VIEWS & REVIEWS

Collecting feathers in the health service

PERSONAL VIEW **Anonymous**

I am a senior practitioner. I am passionate about my work and about the NHS, which is why I have much to say on racism within the organisation. Racism is a threat to any organisation. The police force was the first state body to be publicly exposed as having “institutional racism.” The NHS faces the same allegation. An accusation of racism leads to denial or the accuser being accused of playing the “race card.” It seems that consciously or not some people are blind to racism, at least that which is real for the visible minority.

When I proposed changing my name to give me a better chance of securing an interview to study medicine in the 1980s, I was considered naive; a London medical school proved me not so naive some years later. At my graduation ball the professor of surgery gave me some advice: “Even with your surgery medal you will have to work harder, be smarter, try and join the right clubs and it will still take you longer—if you are lucky.” Fortunately I was not interested in a surgical career. I did come across racism in my career path though. While I was in surgery as a houseman, the consultant surgeon said: “You’re from Africa. Do you think black

Consciously or not some people are blind to racism

people are genetically incapable of running nations?” Except for the rhythmic noises of the gas machine, the theatre was

still. Everyone awaited my answer. My immediate thought was of the consultant being a potential referee, so I took a white feather; I suggested that his query was perhaps a little more complex than just genetics. Covert racism is more interesting. By definition it is subtle, yet more visible to the visible minority and invisible to others.

I was clear about my career and how to go about achieving it. I chose to sidestep racist language, behaviour, and views from colleagues. I could have treated them as potential barriers; I could even have

taken a formal, perhaps legal, route. Sidestepping was safest for me, but in doing so I failed to deal with the issues and left exposed others that followed. I kept collecting feathers. Yet pull the race card and whatever the outcome, the complainant is damaged—career, livelihood. So people just keep collecting feathers.

Despite my European education, indistinguishable English, and confidence, each of my career choices included a wider assessment of the potential for racism. Consider the international medical graduate with an Asian education, accented English, and unquestioning respect for seniors and institutions, grateful for the opportunities in an economically rich system. It is no surprise that the graduate from Bangalore feels more able to access support and direction from senior colleagues also from Bangalore. I chose deliberately to keep away from race issues. I was determined to stand out and be “the doctor” not “the Asian doctor.”

As a trainee I presumed that prejudicial recruitment practice was likely wherever I applied for work. For every application I visited the unit, not to inform myself but to inform potential employers of my abilities over and above a foreign sounding name. Ironically I am now involved in recruitment. I am in a position to implement good recruitment practice, bringing transparency, questioning assumptions, and being critical about supposedly historical practices. If a colleague genuinely believes that applicants with parents in medicine make better doctors, what other prejudices exist? I work on the assumption that most people I encounter and work with are fair, but I know that it takes few to corrupt an

institution and to damage its employees and reputation.

Institutional racism has always been, and always will be, in the NHS. The McPherson report attempted a definition of institutional racism: “the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin which can be seen or detected in processes; attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages minority ethnic people.”

Just as people resent the accusation of being racist because they are unable to see it in themselves, organisations resent accusations of institutional racism. Exposure of such racism lies in building transparent systems rooted robustly enough to fight off the few invisible professionals who are hardwired to damage otherwise forward thinking institutions.

Covert racism is more insidious, more difficult to frame legally, and more damaging than overt racism. When a senior, white, colleague commented in 2005 that a national award bestowed to a colleague from the visible minorities was more to do with achieving ethnic balance, it shows we still have a long way to go.

We have not yet travelled far enough for me to reveal my name, so pass me another white feather. You may know me, but do you know yourself?

The author, who is based in the north of England, wishes to remain anonymous but can be contacted at m.nasrudin@hotmail.com

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Telling the inside story?

A sacked drug company executive claims to spill the beans on the industry in a new book, writes **Jeanne Lenzer**

Peter Rost, erstwhile drug company executive, self proclaimed whistleblower, and now book author, first became a cause célèbre in August 2004 when he wrote an endorsement of *The Truth about the Drug Companies*, the book by former *New England Journal of Medicine* editor Marcia Angell (review *BMJ* 2004;329:862). He posted a commentary on Amazon.com, saying, "I should start with a disclaimer. I'm a vice president within one of the largest drug companies in the world and I have spent close to 20 years marketing drugs. So I guess I'm not supposed to like this book. But the truth is I thought it was fantastic."

Rost's posting was picked up by the media and he became a much sought after guest on television and radio shows. He took up the cause of drug reimportation, a practice that would allow foreign drug companies to sell drugs in the United States. Reimportation, argued Rost, is widely practised in Europe and could drastically reduce drug prices in the US. His position was in sharp contrast with that of his employer, Pfizer, and to virtually all major US drug companies, which vehemently argued that reimportation would allow unsafe drugs to enter the US and would threaten the health and safety of its citizens.

But Rost began to run into trouble long before he became a public advocate of reimportation. In 2001, as the new head of the endocrine care division of Pharmacia, he learnt, according to his account, that the division's flagship drug, Genotropin, a synthetic form of human growth hormone, was being promoted for off-label uses. Off-label promotion of growth hormone is a felony under federal anti-doping laws. Pfizer, which bought out Pharmacia in April 2003, failed to put a stop to the off-label promotions, says Rost.

Rost alleges that it was his complaints about the marketing of Genotropin that led Pfizer executives to fire him. He was first informed in an email message on 3 February 2003 that he was to be sacked, but he managed to hold on to his job for two and a half years, until 30 November 2005, when he was finally let go. Rost filed a *qui tam*, or whistleblower, lawsuit against both Pharmacia and Pfizer in December 2005. In the suit and the book, Rost claims to describe some of the inventive marketing techniques used by the companies to promote sales of Genotropin to "anti-aging" clinics and for the treatment of short children who did not have growth hormone deficiency.

Rost, who paints himself as a regular guy in his book, is the quintessential marketer. Along with the

publication of *The Whistleblower*, he has a Hollywood agent looking for potential movie deals; he has written a fictional thriller about the drug industry entitled *The Wolfpack*; and he is scheduled to be interviewed for *Sicko*, Michael Moore's documentary movie on the healthcare industry.

A niggling aspect of *The Whistleblower* is that Rost repeatedly wastes the reader's time defending his motives for his various actions as he sought to hang on to his job. Some of his actions appear simply indefensible. Rost, who earned over \$600 000 (£305 000; €460 000) annually (exclusive of benefits, annual bonus awards, and stock options) is hardly a man without warts. When Pfizer asked him to fire a number of his colleagues, Rost fired them—while bemoaning their fates in the book. He is at his worst, perhaps, when he spends an entire chapter on irrelevant speculation about the sexual activities of Pfizer's bosses. Rost makes no bones about why he wants to pursue possible sexual improprieties, even though he has no first hand knowledge of the events. "If they feared what I knew about them," he writes, "they would be less prone to take away the lifeline I had left—my salary."

Rost's book claims to chronicle problems in the way the drug industry manages to circumvent rules prohibiting off-label drug promotions. In addition, Rost's endorsement of reimportation is perhaps one of the most articulate defences made in the US. *The Whistleblower* may also reach some lay readers who were not moved to pick up any one of a number of more academic books on the drug industry. Finally, his overview of serious violations by nine top drug companies in his chapter "How corrupt is the drug industry?" should make one thing crystal clear: fines simply don't work. They are, as has often been said, simply the price of doing business.

"Working for a corporation," writes Rost, "is like running with a wolf pack. Everyone helps out and is friendly as long as it benefits the group, but each wolf cares only about himself and will do anything to survive. Compassion, loyalty, caring . . . these are all buzzwords invented to control the masses." Rost's take on the nature of industry might leave one wondering whether Rost isn't simply a very clever wolf himself.

The good news is that when the titans do battle—the fallout can be instructive.

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REVIEW OF THE WEEK

The Whistleblower: Confessions of a Healthcare Hitman

Peter Rost

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Rating: ★★☆☆

"Working for a corporation is like running with a wolf pack. Everyone helps out . . . as long as it benefits the group, but each wolf cares only about himself and will do anything to survive" Peter Rost

Flagging up a necessary division

FROM THE
FRONTLINE
Des Spence

In 1972 I holidayed in communist Bulgaria. My most vivid memory is of my communist father's cherry brandy fuelled rendition of the Red Flag on the bus. Back then the UK Communist party was the preserve of the private school intelligentsia, while many in the proletariat staunchly voted Tory. Despite the catchy drinking songs and natty uniforms, communism fell because its semi-religious dogma allowed its officials to rob their countries blind. So, unlike my father, I am a capitalist, recognising that people need incentives—sticks and carrots.

I do remain a socialist of sorts—perhaps the champagne kind, with my big house and skiing holidays. My kids attend a state school, but it operates a type of postcode selection. I have no need of private medical insurance, as I can be difficult enough to get the best out of the NHS. But

I still see red when it comes to private medical practice. The idea that pain and suffering can be judged by a bank balance is unjustifiable, even to a capitalist. This isn't merely misplaced ideology either. In humble general practice we hear hushed rumours of private medicine: absent consultants neglecting their NHS responsibilities and expressing rage at managers if challenged; consultants offering questionable investigations and charging questionable prices; a private sector that cynically cherry picks cases and dumps complex and chronic ones on the NHS.

Now much of this may just be medical myth, retold by each new generation of GPs. I know many consultants will also see red at such suggestions, and I have no doubt that the majority are fully committed to the NHS. But the

NHS and the private sector are two bitterly opposed teams. Private practice needs to operate, needs to investigate, and needs to churn patients through to make its money and so has huge financial incentive in seeing the NHS fail.

Perhaps it's a throwback to Nye Bevan's historical compromise, but why does the NHS allow its key consultants to play for both teams at the same time? The temptation to bend the system is simply too great. Is it time to make consultants choose a team? Private or public—but not both. NHS consultants should be able to earn extra income within the NHS, but this should be based on patients' needs, not their income. But this is not communist dogma—the NHS doesn't need red flags any more than it needs white flags.

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On the cheap

DRUG TALES AND
OTHER STORIES
Ike Iheanacho

Like much else in health care in Britain, attempts to prescribe drugs by generic rather than brand names can be frustrating. This crucial contribution to containing the national drugs bill is sometimes disrupted by the tactics of the drug industry. And it must be rare to find patients who actively welcome being switched from a product with a familiar name and look.

Despite these negative aspects, the prescribing of generic drugs is a UK success story. That it isn't celebrated (at least, not by patients) owes much to the downbeat way the topic is presented and discussed. Part of the problem is the low key nature of generic drugs and their producers. Few prescribers would struggle to name several major drug companies, yet how many could identify even a single producer of generics, let alone suggest how such outfits operate or relate to noisier, more powerful branches of the industry? This is a little odd, given how essential generic drugs are to the NHS.

Another issue is the language surrounding generics. In particular, unqualified use of "cheaper" and "cheap copies" in discussion of these products does not help. Such terms are too easily misinterpreted as "substandard." Generics are not merely cheaper "copies" but equivalents that (with well documented exceptions) offer the same effectiveness, safety, and quality as their brand name versions and are, therefore, better value for money. Emphasising cheapness is a distraction.

So perhaps it's time to learn from organisations that really know about championing value for money goods. Supermarkets are masters of this game. You won't catch them presenting their "budget" or "value" products in ways that suggest "second rate" or "unfit for purpose." Instead, their promotions carefully avoid making buyers feel mean, stupid, or inadequate for purchases that are made to minimise cost or maximise spending power. And somehow the shops achieve this while also marketing pricier items of undeniably higher class (a complication largely absent in comparisons of generic and brand name drugs).

A key difference between supermarket shopping and being prescribed generic drugs is the consumer's lack of direct involvement in the NHS's purchasing decisions. For patients and some prescribers this can mean that messages of value for money come a poor second to the higher profile trumpeting of brand names. So hearts and minds still need to be won on how generic drugs benefit the nation without disadvantaging individuals.

In areas of expenditure where the public has much less day to day involvement than with drugs, such as defence or local government, the need for cost effective use of central funds goes without saying. Doesn't generic prescribing deserve the same benign acceptance?

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Advice to travellers

I once took a job in the tropics, and my employer sent me for a medical examination to check that I was fit for hardship. My medical was just like the one that Marlowe underwent in Joseph Conrad's *Heart of Darkness*, before he went out to the Belgian Congo.

Marlowe was in Brussels for his medical—a city, he says, that “always makes me think of a whited sepulchre.” And then he adds, “Prejudice no doubt.”

I confess to a similar prejudice. Brussels shows us our glorious future: bureaucracy and sex shows.

Marlowe is told that the medical is a simple formality, just as I was told it was. And so, indeed, it proves and proved.

Marlowe's doctor—an old one, just as mine was—examines him in a perfunctory manner, just as I was examined. “The old doctor felt my pulse, evidently thinking of something else the while.”

Quite so: the old doctor in my case passed his stethoscope swiftly over my chest, the bell hovering just above the surface and never alighting anywhere. He would have heard anything only if I had had a tape recorder inside playing at full volume. It was more propitiation than science, and he muttered to himself throughout.

“Good, good for out there,” mumbled the doctor to Marlowe, and my doctor mumbled something similar. I told him that I took thyroxine daily, and he asked me how many grains. Even in those days grains had not been used as units of measurement for quite a number of years.

“Ever any madness in your family?” the doctor asks Marlowe. I was asked the same question, slightly less than a century later. It depends on what you call madness, I thought. And just like Marlowe I wondered what the point of the question was.

BETWEEN THE LINES Theodore Dalrymple

The medical was just like the one Marlowe underwent in *Heart of Darkness*

The ceremony nearly over, the doctor dispenses advice to Marlowe: “Avoid irritation more than exposure to the sun... In the tropics one must before everything keep calm.”

Of course, in those days the rays of the tropical sun were thought to be dangerous, if not fatal, to white people; even 30 years later Dr Schweitzer recounts in one of his books the case of a man driven stark mad

by a single ray of sunshine that fell on his negligently unprotected neck. The injunction to keep calm at all costs was therefore a very serious one.

My doctor advised that I should be careful of the water and not drink too much alcohol. Insects, he said, were to be avoided.

I didn't altogether succeed in following his advice: I got malaria, jiggers, and myiasis.

As Marlowe leaves the consulting room the doctor says, with an admonitory wag of the finger, “Du calme, du calme. Adieu.”

This reminds me of another time I departed for an exotic destination: India. I was a student, and my trip meant that I would return late to medical school. I went to the dean to ask his permission to do so.

“India,” he said. “Ah...” He looked in the far distance, far beyond the walls of his office, extracting a rare insight from a point at infinity. “A land of people—and animals.”

He gave me his permission, even his blessing; and at the door, as I left him, he repeated, “Remember: people—and animals.”

I've never forgotten it. But what exactly did he mean? The same question has, of course, been asked of Conrad.

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSICS

Tropical diseases By Patrick Manson

First published 1898

“Textbook knowledge” has a bad ring these days. Knowledge grows so quickly that textbooks are assumed to be purveyors of yesterday's news. A century ago, medicine was also changing rapidly, and yet two textbooks, each published in 1898, transformed the medical landscape. William Osler's *Principles and Practice of Medicine* elegantly brought the glad tidings of the new scientific medicine to students of medicine throughout the world. Patrick Manson's *Tropical Diseases* spearheaded a new medical specialty, at a time of global imperialism.

Manson, a genial Scot with practical experience in China, Formosa, and Hong Kong, was then a tropical medicine consultant in London. He had demonstrated that filariasis was transmitted through mosquito bites. This clinical research alerted him to the importance of parasites in “tropical” diseases and to the role of insects in spreading them.

Before Manson, tropical diseases were generally assumed to be simply the diseases of warm climates, which emerged from the confluence of heat, humidity, vegetation, and decay that characterised these areas. Manson reversed the flow of causality: the conditions did not cause disease, but they permitted the existence of unique disease causing organisms. What Manson called

the “cosmopolitan” diseases of the old world—diseases such as plague and leprosy—were ubiquitous because the germs could be found everywhere. They had largely disappeared from Europe.

In a sense, *Tropical Diseases* merely applied the germ theory to diseases of hot climates. Nevertheless, Manson argued, tropical medicine was not simply a branch of bacteriology.

Rather, the range of tropical organisms dangerous to human beings included many other biological groups: worms, protozoa, and plasmodia. Tropical medicine was thus really a branch of parasitology, and since many of the organisms had complicated extra corporeal developmental cycles, and complex means of spread, including via insects, special tools and modes of thought were required to understand the range of diseases found in the tropics.

Tropical Diseases appeared at an opportune time. Manson's protégé Ronald Ross had discovered the malaria parasite in mosquitoes the year before and demonstrated its role in transmitting the disease in birds. Schools of tropical medicine in Liverpool, London, and several European countries established the discipline firmly. Manson oversaw a sixth ever expanding edition in 1917. One characteristic of a classic is that it stays available: the 21st edition of Manson's textbook was published in 2003.

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Genial: Manson

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