommended wait-time benchmarks. In 2004, the Canadian Cardiovascular Society (CCS) (1 of the 6 professional associations in the Wait Time Alliance) established an Access to Care Working Group with a mandate to develop a series of commentaries to expand on the recommendations in the report of the Wait Time Alliance. Some