Jerome P. Kassirer. N Eng J Med 1999;340:466

When Dr. E. Ratcliffe Anderson, the American Medical Association's executive vice president, announced on January 15, 1999, that he had fired the editor-in-chief of the *Journal of the American Medical Association* (JAMA), he said that an important factor in his decision was the publication of a research article on the sexual attitudes of college students. It was not just the content of the article that was at issue, he said, but the fact that the article had been advanced for publication ahead of schedule with the intent of influencing a major political debate. In this case, the issue studied was whether people consider oral-genital contact to be "having sex". (...)

In my view, a medical jounal should not be a dusty archive of clinical studies and review articles, but a lively forum for exposure and discussion of important issues that involve, even indirectly, health and medicine. Articles on ethics, legal issues, health policy, human rights, and health economics published in a respected medical journal can have a bearing on ongoing political decision making at the state, national, and international level. (...)

Robert D. Truog et al. N Eng J Med 1999;340:804

Consider this paradox: if a physician reads a case report about a novel method of ventilation for critically ill patients and wants to try it in the next several patients with respiratory failure he or she treats, the physician may do so provided the patients have given general consent for tratment. On the other hand, if a physician is interested in performing a randomized, controlled trial to determine rigorously which of two widely used antibiotics is more effective at treating bronchitis, he or she must prepare a formal protocol, obtain approval from the institutional review board, and seek written informed consent from potential participants. In each case, the physician is performing an experiment. In each case, there is uncertainty about the best way to treat the patient. Yet in the context of clinical care, the experiment can be done with virtually no external scrutiny, whereas in the context of a clinical trial, the experiment is prohibited unless substantial hurdles are overcome. (...)

To put it another way, physicians can do almost anything they want in the name of therapeutic innovation, but only if there is no attempt to gain systematic knowledge from the intervention. Or, to paraphrase Smithells, "I need permission to give a new drug to half my patients but not to give it to all of them".

Lucius F. Sinks, Kristen A. Zurfos. Med Pediatr Oncol 1998;31:105

The guidelines instituted by a number of health maintenance organizations (HMOs) that require a woman with breast cancer to undergo mastectomy on an outpatient basis has received wide attention. (...)

The issue involves two very basic questions relevent to good patient care that are generic to virtually all situations in medicine.

These two questions are: 1) who decides when a patient not only requires hospitalization but also for what duration of time?, and 2) if major changes in the practice of medicine are to be made,should they not be based on conclusive data provided by well-designed clinical trials?

In the situation of outpatient or "drive-through" mastectomies, surgeons in Connecticut were faced with an arbitrary decision made by some HMOs. The dictum was that patients undergoing mastectomy would not be allowed to remain in the hospital overnight (i.e., more than 23 h). A basic time-honored principle that the physician (surgeon) and the patient are in the best position to decide how long the patient is to remain in hospital had suddenly been preempted. (...)

"Drive-through" mastectomies are an example of the extent to which for-profit managed care companies are prepared to intrude into the doctor-patient relationship and interfere with what the physician considers to be adequate medical care.