



An insider's view of the drug industry, p 776

## VIEWS & REVIEWS

# How gay porn undermines safe sex campaigns

PERSONAL VIEW **Richard Hurley**

In the early days of the HIV pandemic in the 1980s, chilling advertisements included a tombstone-like monolith emblazoned with the AIDS acronym, while John Hurt cautioned, “If you ignore AIDS it could be the death of you, so don’t die of ignorance” ([www.nationalarchives.gov.uk/films/1979to2006/filmpage\\_aids.htm](http://www.nationalarchives.gov.uk/films/1979to2006/filmpage_aids.htm)).

Such terrifying safe sex messages seem to have all but dried up, however. At the same time the depiction, indeed celebration, of unprotected anal intercourse in gay pornography has risen massively. The message this sends to young gay men that sex without condoms is OK is putting them at risk of HIV and other sexually transmitted infections.

The essence of today’s sexual health messages is that, because of advances in testing and treatment, people with HIV live normal and healthy lives. Of course, the reality isn’t so simple, and AIDS has no cure. The government and gay health groups no longer rely on an authoritarian voice to encourage condom use. Instead, campaigns reflect a drive to reduce the stigma associated with being HIV positive.

This has led some gay men to reach warped conclusions—for example, that it is inevitable that they will contract the virus and that when they do it won’t matter too much because of what they see as the panacea of antiretrovirals. Add to this the misconception that post-exposure prophylaxis provides a “morning after pill” for HIV, and unprotected sex seems even less of a big deal.

But AIDS is a big deal. Since 2003 the annual number of reported HIV diagnoses in gay men has consistently increased, to exceed the statistics for the 1980s and 1990s. The incidence in the United Kingdom in 2006 was almost 3000 ([www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb\\_C/1197637002300](http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1197637002300)).

A large and growing proportion of gay

porn DVDs on sale through sex shops and the gay press are condom free—and are marketed as such. Their titles often contain the words “bareback” or “raw,” and their covers sport icons of crossed-out condoms. With increasing deregulation and competition from the internet, porn studios are exploiting taboos to maintain market share.

Bareback sex puts porn performers at risk. Last year the BBC’s *Newsnight* programme reported that HIV infection was diagnosed in four men soon after they took part in a shoot (<http://news.bbc.co.uk/1/hi/programmes/newsnight/7277000.stm>). Some studios reacted to this exposé by setting up the Gaikiss (gay adult industry keeping its sex safer) campaign ([www.gaikiss.org.uk](http://www.gaikiss.org.uk)). This collaboration has developed a code of practice, with advice

from London’s Charing Cross Hospital (which runs a service for people working in the sex entertainment industry) and the support of Gay Men Fighting AIDS. The code aims to protect performers by recommending that condoms be used for anal sex. It also emphasises the need for studios to insist on seeing certificates to show that performers have recently been tested for sexually transmitted infections. The US director Chi Chi LaRue has taken a public stance against bareback porn and produced a public service film to promote safer sex ([www.safesexishotsex.com](http://www.safesexishotsex.com)).

The condom is a physical barrier between partners in what should be a highly intimate interaction and is often criticised for spoiling the moment.

In the post-AIDS mentality, many gay men see bareback sex as more authentic, more pleasurable, and more masculine. If bareback porn does not fetishise risky sex, it at least eroticises it.

The use of condoms in porn films normalises safer sex and offers practical demonstration. Many films show sex between men under the age of 30. And because most young men learn about sex through pornography, it seems likely that they may mimic their screen heroes in their own sexual practice.

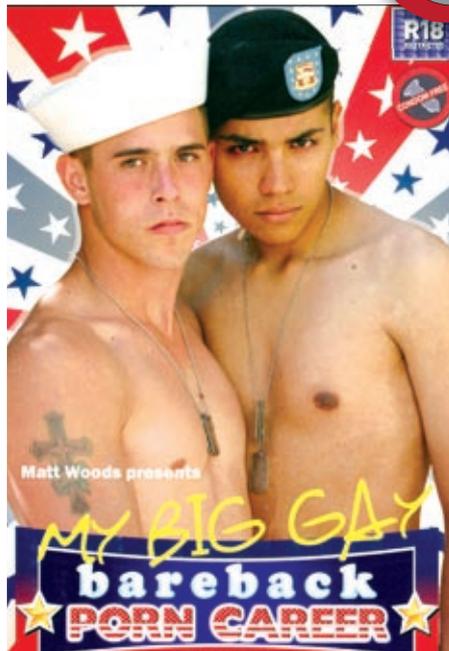
Doctors should:

- Remind their young gay male patients to use condoms, especially with new partners
- Suggest to gay men that they ask about a new partner’s HIV status and that they are honest about their own
- Recommend that gay men be tested regularly for sexually transmitted infections and that this should always include HIV, and
- Demand universal antigen or genomic testing rather than antibody testing, which can detect HIV within weeks or days rather than months after infection.

Richard Hurley is a technical editor, *BMJ*

[rhurley@bmj.com](mailto:rhurley@bmj.com)

Cite this as: *BMJ* 2009;338:b910

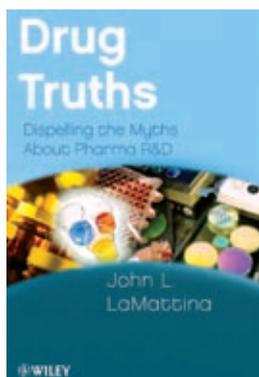


**A growing proportion of gay porn DVDs on sale through sex shops and the gay press are condom free—and are marketed as such**

REVIEW OF THE WEEK

# An insider's view of the drug industry

A view of the drug industry from inside the laboratories is one long apologia, finds **Allen F Shaughnessy**



**Drug Truths: Dispelling the Myths about Pharma R&D**  
 John L LaMattina  
 WileyBlackwell, £16.95, pp 152  
 ISBN 978-0470393185  
 Rating: ★★☆☆

*Drug Truths*, written by a research chemist who spent his career with Pfizer, presents a view of the industry from inside the laboratory. Although he exchanged his white coat for a pinstripe suit as he moved during his career from the bench to become Pfizer's president of global research and development, John LaMattina has not lost his sense of wonder at the drug discovery business and breathlessly presents this side of the industry as he attempts to bust the so called myths that surround it.

The human side of pharmaceutical research is illustrated in the author's recounting of the 17 year development and subsequent heartbreak of torcetrapib, a cholesterol lowering drug. The story begins in 1990 after a report was published on a gene mutation occurring in four families in Japan. The families lacked cholesteryl ester transfer protein, resulting in very high concentrations of HDL cholesterol, low amounts of LDL cholesterol, and no evidence of premature atherosclerosis.

Chemists at Pfizer, including the author, set about finding a chemical inhibitor of this enzyme. By screening thousands of molecules for their ability to inhibit the enzyme, and developing new chemical entities for testing, they identified a substance with weak inhibitory activity. Further years of experimentation yielded a modification that boosted the pharmacological effect to clinically relevant levels.

Now it was the turn of the pharmaceutical scientists, who were tasked with developing a product that would be absorbed when taken as a pill. By the time they were finished, eight years of development and testing had occurred before the first human ever took the drug. In phase I clinical testing, healthy volunteers showed impressive results: HDL cholesterol concentration increased and that of LDL cholesterol decreased after a single dose. At higher doses, HDL rose by 80% and LDL fell by 40% after only two weeks of treatment. The scientists were ecstatic, because the only problem they found at this point was a slight increase in blood pressure, which was eliminated by lowering the dose.

Phase II testing, involving giving the drug to patients with hypercholesterolaemia, produced more surprises: in patients with even slightly elevated triglyceride concentrations, the LDL concentration was not uniformly decreased and sometimes was increased. The scientists surmounted this limitation by combining the drug with a statin (Pfizer's atorvastatin).

The scientists—and the company—were on a roll, and excitement was building. Undaunted by the regulatory requirement that the drug must show an effect on cardiovascular outcomes and not just on laboratory values, they began phase III testing, enrolling more than 15 000 patients to compare the combination with atorvastatin

given alone. Several years into this testing the company announced, with great fanfare, the profound effects on lipid concentrations being reported in the clinical trial. Just two days later the lead scientist received a phone call from the chairperson of an independent data monitoring committee; an interim analysis showed higher mortality in the patients treated with the new drug.

The work of hundreds of scientists over 17 years came to a sad end. The trial was halted, the drug shelved. In unscientific terms a scientist expressed his feelings: "I know I entered an alternate reality that day . . . It must be something that anyone in bereavement might feel. Something was gone that would never be replaced, a hole in my heart that will remain for ever . . . My wife said it best. I was acting as though I had lost a 6-year-old child."

In other chapters LaMattina takes on other criticisms of the industry. He picks the unfortunate example of cyclooxygenase-2 inhibitors as proof that new drugs are safer than traditional medicines. He defends the industry's development of "me too" drugs, making the case (correctly) that doctors need more than one or two options to treat patients and arguing (incorrectly) that each new drug on the market adds a clinically relevant benefit. Is the 24th non-steroidal anti-inflammatory drug that much better than the first few? Do we really need three drugs for erectile dysfunction or 12 individual or combination stimulants to treat attention deficit hyperactivity disorder?

He dismisses the notion of disease mongering, arguing that preventive medicine dictates that risk factors such as osteoporosis, hypercholesterolaemia, and hypertension are true diseases, as are fibromyalgia and post-traumatic stress disorder. He sidesteps the issue of balding as a disease, the alteration of disease definitions such as those of post-herpetic neuralgia, erectile dysfunction, and bipolar disorder to be more inclusive, and the medicalisation of premenstrual symptoms and social awkwardness.

The excitement, pride, and naiveté of the author of *Drug Truths* are palpable and unabashed: "For many scientists a job in the Research and Development labs of a pharmaceutical company is a dream come true." Do not read the book as a careful, unbiased analysis of the industry; the factual and logical holes in its "myth busting" are large enough to drive a truck through. However, the book will be interesting to non-industry readers who want an insight into the emotional side of the drug discovery and development process and to experience the passion of one scientist who has spent his life devoted to identifying treatments and cures.

Allen F Shaughnessy is professor of public health and family medicine, Tufts University School of Medicine, Boston, Massachusetts [Allen.Shaughnessy@Tufts.edu](mailto:Allen.Shaughnessy@Tufts.edu)

Cite this as: *BMJ* 2009;338:b1138

**The author dismisses the notion of disease mongering, arguing that preventive medicine dictates that risk factors such as osteoporosis and hypertension are true diseases**

# The greatest torture

The illnesses of the great and good have always been of interest, not only to themselves, of course, but to subsequent medical people, who amuse themselves by speculating on their nature. The very impossibility of coming to definitive conclusions is part of the fun of this pastime.

Oscar Wilde's father, the surgeon William Wilde, later Sir William, published a book in 1849 about the last illness of Jonathan Swift, entitled *The Closing Years of Dean Swift's Life*, a second edition of which was published the same year and dedicated to William Stokes, of Cheyne-Stokes breathing, Stokes-Adams attacks, and Stokes' law.

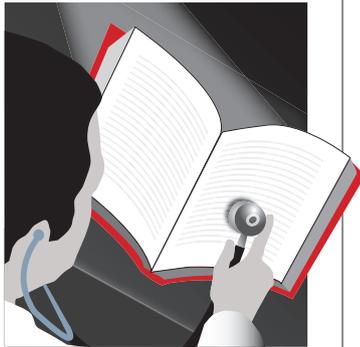
It seems clear that Swift suffered severely from Ménière's disease for much of his life, though the symptomatology had not been gathered into a disease entity at the time Wilde wrote (Ménière published his account 12 years later).

Wilde wrote the book to rescue Swift from the "accusation" that, at the end of his life, he was mad, "in the hope of rescuing his character from some of the aspersions which have been cast upon it." His expressive dysphasia and decline into dementia were, Wilde said, organic affections of the brain that did not start until Swift was in his 70s. Swift had no functional mental illness but had dementia. Modern commentators tend to agree with Wilde.

In 1835 Swift's mortal remains in Dublin were dug up to preserve them from the rising water table then affecting St Patrick's Cathedral, and his skull was examined by phrenologists at the behest of the British Association for the Advancement of Science, then meeting in Dublin. In their opinion the skull showed that its owner had lacked the organ of wit in the brain

## BETWEEN THE LINES

Theodore Dalrymple



**Wilde quotes the story of Swift's expressive dysphasia, of how, on struggling to say something, he suddenly burst out, "I am a fool!" This from one of the greatest masters of English prose**

and was almost mentally deficient; but as this was not really a very plausible conclusion with regard to one of the greatest wits of his age, they also concluded that his madness had altered the configuration of his skull and caused it to fall in. Wilde concluded that phrenology was nonsense.

As is well known, Swift left the great bulk of his estate to establish a lunatic asylum in Dublin, St Patrick's Hospital. He ended his *Verses on the Death of Dr Swift* with the famous lines: "He gave what little wealth he had/ To build a house for fools and mad:/ And

showed by one satiric touch/ No nation needed it so much."

At first the lord mayor of Dublin opposed Swift's scheme, for: "I was apprehensive that our case would soon be like England; wives and husbands trying who could first get the other to Bedlam. Many who were the next heirs to estates would try their skill to render the possessors disordered, and get them confined, and soon run them into real madness." But he relented, seeing the necessity for Swift's scheme.

It was Wilde who laid to rest the myth, widely propagated and accepted, that Swift had been the first patient of his own hospital; it was not built until after his death. Wilde quotes the poignant story of Swift's expressive dysphasia (relayed in the first biography of Swift), of how, on struggling and failing to say something, he suddenly burst out, "I am a fool!" This from one of the greatest masters of English prose.

Montaigne said that the greatest torture is not being able to express what is in one's soul.

Theodore Dalrymple is a writer and retired doctor  
Cite this as: *BMJ* 2009;338:b1226

## MEDICAL CLASSICS

### Neurological Differential Diagnosis

By John Patten First published 1977

John Patten, a former consultant neurologist, first produced this timeless text in 1977 in an attempt to make neurology less intimidating to the beginner. It was one of the first medical books to convey complex concepts in a digestible and understandable form by combining skilful illustrations with case vignettes and thumbnail sketches of illnesses. He cites *Biological Drawings* by Maud Jepson (1938), *Bedside Diagnosis* by Charles Seward (1949), and Frank Walsh's *Clinical Neuroophthalmology* (1947) as the eclectic mix of medical classics that influenced his unique approach.

Often revered as the bible of neurology, this volume provides an invaluable guide for any student or doctor wishing to master the anatomy and pathophysiology of neurological disease.

The author's carefully detailed illustrations demystify the anatomical complexities of the nervous system, making them easier to visualise in memory at the bedside. Remembering the cranial nerves is often a challenge requiring mnemonics and rhymes. Patten's drawings comparing a seventh nerve upper motor neuron with its lower motor correlate are unforgettable.

Another interesting lesson is that "writer's cramp" is not a neurotic syndrome particular to clerical workers but may actually be a prelude to Parkinsonism or other dystonic syndromes.

The book does not aim to replace the need for a manual of neuroanatomy but merely attempts to make it clinically applicable. The ventricular system is underexplored, and the sections on genetics will undoubtedly need updating in the future. However, the fact that a second edition was published in 1996 shows that Patten is aware that differential diagnoses are continually evolving.

When the first edition was completed, lumbar puncture, angiography, myelography, and air encephalography were still the principal modes of investigation. Computed tomography scanning was in its infancy, visual evoked responses had only just been standardised, and magnetic resonance imaging was only a concept. However, Patten was no Luddite; he welcomed these new developments as complementing our ability in locating neurological pathology. However, in his preface he warns against an otiose approach to diagnosis through an over-reliance on imaging: "A 'scan first and think later' philosophy has little to commend it, and yet threatens to take over as both an expensive, and in many instances ineffectual, method of working. At least 75% of neurological practice does not deal with diseases where there is a simple solution that can be revealed by scanning."

Patten reminds us that in many parts of the world neurologists have no access to the full range of modern investigational techniques. Even in developed areas, limited access and expense may preclude their use. This is a useful lesson for all who work with finite resources. David Shooman, ST1 neurosurgery, Southampton General Hospital, Southampton [shooman@doctors.org.uk](mailto:shooman@doctors.org.uk)

Cite this as: *BMJ* 2009;338:b1263

## Squaring circle time

FROM THE  
FRONTLINE  
Des Spence



I stood on the stage holding my spear. A bit part. Mary and Joseph held centre stage, and the narrator's voice boomed around us. Like many primary school heroes, Joseph ended up in jail, and Mary became a teen mother. I was an academic nobody, with no label of dyslexia and no classroom assistant. But I could tell a joke, was good at conkers and football cards, and would stick up for my friends. We didn't try to punch the teacher, and in turn teachers tried their best to teach us, long before they became completely distracted by "targets." We all seemed happy enough. Not even the teachers' pets knew what "esteem" meant. It is odd, then, that esteem is now the watchword of childhood, with schools now responsible for children's emotional "wellbeing." Esteem is now not some vague aspiration but an absolute entitlement enshrined in new educational initiatives such as "SEAL" (social and emotional aspects of learning).

School has become a daytime television talk show of emotions—all circle time, school counsellors, and citizenship lessons. Today it is parents' duty to emotionally indulge our children, to protect them from every slight, cross word, and potential failure. The concept of high

esteem is the very fabric of the narcissistic "me" culture, woven from constant worthless praise. But as adolescents steer gingerly round the corners on the freeway of expectation towards adulthood, a car sticker proclaims the problem: "Prince/princess on board." The modern consequences are an inability to compromise, share, or accept criticism or failure. Employment difficulties, relationship problems, and unhappiness all end in the doctor's lap. High self esteem may not be what we think.

But the instruments of government, such as education initiatives and medicine, serve only to undermine the esteem and authority of the family. Also, esteem is a dynamic force and has to be earned. Esteem doesn't make us persevere or deliver friendship and happiness; it's a result of these things. The SEAL initiative is chasing the impossible end of a self esteem rainbow, and in the process it will generate yet more medical fallout. Teachers should be left to teach, and the time has come to acknowledge that it's better to be a happy nobody than a forgotten, formerly esteemed somebody.

Des Spence is a general practitioner, Glasgow [destwo@yahoo.co.uk](mailto:destwo@yahoo.co.uk)  
Cite this as: *BMJ* 2009;338:b1225

## Wii-habilitation

THE BEST  
MEDICINE  
Liam Farrell



In Ireland we have an ancient law that the more obnoxious a relative, the more likely they are to gravitate towards your hearth. My many siblings were quite willing to shoulder their fair share of the burden, but they mysteriously developed a serious and disfiguring infectious disease just as Auntie Josie's massive orbit was about to degrade into devastating planetfall.

Auntie Josie's disposition was not kindly. Her religious begrudgery, in that great tradition stretching from Torquemada to the Taliban, decreed that not only was the glass half empty, some other greedy bastard had already drunk the best of it. When my little Gracie was born, and I presented her to Auntie Josie, I expected at least a few bills and coos. "Little girls were born to suffer," she said.

And at Christmas she would observe, "Christmas is a sad time, very sad." Take all the fun in the world and get rid of it, that's how much fun she was.

But something wonderful

happened last Christmas Eve, on that most magical night of the year. I woke in the early hours, the stars bright, the little fire-folk sitting in the sky, disturbed by an unfamiliar sound. It sounded like . . . chuckling, which slowly increased in volume and pitch until peals of girlish laughter were ringing in the air like silver bells. I slipped on the pyjamas Santa inexplicably brings every year, crept downstairs, and peeped into the living room, where I beheld a remarkable sight.

Auntie Josie was hippety hopping up and down on the Wii, Santa's present for Gracie. Encouraged by the onscreen homunculus, she spun and pirouetted like a gazelle; for a woman whose only usual activity had been to squat toad-like in front of the fire and cultivate her admittedly magnificent erythema ab igne, this was an unprecedented demonstration of gymnastic dexterity. And the true miracle of Christmas: she looked happy. Like the ranks of Tuscany in Thomas Babington Macaulay's

poem, I could "scarce forbear to cheer," especially with the prospect of an entertaining flatline. What better way to go, I mused, than among family who love you, or can barely tolerate you. Since then not only have her balance, posture, and mobility improved, but her demeanour has also moderated.

This Damascene epiphany is anecdotal evidence only, but imagine a Wii for every nursing home, every house with a granny, and every couch potato and the incalculable possibilities in rehabilitation and restoring mobility and general jollification. Of course, once the Wii is medicalised we'll need health and safety assessments, training courses, tutors, diplomas, degrees, professors, academic processions, the whole gestalt, but it will be worth the pain. If the Wii can render my Auntie Josie slightly less homicidal, it can do anything.

Liam Farrell is a general practitioner, Crossmaglen, County Armagh  
[drfarrell@hotmail.co.uk](mailto:drfarrell@hotmail.co.uk)

Cite this as: *BMJ* 2009;338:b1215