The appearance of racialised drugs on pharmacists' shelves only increases the need to attend to the myriad social sources of disparities in morbidity and mortality. Although to turn a profit from fighting racial discrimination is difficult, effective medical care demands continued awareness of the complex social dimensions of diseases, such as hypertension and cancer.

Conflict of interest statement

I declare that I have no conflict of interest.

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If direct-to-consumer advertisements come to Europe: lessons from the USA

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Direct-to-consumer (DTC) advertisements for prescription medications might one day be used in Europe. If some lobbies have their way,[1,2] European doctors and patients will face situations similar to those that have confronted their counterparts in the USA during the 9 years since the US Food and Drug administration relaxed its regulations on pharmaceutical advertising. In the years hence, ever-growing numbers of patients have visited doctors requesting drugs by name after having seen advertisements for drugs, such as antidepressants, antihistamines, antihypertensives, and cosmetic drugs on television, the internet, in magazines, and seemingly everywhere else.

In the event that DTC advertisements cross the Atlantic Ocean, European doctors and patients might take heed of the cautionary tales of American critics who contend that consumer-directed promotions oppose the interests of medicine. Such criticisms often focus on what might be called the intended effects of DTC advertising: namely, that these advertisements effectively induce patients to ask their doctors for specific drugs in ways that effectively encourage doctors to grant these requests. For instance, in a recent study of antidepressant advertising, Kravitz and colleagues[3] suggest that DTC advertising substantially increases brand-specific prescriptions, often for weak indications. And, in *The truth about the drug companies: how they deceive us and what to do about it*,[4] Marcia Angell contends that consumers are "duped" by deceptive advertising practices. Such assertions contribute to more serious concerns that, although drugs undoubtedly save lives, drug companies extend the markets for their products by manipulating consumers before they arrive at the physician's office.

Critics from the USA, however, have been fairly silent about what might be called the unintended effects of DTC advertising: the ways in which these advertisements challenge assumptions about what being a doctor or a patient means, the assumptions that both parties make about drugs, and the social contexts in which clinical encounters take place. Such effects are not the primary concern of drug companies, yet are no less important for understanding the impact of DTC advertising on medical culture in the USA. For example, fairly little has been said about the effect of patients requesting prescription drugs by name on traditional notions of medical authority, medical communication, or the doctor-patient interaction. Of course, patients have asked for particular treatments since the beginnings of professional medicine. Yet DTC advertisements have changed the ways in which physicians and patients speak and listen to each other. Research suggests that at least 40% of visits in which discussion about a DTC-advertised drug takes place result in a prescription for the advertised drug, and in more than half these cases, physicians claim to have prescribed drugs to accommodate the patient's request.[5] Patients have been emboldened to embrace decisions that were once the sole domain of the physician: selecting the appropriate drug and, by extension, the diagnosis. Physicians, meanwhile, have at times been forced to choose to either concede to or disappoint their

patients. Both parties have thereby occupied new roles and new subject positions, especially when their conversations revolve around prescription drugs.

Also overlooked by most US publications are the ways in which DTC advertising has changed physicians' own understandings of the treatments they prescribe. Of course, countless studies—almost as prevalent as the advertisements themselves—examine the effect of the advertisements on prescribing practices, and an equal amount of market analysis assesses changing patient attitudes and behaviour.[6] But fairly little has been written about the ways in which doctors' own beliefs about and expectations of prescription drugs are shaped by the fact that they too are members of US culture, and are as such subject to the same advertisements as are their patients. To suggest that medical knowledge somehow protects physicians from cultural trends seems irrational; yet whether DTC advertisements affect doctors and patients similarly remains a matter of speculation.

DTC advertisements have also amplified, and in some cases changed, cultural expectations about illness and health. For instance, television in the USA is replete with images of Levitra-invigorated men throwing footballs through tyres, or women who are proficient at motherhood duties because of antidepressants.[7] Even the outfield walls in many professional baseball stadiums now carry colourful billboards touting the latest erectile-dysfunction treatments to players, coaches, and fans. Such representations undoubtedly represent savvy marketing, yet they also show how advertising of drugs calls on and reflects existing cultural assumptions about matters such as gender, sexuality, race, and class to create expectations for prescription drugs. The advertisements connect prescription medications with assumptions about what it means to be a normal man, woman, black person, white person, lover, worker, or a host of other abstract, protean roles in US society. By doing so, the advertisements promote information not only about drugs, but also about the social contexts in which medications accrue symbolic meanings that, one might well surmise, play out in clinical contexts.

For better and for worse, DTC advertising thereby demonstrates how medicalisation intersects with values that drug advertisers are surely adept in recognising, but that are already present in the ways doctors and patients conceptualise categories of illness, health, and gender—otherwise the advertisements would be ineffective. Yet, evidence suggests that US clinicians have struggled with these new relationships, expectations, and roles. Even though DTC advertisements overtly encourage conversations between doctors and patients, many physicians suspect covert attempts to usurp their authority or dictate clinical decisions a priori. The result is tension, not only between doctors and drug companies, but between doctors and patients. For instance, a US Food and Drug Administration survey of US physicians showed that 47% felt pressure from patients to prescribe advertised drugs, 62% said DTC advertising had caused tension between themselves and their patients, and 92% said they could think of at least one patient who instigated discussion about an advertised drug.[8] Such findings have led to calls to more tightly regulate or abolish DTC advertising.[9]

More nuanced clinical conversations about prescription drugs are needed between doctors and patients. Instead of feeling pressure or viewing prescription interactions solely as yes or no decisions, physicians should become more aware of, and constructively address, the intended and unintended expectations and misperceptions raised by DTC advertisements.

Such an approach would require physicians to be trained to identify the social narratives around prescription drugs at the same time as they are trained to identify the drugs' chemical effects. Understanding the nuances of pharmacodynamics, drug interactions, and clinical diagnoses remain vital. Yet, nowadays, such skills might be enhanced by the mastery of clinical strategies to allow patients and doctors to identify and discuss their preconceived expectations about prescription drugs—what might, in an earlier era, have been called the transference and countertransference of pharmacology. Do patients think that medications might help them become better parents, students, or athletes? Why, or why not? What is the source of these beliefs? How do the answers to these questions intersect with a particular clinician's own expectations with respect to the potential benefits of treatment? Clinicians might also learn to become more attentive to expressions of illness that are different from the stereotypes promoted by drug advertisements. They might be asked to consider, for instance, the clinical relevance of an economy in which, during the second half of the 20th century, antidepressant advertisements promoted stereotypes of white women whereas at the same time largely excluding representations of patients from ethnic minorities, men in the role of fathers, people in same-sex relationships, and other groups.[10]

The 9-year US experiment with DTC advertising ultimately imparts an important lesson about clinical interactions, whether or not these advertisements are exported, regulated, or banned. DTC advertisements expose ways that doctors and patients might understand, and explicitly discuss, how market forces, cultural ideologies, and often unspoken expectations affect beliefs about prescription drugs. By recognising these forces, doctors and patients can begin to take control of issues that seem to be imposed by the drug industry, but in fact are dependent on values, judgments, and assumptions made by both participants in the examination room.

Conflict of interest statement
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Bullets, balance, or both: medicalisation in HIV treatment

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For the past 2 years, I have directed the Understanding Lipids Project, which examines the changing relation between biomedical disciplines at the clinical level, where doctors and nutritionists work to educate and deliver services to HIV-positive people with lipodystrophy and other metabolic side-effects of HIV. In this setting, I have seen clinicians, patients, and consumer advocates caught up in a subtle disciplinary shift; a shift away from a focus on virology and the blasting away of HIV with drugs, towards an approach that includes more medical subspecialties, with endocrinology having a substantial part to play.

In the many hours I have spent observing discussions between doctors and patients about the patients' drugs and their bodies, while working on a project examining the experiences of patients with metabolic complications of HIV drugs, I have seen firsthand the clash of thinking between HIV-positive patients—acculturated to virological thinking after years of undergoing antiretroviral therapy—and the specialist physician responsible for determining the causes of their metabolic disorders, himself acculturated through years of training and practice in his clinical specialty. In interactions between patient and doctor, doctor and drug-company representatives, and endocrinologists and HIV doctors, I have noted how the two medical specialties—HIV care as evolved in the context of research virology, and endocrinology as practiced in the clinical setting—each with its own culture and self-image, compete and collaborate, as they try to balance the problem of viral load (addressed with antiretroviral therapy) with that of disordered blood lipid and glucose concentrations and visible physical changes (addressed with drugs, diet, exercise, and sometimes cosmetic surgery). In the clinical encounters and in educational forums on lipodystrophy I have noted the continuing struggle by patients to make sense of two understandings of their bodies. On one hand, their bodies are battlegrounds, with virology promoting killing the virus as the solution. On the other hand, their bodies are systems seeking equilibrium between food and exercise, good and bad cholesterol, and bodily compensation for the toxic effects of lifesaving pharmaceutical bullets. Whereas virological solutions are additive—firing stronger bullets when weaker ones fail—endocrinology proposes balance; that is, introducing chemicals only when diet and exercise have failed.

Work on this project has forced me to rethink my assumptions about how medical ideas enter the social world. In my earlier work, I considered competition between medical science subdisciplines[1] and the process of cultivating good patients, through advertising, health promotion, and clinical interaction, to be largely separate processes.[2] After investigating these views in the clinical setting, I now see clinical encounters, with their continuing negotiation of diagnosis and treatment, as a space in which the uncertainties and disputes in biomedicine and society as a whole are staged and reproduced over time, doctor by doctor and patient by patient.

This is not to suggest that science moves uniformly forward. The history of AIDS has been full of complicated challenges to the internal coherence of science led by activists and patients against biomedicine, but also by practitioners within the emerging specialty of AIDS care, as different research communities struggled to define and explain the emergent syndrome.[3] Through the 1980s, a strong coalition formed between people highly identified with their medical diagnosis (people with AIDS) and a class of medical specialists: the AIDS doctors. AIDS doctors, once aligned only with their original speciality, became forcibly interdisciplinary as they absorbed the crucial new knowledge that virology offered for treatment of people with HIV. These AIDS specialists were often unglamorous family physicians, but their broad clinical experience made them more practically interdisciplinary than other specialists. Over time, as AIDS research and treatment embraced virological solutions, so did they. In the intimacy of the newly specialist AIDS doctors' offices, a