LETTERS

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INSTITUTIONAL RACISM

Lack of support for staff to combat racism

I am currently managing an incident where a nurse in a nursing home requested, on behalf of a resident, a white doctor to attend the resident out of hours.[1] All our telephone contacts are recorded. It was chilling to listen to an Asian nurse identify herself during the conversation as unsuitable to enter the resident's room to do a finger prick blood glucose test. Our doctor, who is also South Asian (although this not discernible from the telephone conversations), advised her that she would have to ask a white nurse.

The most nefarious aspect of this is how the nurse was co-opted into being complicit in furthering this resident's discriminatory agenda. Even more worrying was her lack of empowerment and support from the care home's management to resist becoming complicit. I can only imagine what this newcomer to the country, who was providing an essential service in a needed area, thinks of the indigenous population and the lack of structures in place to protect her from racism.

I agree with Ahmad that this is how genocide starts and why he considered this incident in relation to developing attitudes in German society at the beginning of the Nazi era.[2] I have plotted a course of action to deal with this, but would be interested in any suggestions.

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Competing interests: I am Jewish.

1 Moghal N. Allowing patients to choose the ethnicity of attending doctors is institutional racism. *BMJ* 2014;348:g265. (4 February.)
2 Ahmad N. [Electronic response to Moghal N. Allowing patients to choose the ethnicity of attending doctors is institutional racism.] *BMJ* 2014. www.bmj.com/content/348/bmj.g265/rr/685549.

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A case for "reasonable discrimination"

A respondent to Moghal's article asks whether allowing patients to choose the ethnicity of their doctor would allow greater acts of discrimination to occur—for example, on the grounds of sexuality or religious beliefs—which she describes as "absurd scenarios."[1 2] I do not consider such requests absurd. I give all the help that I can to a patient needing a cervical smear who asks to see my female partner (gender), or a lesbian requesting such intimate examination (sexuality). I would consider it reasonable for patients to choose to consult one of my Welsh speaking partners if they preferred a consultation in their first language (culture). Imagine a woman who has just been raped by a man attending the emergency department and requesting a female doctor, or a woman who has been raped by a black man requesting to see a white woman. What about a Jewish holocaust survivor asking not to see the German doctor? How should you respond? I think "reasonableness" is a fair test.

Diversity and equality are both desirable, and remain distinct goods, as Aristotle first noted. I think that the term "discrimination" should always be qualified by "unfair or unreasonable discrimination" before we react. And, yes, I too would like it to become a "never" event. We are slowly getting there.

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Competing interests: None declared.

1 Moghal N. Allowing patients to choose the ethnicity of attending doctors is institutional racism. *BMJ* 2014;348:g265 (4 February.)
2 Khan S. [Electronic response to Moghal N. Allowing patients to choose the ethnicity of attending doctors is institutional racism.] *BMJ* 2014. www.bmj.com/content/348/bmj.g265/rr/685730.

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UNDER THE INFLUENCE

Lessons from Scotland's experience of alcohol pricing

For those looking to learn from the Scottish experience of the implementation of alcohol minimum unit pricing, there are relevant issues other than those covered by Gornall.[1]

After Scotland's first alcohol action plan in 2002, the monitoring work of the Information Services Division of NHS Scotland was crucial in making the case that action was needed. The Monitoring and Evaluating Scotland's Alcohol Strategy team's more recent publications continue this work.[2]

The alcohol industry has not acted as a single entity. From the 1980s, trends towards higher levels of drinking at home, driven by cheap supermarket products, were evident to practitioners. This move away from the potentially moderating pub environment was also of concern to others. The independent pub trade in Scotland, led by the Scottish Licensed Trade Association and supported by Tennent Caledonian and Brewdog, were early supporters of minimum unit pricing. Brewdog showed where the interests of health advocates and craft brewers coincided, saying of minimum pricing plans, "The proposals will mean that the multi-national corporate hammerheads no longer be allowed to discount their liquid cardboard to embarrassingly pathetic levels… Craft brewers can't, and shouldn't, discount their beers and sustain losses."[3]

The Scottish Nationalist Party is well informed and ambitious on alcohol policy. The international recognition it has had is well deserved. However, the Scottish Greens have long supported minimum unit pricing, the Liberal Democrats have supported it since 2011, and the Scottish Conservatives since March 2012. Labour abstained in the May 2012 vote, and minimum price legislation was passed without opposition.

So the Scotch Whisky Association (membership includes vodka manufacturers—vodka now outsells whisky by 40% in Scotland[4]) is opposing many other parts of the alcohol industry as well as parliament. Minimum pricing has passed the scientific, political, and legal tests so far. The Scotch Whisky Association should match the responsible stance of other industry groups, accept defeat in the courts, and let the Scottish government get on with implementation and evaluation.

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Competing interests: None declared.

Full response at: www.bmj.com/content/348/bmj.g1274/rr/685695.

1 Gornall J. Under the influence: Scotland's battle over alcohol pricing. *BMJ* 2014;348:g1274. (6 February.)
2 NHS Health Scotland. Monitoring and Evaluating Scotland's Alcohol Strategy. 2013. www.healthscotland.com/scotlands-health/evaluation/planning/MESAS.aspx.
3 BrewDog. BrewDog backs minimum pricing. 2012. www.brewdog.com/blog-article/brewdog-backs-minimum-pricing.
4 NHS Health Scotland. Retail sales estimates in Scotland, by price band, 2009-2012. www.healthscotland.com/uploads/documents/21782-Off-trade%20price%20band%20distribution%20data_2009-2012_August%202013.xls.

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ETHICS OF TREATING VEGETARIANS

Support for vegetarians in decisions about animal products

As doctors in anaesthesia and critical care, honouring a patient's stance to abstain from animal products can be problematic.[1] Some people may refuse life saving interventions. Patients need to make their wishes known in advance and in writing with regard to products such as blood, gelofusin, hyaluronidase used in ophthalmic anaesthesia, aprotinin, some surgical glues, and the bovine patch used in cardiac surgery. In addition, novel treatment of *Clostridium difficile* with faecal transplantation is proving to be effective but might be unacceptable to some.

Vegetarians may need similar support in communicating their decisions to that received by Jehovah's Witnesses.

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Competing interests: None declared.

1 Tatham KC, Patel KP. Suitability of common drugs for patients who avoid animal products. *BMJ* 2014;348:g401 (4 February.)

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Advice on drugs for patients with strict dietary beliefs

Tatham and Patel have highlighted an important problem that healthcare professionals can face when caring for and treating patients of different ethnic backgrounds with strict dietary beliefs.[1]

It is worth noting that UK Medicines Information has produced a document for doctors, pharmacists, and other healthcare professionals in the NHS to help them when confronted with this clinical dilemma.[2] The document is freely available through NHS Evidence and may help to facilitate the production of local guidance across primary and secondary care settings.

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Competing interests: None declared

1 Tatham KC, Patel KP. Suitability of common drugs for patients who avoid animal products. *BMJ* 2014;348:g401 (4 February.)
2 UK Medicines Information. How can I find out if medicines may be considered "Kosher" or "Halal"? Q&A No 381.1. www.ukmi.nhs.uk/activities/medicinesQAs/default.asp.

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DOCTORS' COMPETING INTERESTS

A registry should include all payments by private hospitals

We welcome the suggestion that the General Medical Council should set up a register of doctors' interests.[1] We also think that all doctors should make an annual disclosure of such interests or a positive declaration that they have none.

The Competition Commission has recently highlighted widespread incentives that private hospitals and clinics offer to doctors.[2] These incentives take many forms, including cash payments, free or discounted accommodation, and more complex arrangements, such as equity in clinics or hospitals sometimes funded by loans from that institution. The commission currently proposes to prohibit most of these arrangements, although some equity arrangements may still be allowed. We welcome this decision because we believe that such payments are aimed at influencing doctors' decision making.

We believe it is essential that any register should go beyond payments by drug companies and include all payments to doctors by device manufacturers and private hospitals, clinics, and laboratories (other than salaries paid to doctors who are employees of those facilities).

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Competing interests: Both authors have submitted evidence to the Competition Commission about such payments on behalf of Axa PPP Healthcare.

1 McCartney M, Goldacre B, Chalmers I, Reynolds C, Mendel J, Smith S, et al. Why the GMC should set up a central registry of doctors' competing interests. *BMJ* 2014;348:g236. (15 January.)
2 Competition Commission. Private healthcare market investigation. 2012. www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/provisional_findings_.pdf.

Cite this as: *BMJ* 2014;348:g1708

The need to eliminate commercial conflicts of interest from medicine

Concern over whether the Association of the British Pharmaceutical Industry is truly committed to creating a registry that discloses doctors' financial relations with industry echoes US discussions on commercial conflicts of interest (COIs) before the Sunshine Act became law.[1] The parallels are striking, including a fixation on the wrong problem.

For years Jerome Kassirer, former chief editor of the *New England Journal of Medicine*, has argued that a preoccupation with disclosure of commercial COIs sidetracks the public interest.[2] It does this by concealing the real problem—the corrupting influence of commercial conflicts. Kassirer's concern was that the stress on transparency was taking us down the wrong governance path by excluding the need to eliminate commercial conflicts, especially for oversight bodies that assess the integrity of data.

Kassirer's view is shared by analysts who investigated disclosure of commercial COIs on Wall Street.[3] Disclosure failed to prevent Wall Street scandals and kept the commercial conflicts and biases in place. It helped to preserve the status quo. A recent study suggests that a similar pattern can be found in psychiatric medicine, and that we need to go beyond transparency of commercial COIs to effectively tackle bias.[4] Little wonder that the drug industry enthusiastically endorsed the Sunshine Act with its stress on disclosure.[5]

We need to refocus and rejuvenate our efforts to eliminate commercial COIs from medicine, despite the formidable obstacle. The current focus on disclosure alone to tackle this problem in the UK may work against the public interest, despite good intentions.

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Competing interests: None declared.

1 Goldacre B. Problems with ABPI proposals to release data on payments to doctors. *BMJ* 2014;348:g1301. (5 February.)
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3 Wilson M. The Sunshine Act: commercial conflicts of interest and the limits of transparency. *Open Med* 2014. www.openmedicine.ca/article/view/628/534.
4 Cosgrove L, Krimsky S, Wheeler EE, Kaitz J, Greenspan SB, DiPentima NL. Tripartite conflicts of interest and high stakes patent extensions in the DSM-5. *Psychother Psychosom* 2014;83:106-13.
5 Carl E. Whose afraid of sunshine laws. *Chronicle of Higher Education* 2014. http://chronicle.com/blogs/brainstorm/whos-afraid-of-sunshine-laws/48641.

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