**"Do we elect politicians
just to visit their
convictions on us?"**
**Review of *The Blair*
Years, p 1100**

VIEWS & REVIEWS

A few lessons about drugs and gun crime

PERSONAL VIEW Ademola Odunfa

I arrived in Jamaica in April 1990 after landing a job at the Ministry of National Security in Kingston. I was there to boost the ministry's pathology staff because of the country's high murder rate. Jamaica has been variously described as the most violent or dangerous place on earth, although it also has one of the highest numbers of churches per square mile.

With our young family of five my wife and I were received warmly by staff. Most of my medical training had taken place in Nigeria, but we quickly settled into our new surroundings, and the work began in earnest.

Kingston is a highly volatile city of about one million inhabitants. The notorious downtown area is a place you don't visit after 6 pm unless you are armed, ready to battle for your life, or both. Murder here was seen as just one of those things, and nobody really batted an eyelid. The only thing the relatives asked you after a postmortem examination was how many shots did he get. It was just another murder. People in Kingston were murdered in the most bizarre ways. I once conducted an autopsy on a man with only parts of his body available for

I had a police escort if I had to do a postmortem examination at the Kingston Public Hospital morgue, and even then it was still risky

examination. Another time there was just the lower half of a man—the upper part had been destroyed to make identification difficult. DNA analysis was not readily available in Jamaica in 1990. It wasn't until a year or so later that a seminar entitled "DNA fingerprinting" was

arranged for government pathologists—and many more years before the analysis actually became available.

Gang warfare and control of drug distribution in particular areas are said to be responsible for most of the crime, which was concentrated in downtown Kingston.

Jamaica's dangerous streets: relatives and friends grieve over the casket of a 15-year-old girl killed this year by a stray bullet

COLLIN REID/APPA

Murders uptown usually resulted from robberies, especially of residents returning from overseas, who were believed to have brought back huge sums of money; political killings; or accidental discharge of weapons. But these pale in comparison with what happened downtown. In the early 1990s it was very dangerous to walk downtown in Kingston; I had a police escort if I had to do a postmortem examination at the Kingston Public Hospital morgue, and even then it was still risky. You would hear sporadic gunshots as you drove through town. There the usual weapon of choice among men was a handgun or automatic rifle. Among women, especially local women, it was a knife—sophisticated women also used handguns. Suicide was common. I remember the case of two young university lecturers, both doctors, who ended their lives because they were suspected of infidelity.

At the end of my three year contract I was seconded to the Ministry of Health and posted to Montego Bay. I later learnt that my boss back in Kingston had thought that I was getting too popular with the police because I responded to their calls at any time of the day or night.

In Montego Bay I had to double as hospital pathologist and police pathologist. At the same time I was regularly called back to Kingston to attend court, usually

with a police or army escort. I used to find that the crown counsels liked to play God. They would call you up at very short notice and without any apology. You couldn't even complain to the judges, who usually took the side of the attorneys. The judge at the Gun Court, which deals exclusively with firearms cases, usually took pains to explain to the accused that the pathologist is not an eyewitness but

that he is just going to relate his findings from the postmortem examination. This is important as Jamaica's witness protection programme does not work properly, and many eyewitnesses are easily eliminated by cronies of the accused, usually as a result of tips from the security forces.

In 1996 I was posted back to Kingston and stationed at the Public Health Laboratory. At this time there was an outcry about the high number of extrajudicial killings by the armed forces and especially by the police. Local human rights groups were scouting for pathologists who were willing to risk their necks and testify against the armed forces. I accepted the challenge. Of course, this put me in the authorities' black books, and I received death threats on more than one occasion. I attended about 100 postmortem examinations on behalf of the human rights groups and went to courts about 10 times for similar cases. However, no convictions were made against the police in any of the cases.

In all, in my 16 years of pathology practice in Jamaica I conducted about 1000 postmortem examinations, more than half of which were murders. Of these, 80% were gun crimes. The rest were stabbings, bludgeonings, suffocation, and strangulation.

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The bitterest pill

FROM THE
FRONTLINE
Des Spence

In 2004 I attended a parliamentary subcommittee meeting and sat with stars of the medical firmament such as Andrew Hexheimer, David Healy, and Ike Iheanacho. I was there simply as an honest witness to the excesses I had seen and to express support for the No Free Lunch group (www.nofreelunch-uk.org). I was a mere pimple on an ailing and delirious drug industry being dragged down by a virulent infection called marketing.

After all its high living, the drug industry is now hung over and needs to sort its life out—there are no more magic pills. Once the darling of the stock exchanges it now receives dire reports on its future profitability and witnesses a steep fall in the number of new drugs being approved. And under media attention it is experiencing drug induced flashbacks to the night of excess before: lap dancing clubs, Wimbledon tickets, and funds slipped to medical experts and charities, and so on.

But all this is a painful and long overdue correction—the bursting of the bubble that is the notion that societies' social sicknesses can be cured by pills. Can we doctors help the industry? Yes: we must stop seeing pharmaceutical representatives. This is a logical move on several levels. Such contact increases costs and exposes patients

to the dangers of new drugs, and the associated hospital-ity is inappropriate for public servants, undermining the status of doctors in the eyes of the public.

But there is also a new economic argument. The open doors to doctors' surgeries have allowed pharmaceutical marketing departments to gain a stranglehold over business plans and stifle true innovation. It is estimated that the firms spend a third of turnover on marketing but only a fifth on research and development. Worse still, most of this research is not innovative but centred on “me too” drugs that seek merely to increase companies' foothold in profitable established markets. But a “me too” strategy doesn't even cut costs through true competition, for there is an unwritten agreement in the industry that undercutting of prices merely erodes overall profitability.

Preventing access of drug company representatives to doctors would help stop drug companies putting marketing above innovation and force a change in the business culture. This might result in much blood on the carpets of corporate boardrooms, but a return to innovation offers the only hope of a cure to the industry's illness.

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Competing interests: DS is the UK spokesman of No Free Lunch.

Now and then

DRUG TALES AND
OTHER STORIES
Ike Iheanacho

He died in 1993. His book was published more than 40 years ago, has long been out of print, and isn't widely known. So, how could he still be saying anything relevant about a field as dynamic as drugs?

Brian Inglis's *Drugs, Doctors and Disease: A Survey of the Pharmaceutical Industry* appeared midway between the thalidomide scandal and the UK's Medicines Act 1968, which provided a crucial brake on drug company activities. It is worth reflecting on just how bad things had been. Facing little or no regulation, drug companies were running riot. Products were inadequately tested before launch, misleading promotion flourished unchecked, and cartels kept some drug prices obscenely high. And, importantly, no safety culture existed that ensured disclosure of unwanted effects of treatments.

Authorities in the United States had decided that enough was enough. A congressional inquiry chaired by Senator Estes Kefauver

prompted groundbreaking legislation to control approval, marketing, and promotion of medicines. Brian Inglis's book was in part a push for a similar investigation in the UK.

Like many of the best commentators on the drug industry he was neither a healthcare professional nor a scientist. And like many of the best writers on anything he was Irish. The academic's intellectual rigour and the skills of a natural communicator glow throughout *Drugs, Doctors, and Disease*. But being scholarly, lucid, and concise doesn't account for the book's enduring value.

It is the stunning quality of the author's insights that makes the text so brilliant, despite the huge changes in circumstances four decades on. A few examples? He emphasised the dangers of resistance to drugs, related to inappropriate advertising and misuse of antibacterial drugs. He debunked attempts to present promotion as the supply

of unbiased information, drew attention to inadequate training of medical students in pharmacology and therapeutics, poured scorn on doctors' self deception that they were (uniquely) immune to advertising, and cautioned against the too cosy relationships that develop between the industry and those meant to regulate it. None of these issues (and many others he raised) can be considered remotely out of date.

Also, he was not especially interested in knocking drug companies. Rightly, he found much to praise about the industry but was highly critical of the environment in which it was allowed to operate.

In short, he showed how society gets the industry it deserves—a truly timeless message. In the 1960s governments, regulators, doctors, and the public could plausibly plead ignorance to such a suggestion. What excuse do we have now?

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The God delusion

In his essay "Nature" (one of the *Three Essays on Religion* published posthumously in 1874), John Stuart Mill denies that one can decide on the morality or immorality of a course of action by describing it as natural or unnatural. Either the word "nature" means all that occurs in the universe; or it means all that happens in the universe with the exception of the deliberate actions of mankind. In neither sense can nature provide us with any moral guidance. This is obviously of interest to medical ethicists struggling with morality or otherwise of genetic engineering.

The following words appear in Mill's essay: "The consciousness that whatever man does to improve his condition is in so much a censure and a thwarting of the spontaneous order of Nature, has in all ages caused new and unprecedented attempts at improvement to be generally at first under a shade of religious suspicion . . ."

In my copy, a first edition, a previous owner (a Victorian, to judge by the handwriting) has written the word "Chloroform" (sic) in the margin opposite these words. And this, of course, brings me to Sir James Young Simpson's pamphlet, "Answer to the Religious Objections Advanced Against the Employment of Anaesthetic Agents in Midwifery and Surgery," which he wrote in December 1847, shortly after his discovery of chloroform anaesthesia.

Simpson, a man of fairly humble background—who, showing extraordinary academic promise at an early age, was selected by his father from among his siblings for an education—was a man of wide interests, including archaeology; he loved nothing so much as a good controversy. He was a formidable pamphleteer, commanding an excellent, vigorous style in the service of relentless logic.

BETWEEN
THE LINES

Theodore Dalrymple

If God had not wanted man to relieve the pain of childbirth, says Simpson, he would not have made chloroform available to him

He argues against those who said that to give chloroform to women in labour was impiously to try to reverse God's curse on women in Genesis, "in sorrow shalt thou bring forth children." If this part of the curse were taken literally to mean physical pain, he says, why not the other part of the curse, that "in the sweat of thy face shalt thou eat bread?" All attempts to mitigate labour, and improve the land by removing the "thorns and thistles" that it "shall bring forth to thee," would likewise be forbidden, says Simpson. Indeed, the whole of the medical profession would be sacrilegious on the same view, because it attempted to delay man's return to dust ("dust thou art, and to dust thou shalt return") that was part of the same curse.

If God had not wanted man to relieve the pain of childbirth, says Simpson, he would not have made chloroform available to him. Besides, those who argued against chloroform on religious grounds had long attempted, unsuccessfully, to relieve the pain of childbirth, and it cannot be forbidden to do successfully what it is forbidden to do unsuccessfully.

Simpson then goes on to demonstrate, by reference to Hebrew philology, that the common acceptance of the meaning of the Bible is based on a misapprehension of Hebrew words. Sorrow in the Biblical curse on women means labour, not pain. Finally, Simpson points out that the same argument from sacrilege was advanced against Jenner's vaccination, but everyone now acknowledges that it was a ridiculous argument. Altogether, Simpson's is a bravura performance. The only problem is that Simpson, being an avid self promoter, had made up the religious objections. He was destroying a straw man: but he did it thoroughly.

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSICS

12, 20 & 5: A Doctor's Year in Vietnam

By John Parrish First published 1972

Published four years after *M*A*S*H* (BMJ 2007;334:47) and six years before *The House of God* (BMJ 2007;334:99), this book shares some of their themes of comradeship and redemption among doctors under almost intolerable pressure.

While working as an internal medicine trainee John Parrish was given the choice of conscription into the infantry or volunteering as a doctor in the navy. His book gives a factual and blunt description of a year's service as a US navy physician in Vietnam, working with the US Marine Corps in field hospitals, under fire, and close to the front line. His sense of unreality at the perfunctory induction period is followed by immediate exposure to the brutal reality of war, as the hospital commanding officer takes him and his contemporaries on a tour of the hospital triage room immediately after severely wounded and dying casualties have arrived.

The contrast between his last civilian post among dying haematology patients and his new role treating military trauma patients is dramatic, and along with his colleagues he has to learn trauma management almost from scratch.

Despite their inexperience the doctors soon become experts at trauma resuscitation and give their best for their comrades, working through unimaginable psychological stress and physical exhaustion. The ethos of the hospital is to provide the best possible care to the injured, and all the departments work efficiently to this

Where to learn trauma management from scratch

to the numbers of stretcher cases, walking wounded, and dead that arrive with each helicopter.

Parrish's training in internal medicine means that he is assigned medical problems that range from snakebites to meningitis. He also helps the nuns who run the tuberculosis hospital in Hue, which is later attacked by the North Vietnamese army. After a while, even his most harrowing duty becomes routine: visiting "graves" each morning to write the death certificates for those killed.

Many aspects of this book will be familiar to doctors with military experience: the endless waiting for transport and for casualties to arrive, the dreadful food, the camaraderie, the macho culture and ribbing of colleagues, the boredom punctuated by intense activity.

Parrish conveys well the black humour and the professionalism of doctors caring for patients in difficult circumstances, as well as the toll that the situation takes on them. US military medicine has changed, and the doctors are now genuine volunteers, but the challenges of caring for injured soldiers remain the same.

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REVIEW OF THE WEEK

When Blair went to market

Blair's Damascene conversion to market forces was one of the many differences he had with Gordon Brown, a new television series has shown. Where does that leave the NHS under Blair's rival, asks **Tony Delamothe**

LEWIS WHYLD/REX FEATURES

Explicitly about the relationship between former prime minister Tony Blair and his chancellor, Gordon Brown, this programme provided an interesting insight into some of the key moments of the Blair government's relationship with the NHS. It also gave some hints as to what to expect from the Brown government.

First off was Blair bouncing Brown into providing five years of 5% annual increases in the NHS budget, which would bring UK spending up to the European average. Blair chose Sir David Frost's television programme for his momentous announcement one Sunday morning in January 2000. Minutes after the programme "Number 10 hit the phones." It being a Sunday, all the facts and figures were locked up in Whitehall offices. About the time the Department of Health's chief economist had made the figures add up (using the sophisticated calculator of his daughter's boyfriend) it dawned on Blair's advisers that Blair had not told his chancellor about the biggest spending announcement they would ever make.

Even this early in his government there was a hint that Blair had to resort to guerrilla tactics to achieve what he wanted in the face of Brown's implacability. Insiders commented: "Gordon Brown saw himself as the senior partner" . . . "For much of his time [Blair] couldn't get his way." Already by then Frank Field, Blair's new broom in pensions, had been dropped: "Gordon was adamant that nothing was going to happen." Whenever money was involved, the question of who was really boss was never properly resolved, and even led to an abortive plan to drop Brown early in the government's third term.

Bitter divisions surfaced between Blair and Brown over how to reform health and education. True to form, both men wanted to do it their own—different—way. Before the 1997 election, Blair had anathematised the use of markets to improve public services: "First of all we'll get rid of that Conservative internal market that has caused so much damage in the National Health Service.

The Blair Years: Blair and Brown (episode 1)

BBC 1, 18 November at 10 15 pm

Rating: ★★★★★

I can envisage what conviction based medicine would look like, and it's not a pretty sight

We've had enough of running it like a supermarket—it's not a supermarket, it's a public service."

But within a few years, Blair underwent a Damascene conversion, the reasons for which we'll presumably have to await publication of his diaries. He became convinced that hospitals and schools needed market incentives to improve: "A quasi-market situation, where you can contest the service or the consumers get greater choice, injects this greater sense of dynamism. Contestability, competition—it's basically breaking down the monolith of the old public services."

Brown's response to this distinctly non-Labour view was to emphasise the limits and failures of markets. "Our clear and robust defence of markets must be combined with a clear and robust recognition of their limits. In health, not only is the consumer not sovereign, but a free market in health care will not produce the most efficient price for its services, so that many market failures in health, if taken individually, challenge the adequacy of markets to provide efficient market solutions."

Blair and his then health secretary, Alan Milburn, were pushing for foundation hospitals, with freed up management and financial controls. Brown's response was a 50 page memorandum setting out his objections to their proposed financial regime. This time, presumably the option of announcing it as a *fait accompli* on Frost was out, and a compromise was thrashed out.

At the time when he might have handed the premiership to Brown, he decided he needed to stick around to carry his domestic reforms through. "There were certain things I wanted to get absolutely secure and bolted down before I left."

How insecure and unbolted down they were became apparent in the week the programme was broadcast. Not five months after Blair handed over to Brown, the government announced that one of its main routes to inject contestability and competition into the NHS has been cut by two thirds (see News p 1066). Can a politician really believe that something can be set so firmly in stone that a successor can't dynamite it at will?

Ultimately, "What you owe people is your conviction: you owe them the duty to do what you believe to be right." Not necessarily "be right," Blair was at pains to explain, just to do what you believe to be right. He said this in the programme in the context of his public service reforms but he's said it before regarding his decision to go to war in Iraq. It begs the question: are strong convictions enough for a politician? Do we elect them just to visit their convictions on us? I can envisage what conviction based medicine would look like, and it's not a pretty sight.

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