kapcsolatos írásait, cikkeit a 2006-os és 2007-es évre vonatkozóan. A lekódolt cikkek alapján részletes tartalomelemzést készítettünk, s kvantitatív eszközökkel jellemeztük a korrupció különböző típusait.
A kutatás átfogó célja, hogy hozzájáruljon az üzleti korrupció alaposabb feltárásához, valamint mélyebb megértéséhez és magyarázatához. Ehhez a kutatás során a hangsúlyt a konkrét korrupciós helyzetek és mechanizmusok megismerésére, nem pedig a korrupció észlelésére vagy a korrupcióról kialakított vélemények felmérésére helyeztük. Az előadás a kutatás fontosabb eredményeit összegzi.

**Szarvák Tibor[146], PhD**

**Agóra projekt Szolnokon, avagy térteremtés a kultúrában és a városfejlesztésben**
(Agora project in Szolnok- Creating space in culture and city development)

Az előadásban a 2008 tavaszán, az NFT II-ben, a nem pólus központok számára meghirdetett kulturális agóra projekthez készített empirikus háttérkutatásunk eredményeit ismertetjük. A vizsgálatba bevontuk a megyeszékhely térkapcsolataiban fontos területeket (így a szolnoki, a törökszentmiklósi, a kunszentmártoni és a mezőtúri kistérséget; valamint az Alsó-Jászságot és Abony várost).

A felmérésben arra kerestünk választ, hogy miként teremthet a kultúra (a fogalom fizikai és szellemi értelmében) várost, közösséget / közösségeket. Fontos kérdésünk volt az, hogy milyen lehetőségek vannak a kreatív társadalmi osztály igényeinek kielégítésére. Kutatásunk lényeges dimenziója volt a közösségek kulturális térhasználatának, tájékozódási szokásainak, valamint program-vonzerő vizsgálata is.

**Szathmári, Milán[147]**

**A klinikai vizsgálatok szociológiája**
(Sociology of clinical trials)

The purpose of my presentation is to lay down the basics for interpreting and analysing the rapidly expanding phenomena of clinical trials. After giving insight to the aim, essence, players, institutional and legal frameworks of clinical trials I am going to demonstrate the emergence of this phenomena with numbers. I will show how the number of clinical trials, involved investigator sites (hospitals), principal investigators (physicians) and participating subjects grow over time in North America, Western Europe and Central and Eastern Europe in the past decade.
In my interpretation the spread of clinical trials is the fulfilment of the empiricism in medicine. More precisely the patients are treated in a standardized way according to the protocol of the trial. The results of measurements of patients are connected in one single database. Only by this it is possible to detect rare adverse events (lack of adverse events=safety) and to evaluate efficacy (efficacy=the investigational product heals the illness). Patients are still measured and evaluated individually too, but by making the treatment of patients uniformized the evaluation of the investigational product gets a solid

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statistical foundation. If the results are promising then the investigational product will be registered by the competent authority and will be marketed as a medication.
I intend to demonstrate that by the so called active controlled trials the pharmaceutical companies are constantly controlling each other. In such trials the pharma firms compare their own investigational product with a registered medication of another pharmaceutical. In placebo- and active controled trials the own investigational product is compared to placebo and to one or more registered medication. Mandatory reporting to competent authority ensures that a product inferior to placebo cannot stay in the market. One related hypothesis of mine is that the investigational products tested in pre-registration Phase III trials are better than registered medications available on the market. Another of my hypothesises is that patients participating in clinical trials are of better social standing than those who do not participate. This because they have better access to elite clinics of the capital and of major university towns (where most of the trials are conducted). These two hypothesises contradict popular beliefs which say that the pharmaceuticals test unnecessary and harmful substances on defenceless groups of people only to market these product later to the harm of greater masses.
Sociologist have long ago turned their attention to the rights of patients participating in clinical trials. The fundamental problem is that it is not known empirically whether the investigational product is safe and efficient. It is only supposed to be safe and efficient on a theoretical basis. To find out the truth a lot of patients must take the uncertainty of allowing the investigational product to be tested in them. This is the only way the empirical medicine can advance. I am going give brief insight into the sociological literature of signing (getting the patients to sign) the patient informed consent form and into the literature of the relationship of the investigating physician and patient.
Using placebo (randomizing patients to placebo group) deserves particular attention. Is it ethical to give placebo to patients instead of giving them an available medicine or a promising investigational product which could improve their condition? On the other hand placebo control is what makes the evaluation of the safety and efficacy of an investigational product scientifically well-grounded. This is the precondition of the development and registering of good medications – the creation of a public good for the benefit of all. Free riding occurs: there are local ethic committees (hospitals) and central ethic committees (countries) who do not approve placebo controlled trials. Therefore the non-use of placebo is questionable ethically too.
At the end I will show that the phenomena of clinical trials is in line with a current marxist theory of the sociology of health and medicine. Proletarianization theory says that the physicians too are subject to the rationalizing and routinizing logic of capitalism. The bourgeois entrepreneur doctor once of unquestionable authority, who cured patients at their own home, in person, individually, is transformed into a proletarian working anonymically in the pressure of market forces, surrounded by complex health care industries. The physician who is working in a complex system of pharmaceuticals sponsoring clinical trials, contact research organizations, regulatory authorities, local and central ethic committees is in fact a proletarian who is kept from becoming totally proletarianized only by his medical degree, which still maintains his monopoly to reach patients and to decide on their treatment (which medication to prescribe for them or which clinical trial to enrol them into). However, in the pressure of the health care industry the medical profession is no doubt „on the defensive". At the same time, according to our first hypothesis this new way of medicine still produces better outcomes