reviews

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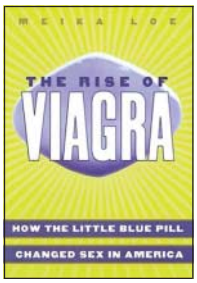
The Rise of Viagra: How the Little Blue Pill Changed Sex in America

Meika Loe



New York University Press, $27.95, pp 288
http://www.nyupress.org
ISBN 0 8147 5200 4

Rating: ★★★

Is there any aspect of human life more connected to one's sense of self than sex? If we change the way we think about sex, surely we are changing the way we think about ourselves? If we change sex, we change ourselves. This is the simple, frightening argument at the heart of Meika Loe's sociological analysis of sildenafil (Viagra)—frightening not because some dark commercial conspiracy is revealed, but rather, because it seems that some profound and perhaps unwelcome changes may be taking place in our culture and in our bedrooms, imperceptibly.

A self described activist scholar and assistant professor of sociology and women's studies at Colgate University, New York state, Loe has a strong academic interest in men and sex. She even spent some time as a waitress at a restaurant chain called Bazooms in the 1990s, where the women "wear short shorts and tight tank tops," on a kind of undercover research mission. Relating a short account of her experiences at Bazooms, she contrasts the restaurant's tawdry reality with its prefabricated fantasy, setting the stage for her critique of the costs and benefits of the Viagra nation, a modern America where "our sexual status quo has shifted dramatically."

The chief focus here is not the blue pill itself, but the marketing of both the pills and the new disorder of erectile dysfunction or "ED" that helped create the market for those blue pills. Loe is part of a wider global group of researchers taking an active interest in the corporate sponsored medicalisation of ordinary life, in this case arguing that the promotion of erectile dysfunction is another example of "blurring disease and discontent."

Items reviewed are rated on a 4 star scale (4=excellent)

Attending company sponsored scientific conferences, academic seminars, and educational meetings featuring industry funded researchers who are "raising awareness" about sexual dysfunction, Loe has gathered and now published a wealth of extremely valuable evidence. Rather than science, she concludes it was a potent cocktail of the profit motive, seductive rhetoric, and exaggerated statistics that helped build the disease that became the mass market for Pfizer's Viagra. "This was largely a result of the work of a handful of Pfizer investigators and consultants, who claimed, adapted, and expanded the medical category 'ED,'" she says, pulling no punches. "These spokespeople, with the help of journalists, constructed a sexually dysfunctional populace—a market primed and ready for Viagra."

The power of *The Rise of Viagra* lies in its clear observations of this fresh new process of disease creation, which is transforming normal sexual difficulties into the symptoms of treatable illness. There are many revealing and engaging interview quotes from some of the key players in the ongoing conflict around the medicalisation of sexual problems, from both the proponents and the critics.

The book's weakness, for me, is that the interviews with men and women using Viagra, experiencing it first hand, are not well enough integrated with the wider arguments and analysis. While the sociologist Loe clearly has a deep and warm respect for the subjects of her research, many of whom are candid about personal sexual experiences with the drug, and some of whom have had very positive experiences with it, she doesn't succeed in drawing these characters or their testimony into the major drama of the book. Sometimes they feel a little bit too much like extras in the cast.

Medication and medicalisation carry risks and benefits. Without doubt there are men and women everywhere whose lives and selves have been improved for the better by the enhanced sexual life a drug like sildenafil can sometimes help deliver. But on the other side of the ledger are the costs and side effects of both the drug and the new disease. How many sexual lives have been harmed around the world, as Pfizer and its competitors have pumped millions into saturation advertising campaigns, dressed up as "awareness raising" about sexual dysfunction, promoting the idea that almost half of all men have some problem that may require a pill to fix it? We don't really know the answer to that question, because scientific inquiry into the processes of disease mongering is at such an early change. Large, rigorous, and multinational research projects that attempt to understand and document the impacts of disease marketing on individual thinking and behaviour would be extremely timely. Some observers, included Loe, are convinced there is a real danger when healthy people are bombarded with advertisements telling them they are sick: "worrying about ED may in fact cause ED," she says. It is time for the research community to see if she is right.

THE IMAGE WORKS/TOPFOTO

Loe examines how Pfizer created a market for its blue pills

Some of the more interesting and provocative insights come when Loe has her feminist hat on, suggesting that the marketing of Viagra, with its obsessive and narrow focus on the hard penis, is helping men reclaim dominance, and (re)"erect the patriarchy." She is clearly right when she observes that "a hard penis is not always the best solution to relationship or self-esteem problems," but her wider arguments linking the rise of Viagra to a reassertion of patriarchy require more fleshing out.

Part of the problem with any discussion about Viagra is the confusion around whether it is a pill for healing a medical problem or an aid to sexual enhancement. The difficulty in trying to find the line between ordinary life and treatable illness is that marketing departments are spending hundreds of millions of dollars and pounds every year deliberately trying to blur them.

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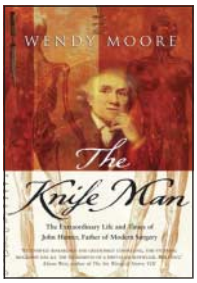
The Knife Man: The Extraordinary Life and Times of John Hunter, Father of Modern Surgery

Wendy Moore



Bantam Press, £18.99, pp 482
ISBN 0593 052099

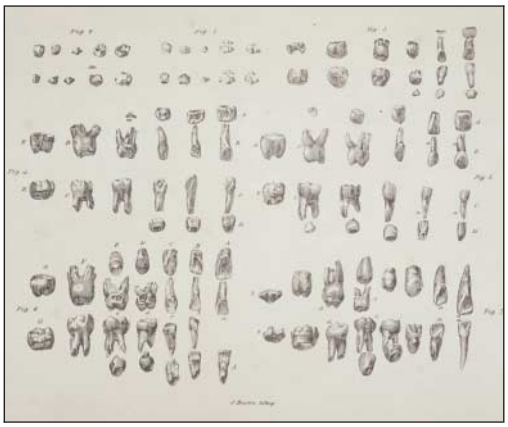
Rating: ★★★

John Hunter (1728-93), surgeon of St George's Hospital, was a brilliant observer, naturalist, and thinker, as well as being an innovative doctor. His philosophy of surgery and his teachings were based on his close observation of his patients, both in life and after death, and on a truly amazing study of the whole field of biology, from the artificial fertilisation of moths' eggs to dissection of the whale. He proudly claimed to pay little attention to the writings of his contemporaries or his predecessors. Although he cannot be said to have made a particular major advance in surgery, his fresh approach to the subject entitles him to be regarded as the father of scientific surgery in the United Kingdom.

Hunter's life is a biographer's dream. Born a farmer's son in a village outside Glasgow, he was slow in learning to read and write, disliked school, and preferred to wander through the countryside observing nature. At the age of 20, having failed to find any vocation, he joined his brother William, 10 years his senior, who had already established himself in London as a teacher of anatomy and a highly successful obstetrician—he was to deliver the children of Queen Charlotte, wife of George III. Here John proved to be a brilliant dissector and investigator. He studied surgery under Cheselden and Pott, became a student and then house surgeon at St George's, had three years' experience of war surgery on active service during the Seven Years War, and, in 1768, was appointed to the staff of St George's.

The range of his interests is staggering. He studied transplantation of tissues in animals and transplanted teeth in man—indeed, he wrote the first major monograph on the teeth. He carried out artificial insemination, elucidated the exact nature of the placental circulation by careful injection studies (including that of a woman and her child who died at term), pioneered controlled clinical trials by showing that pills made of bread were as "effective" as the conventional remedies of his day in the treatment of gonorrhoea, studied collateral circulation after vascular ligation, and described the operation of ligation of the femoral artery in the subsartorial (Hunter's) canal for popliteal aneurysm. He made important discoveries in the growth of bone, the descent of the testis (he described and named the gubernaculum), and wrote an extensive monograph on gunshot wounds. He was the first to describe the haematogenous spread of cancer, and his specimen of a sarcoma of the femur with secondaries in the thorax can be seen to this day in the Hunterian Museum at the Royal College of Surgeons of England.

But over and above these studies, he founded a school of scientific surgery, including among his disciples Henry Cline, John Abernethy, and, perhaps above them all, Astley Cooper. Edward Jenner was a pupil and became a lifelong friend. It was to Jenner that Hunter wrote the advice "But why think? Why not try the experiment?" which perhaps sums up his philosophy.



WELLCOME INSTITUTE

Hunter's many achievements included the first major monograph on teeth

Hunter's lectures were like no others at the time. Not for him lists of anatomical facts or standard descriptions of surgical operations. His teaching ranged over the whole range of the "animal oeconomy." He discussed the differences between living and inanimate matter, the physiology of the organs of the body and how this was disturbed by disease. His lectures were difficult to follow—many students dropped out—but part of the problem was that Hunter had to search for a new vocabulary to discuss these new and controversial topics. We need to remember that he was struggling to explain these phenomena in the days before effective microscopes, before the bacterial causes of wound infections and "fevers" had been discovered, and a century before Darwinism.

It is no wonder that this remarkable man should have had more books and articles written about him than any other British surgeon apart from Joseph Lister (with whom he shares the distinction of having the only public statues erected in their memories in the United Kingdom). Indeed, the first biography of Hunter, admittedly a scurrilous attack upon him, was written by Jesse Foote the year after Hunter's death.

Wendy Moore, a writer and journalist, is to be congratulated on this latest account of the life and times of John Hunter. As a good journalist, she makes excellent use of her material. She describes with gusto the unpleasant sights and smells of the 18th century dissecting rooms, with their putrefying body parts; the midnight forays of the "resurrection men" as they expertly reopened fresh graves and hauled out the corpses by means of a rope around the neck. She describes the agonies of surgery in those pre-anaesthetic days and the crude attempts to cure unpleasant diseases whose causes were still being explained by humoral theories dating back to the times of Galen. She has done her homework well; she has chosen her illustrations with care and her extensive research is demonstrated by her reference list and her 60 pages of notes on the text. She has produced an easy to read account of the life of this remarkable man which, although presumably designed with a lay audience in mind, will be read with pleasure by the professionals.

Here and there we can debate some of her conclusions. Hunter was interested in whether gonorrhoea and syphilis were two separate diseases or, as was commonly believed, were the early and later manifestations of the same infection. He investigated this in 1767 by inoculating "venereal matter from a gonorrhoea" into two puncture wounds on the glans and on the prepuce. The subject developed, firstly, the typical gleet of gonorrhoea, then went on to produce a chancre and then the manifestations of secondary syphilis. Of course, we now surmise that the donor must have had both conditions. These experiments are fully described in Hunter's monograph *Treatise on Venereal Disease.*

In 1925 Sir D'Arcy Power, in his Hunterian oration entitled "John Hunter, a Martyr to Science," alleged that the subject of Hunter's experiment was Hunter himself and that he subsequently died from syphilitic disease of the arterial system. Wendy Moore, like many others, goes along with this hypothesis. However, the late George Qvist, in his biography of Hunter published in 1981, argues, I believe quite convincingly, that Power's opinion was "completely erroneous and irresponsible." Hunter certainly used himself on many occasions as an experimental model, and his writings abound with the use of the personal pronoun in these studies. However, his venereal inoculation experiments are described in an impersonal manner and, moreover, there are other references in his works to deliberate inoculation of patients with venereal matter. Furthermore, the detailed account of the autopsy performed on Hunter by his brother in law, Everard Home, describes the classical appearances of arteriosclerotic disease with calcification of the coronary arteries and with no evidence of the late manifestations of syphilis.

Harold Ellis *clinical anatomist, King's College London/Guy's campus*

FM AM

Why Did We Do That?

BBC Radio 4, 14 February, 8 to 8 30 pm

Rating: ★★★

Public awareness of antibiotic resistance is perhaps higher than any other aspect of health, possibly with the exception of cancer. The tabloid newspapers lambast dirty hospitals infested with resistant "killer bugs." History, however, is often forgotten. Stepping back a generation, doctors were familiar with hospital wards full of patients succumbing to sepsis in the pre-penicillin era. Indeed, a finger run down the roll of honour of any first world war regiment often testifies to as many who "died from wounds" as were killed in action.

Chris Bowlby, the presenter of this programme, sought to trace the background of the overuse of antibiotics in a climate where a spokeswoman for the World Health Organization estimated, apocalyptically, that half of the antibiotics prescribed were unnecessary.

The story had three main players: the medical profession, the pharmaceutical industry, and the patient. All three had good intentions. However, all three were overzealous. A fourth, the postwar zeitgeist, also played a part. The discovery of penicillin corresponded with a national sense of euphoria. The "mould juice" became the universal panacea. It was even incorporated into toothpaste and lipstick.

The story was not, though, as Bowlby correctly identifies, about heroes and villains. It is entirely understandable that a drug (penicillin) that could save the life of a 15 year old boy from life threatening periorbital cellulitis would transform the prescribing habits of postwar doctors.

Where did it all go wrong? Sir Alexander Fleming, who discovered penicillin, warned of the risks of antibiotic resistance in his acceptance speech for the Nobel prize. A postwar GP identified a generation of patients seeking medication for minor complaints and a medical profession keeping them happy with a bottle of medicine. This was compounded by a low level of surveillance for antibiotic resistance in the United Kingdom and strong marketing by the pharmaceutical industry.

Political interventions and more prestigious research areas seem to have contributed to a prolonged downturn in antimicrobial research after the second world war. A US surgeon general claimed that infection was yesterday's problem. Research into new antibiotics withered as the research community supported by the pharmaceutical industry moved away from antibiotics with limited duration of usage to drugs such as cimetidine and ibuprofen with potential for more lucrative, lengthy, or lifetime use.

The international medical community has responded differently in establishing its thresholds for prescribing antibiotics. One man's respiratory infection appears to be another man's common cold or influenza. Recent evidence suggests that Dutch family practitioners fall into the former camp and Flemish ones into the latter. If I had one criticism of the programme, it would be that it underplayed the complexity of factors explaining the difference in use of antibiotics (incidence of community acquired infections, culture, and education).

If penicillin were discovered tomorrow, I suspect that we might all behave as our forebears did.

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TV

Inside Saatchi & Saatchi

BBC 2, 15 February, 9 50 to 10 30 pm

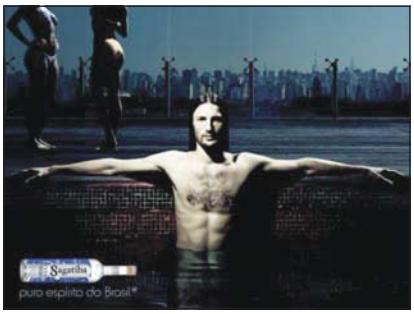
Rating: ★★★

How do you get people to become drinkers of a new alcoholic beverage? Given the current popular image of young Britons as alcohol fuelled party animals, you might wonder if they need much encouragement. But the manufacturers of the Brazilian drink Sagatiba want their new tipple to have a chic global presence, a must-imbibe for all the bright young things of the coolest bars in London, Amsterdam, Rome, and Paris. And they have £20m to spend on their European campaign to persuade more and more people to drink more and more of the stuff.

Sagatiba the company wants Sagatiba the spirit (38% proof) to become as big as Bacardi. At present the drink—an "upmarket" type of cachaça, which is a beverage distilled from sugar cane and normally drunk on street corners in Brazil—is almost unheard of outside its country of origin. Brazil exports only 1% of its cachaça while Russia exports 50% of its vodka. Enter advertising agency Saatchi & Saatchi. Surely the name that sold Margaret Thatcher's Conservative government to UK voters can sell anything? Surely Saatchi & Saatchi (the front steps of whose London headquarters bear the motto "Nothing is impossible") can get the world drinking Sagatiba?

The Brazilians believe that the Sagatiba campaign should emphasise the "purity" of their product and that it should bring Brazil to London (this is "a drink for hot, hot people"), but they are keen to avoid the clichés—so "no fruit on the head" or "happy Latin people dancing away." Saatchi & Saatchi's first effort—built around the slogan "Pure, so you don't have to be"—fails to impress the clients. "We want great, not good," they say.

In the end, the Saatchi & Saatchi creative team find a model who looks like Brazil's most famous icon, the statue of Christ the Redeemer in Rio de Janeiro), and decide to put him in scenes "that capture the real spirit of Brazil," photographing him, his arms outstretched, in a bar, a swimming pool, and a nightclub, and on the back seat of a taxi. "Pure spirit of Brazil," says the slogan. Pure genius, say the Brazilians.



Coming soon to a smart bar near you

Not all goes exactly to plan, however. The exorbitantly expensive Hollywood photographer, engaged to make the model exude the requisite degree of heroism, never makes it to the shoot in São Paulo because of a visa hitch. But after tense scenes involving executives in helicopters, mobile phones attached permanently to the sides of their head, the project goes ahead with a replacement photographer. The advertisements are now set to appear in glossy style magazines across the globe.

This wasn't the kind of programme to examine the morality of adding another strong alcoholic drink to the bar menus of the world (as one of the team said, "the whole point is to get people into a bar to drink Sagatiba"). But it offered a fascinating insight into how much time, money, energy, and a kind of creepy corporate enthusiasm (these are people whose conversation is peppered with phrases such as "brand values," "brand ownership," and even "brand beauty") goes into making people want something that they do not need. It showed exactly what public health professionals are up against.

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PERSONAL VIEW

Hot buttons and quality

I am a retired general surgeon. I was rung by my daughter one Saturday evening and faced with a problem. "My neighbour's wife is in hospital in this city, and he is very concerned about her management," she said. "She had an operation recently on her bladder—one to enlarge her bladder using bowel—and this was successful. And then she had a stroke and had to be transferred to a stroke unit (unfortunately on a bank holiday). Her husband was told that she would need regular bladder washouts and that these would be done on the new unit."

She continued: "While she was making a good recovery from her stroke, he was concerned that she appeared to be lying in a wet bed and asked the nurses about this. He was told that either the catheter was blocked and urine was leaking round it or she was getting incontinent. He asked why the bladder washouts were not being done. And at this point confusion set in. One nurse averred that she couldn't have bladder washouts as there was no catheter in, while another nurse realised that there was a catheter in situ and did a bladder washout. The patient became confused and couldn't drink, so an intravenous drip was set up. There was temporary improvement. Now she is deteriorating, and he is afraid she might die."

No further washouts were done, and her condition deteriorated. My daughter had rung the ward concerned but got a very tart response as she was not a relative, even though she had been authorised by the husband to take this step. She was told that no catheter was in place. What could I do? The surgeon concerned could not be telephoned, because he was not in my ancient copy of the *Medical Directory*. The hospital was at least 90 miles away from me. The patient was afraid of voicing her concerns as she was frightened that the ward's staff would "take it out" on her. Her husband clearly did not understand many of the details of what was going on. (He thought the carotid arteries were "glands.")

I could not make any headway (it was a weekend), and it was clear that someone with the ability to intervene was necessary. So it was that I arranged to drive there in the hope that I could speak to somebody on the Monday morning.

We welcome submissions for the personal view section. These should be no more than 850 words and should be sent electronically via our website. For information on how to submit a personal view online, see http://bmj.com/cgi/content/full/325/7360/DC1/1

On Monday morning, when I visited the hospital with the husband, it became clear that the "stroke team" would not be available for interview during the short time I had available there, and the ward sister was unwilling to discuss the matter with me as I was not a relative. However, I was allowed to listen to the conversation held between her and the husband. "No, she cannot have a bladder washout as there is no catheter in situ. And anyway a bladder washout has the danger of ascending infection," she said. The husband told the ward sister that a catheter was indeed in situ, with a bag attached, but this made no difference. (How they managed her fluid balance chart without knowing that there was a catheter remains a mystery.) The surgeon was away in a distant hospital, and I received no answer when I telephoned the stroke team's office, although I was able to leave a message on the phone. Impasse.

I finally got through to the surgeon in his distant hospital, and at once the whole matter was amicably and helpfully settled. Within a short time a specialist was doing a bladder washout, inserting a stopcock between catheter and bag so that the bladder could learn to fill and empty, and putting up a drip. The patient recovered and remains well and grateful.

> It was clear that someone with the ability to intervene was necessary

How can such problems be avoided in large hospitals staffed by super-specialists, none very cognisant of the workings in the others' departments? Surely it should not be necessary for worrying relatives to call in someone from 90 miles away when such problems arise?

Hospital doctors could apply certain principles:

- When patients or their relatives voice concerns, be interested and share their concerns. Don't try to cover up with spurious explanations—you are likely to get caught out before long.
- When transferring a patient over a holiday period take extra care that the treatment regime is fully understood by the team taking over and that continuity of care is maintained.
- Always be polite. Remember that you are their servant, not they yours.
- Never allow class or other social differences to interfere with your relationship with your patients and their relatives.

Unable to sleep in the small hours after the trip home, I watched a television programme about quality in the catering industry. "Hot buttons" were being recommended. Apparently the idea is to make quality improvement fun. Any idea to improve quality is called a hot button and encouraged. Perhaps we need hot buttons in medicine.

SOUNDINGS

Climate of fear

When it was part of the former Soviet Union, Moldova was called Moldavia. Now it prefers the Romanian version of its name. Most people have heard of it but, uniquely among European nations, nobody knows where it is. Go straight on past Transylvania and you can't miss it.

Of course I went by plane. Checking in for Chisinau, the capital, I saw my bag disappearing down the conveyer, apparently labelled for Kiev. There followed one of those embarrassing airport moments until I learned that KIV stands for Kisinev, the Russian name for the city. (Kiev's code is IEV.) Oh. Sorry.

The demise of the Soviet Union left Moldova with Soviet architecture, a fine opera company, and no money. And a medical system steeped in doublethink. On the one hand doctors are subject to meticulous centralised control. On the other hand their state salary is around £32 ($60; €46) a month, making a parallel economy inevitable.

We were there to advise local specialists about perinatal audit and confidential inquiries. In the United Kingdom, we told them, we depend on full and honest reports from doctors and midwives. In Moldova, they replied, things are different. People are punished. If a pregnant woman dies the Ministry reacts quickly, sending officials to identify the guilty employee, who is then fired. A climate of fear does not encourage constructive reflection, they said, any more than it fosters a culture of accurate and contemporaneous note keeping.

But, we reminded them cheerfully, you're free now. You're just like us. You can share problems with your managers and politicians and work together to make things better for patients. Our Moldovan colleagues looked unconvinced as we insisted this is how we do things in the United Kingdom.

I was unconvinced too. Does the British working doctor trust the medical politicians any more—let alone the party politicians? In which of the two countries do doctors have to prove to their employers that they are not mass murderers? Which nation, I wonder, has the scarier healthcare commission?

The temperature in Chisinau in January was below freezing but the Moldovans were used to it. They produce splendid wine and brandy and when work is over, in private people laugh. They don't long for early retirement. They know how to cope with the climate. We could learn a lot from them.

James Owen Drife *professor of obstetrics and gynaecology, Leeds*