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**Sir Douglas Black in interview with Sir Gordon Wolstenholme
Oxford, 13 May 1987**

GW Douglas, I've had the pleasure of talking to you on audiotape at the College [Royal College of Physicians] and on that occasion we did quite a bit about your family background and your medical life and so on, so I'm going to take it that's available at the College and we don't repeat it today. Inevitably, there will be some overlap, of course, but I would like you if you will to discuss some major aspects of medicine, and perhaps we could start with something fairly simple like the NHS. What I thought we might first discuss are some of the sort of more governmental or national aspects of medicine, and I think we could say that both of us greatly welcomed the National Health Service when it was established and I think both of us would feel still that it was a most desirable thing, but nevertheless there have been great disappointments in the way that it has developed or failed to develop. I wonder if you like to comment, to start with, on your own feelings about disappointment or where you think it has gone wrong or what might have been done better. Is that too big a question to start with?

DB No, I don't think so at all as it forms the central question of the whole thing and I totally corroborate what you said that I'm a tremendously warm advocate of the National Health Service. I welcomed it when it first came in and, of course, I worked within it through the university sector as it happened for many years and I was very happy doing so. I think I'd go very much along with [Francis] Avery Jones' analysis, which was that, you know, until the early Seventies it really was doing splendidly. There were more resources perhaps and there was a tremendous morale. Now, nothing ever happens as a result of a single cause, but I think there has been a certain lack of morale and that's tremendously important in the people who work within the NHS and there are, I think, a variety of causes. There have been the sundry reorganisations. I mean, it really isn't good for plants to be pulled up by the roots every few years and inspected and then put back perhaps upside down. I mean, there have been, you know, three exercises of that kind and that branch of the profession, the community physicians, from whom so much was hoped, they have been put into repeated uncertainties. This is not a partisan thing, successive governments have, you know, done this to them. I think the first real reorganisation was Keith Joseph¹ before he turned his attention to education with equally good results, and I think that's been one factor. Then another factor has been, I think, considerable encouragement to the private sector. Now, I have nothing inherently against the private sector – I sent my own boy away to Winchester – but I think that it should be something that is there at the margin as a standard setter to some extent, though I must admit it set standards both up and down. I mean, you can get some of the worst treatment in a private hospital as well as some of the best and I think that's been another factor. Various fiscal measures have encouraged private practice and, of course, interestingly and paradoxically, one of the new supporters of private practice are the trade unions, particularly the electricians, so that again is an interesting slant. I think, Gordon, that's probably enough to be

¹ Sir Keith Joseph, Secretary of State for Social Services, Department of Health and Social Security, 1970-74.

starting with, there are other things, aren't there?

GW Well, I'm interested that you've picked first on the morale question because I think that for the first twenty years at least of the health service, the very idea of an NHS was a source of pride to the country. Even if we recognised it had faults and flaws in its working, nevertheless we were terribly proud of it, perhaps almost too proud of it, but the... in time it seemed to me that people didn't know to what they were being loyal. In the old days you did know in a big teaching hospital at least that there was somewhere up at the top, a governing body or perhaps some distinguished person, who personally represented the ultimate in that particular set-up, and then it became a lot of unknown and faceless individuals who were somewhere up above manipulating things. And it's very hard, isn't it, to be loyal to something you don't understand or don't know?

DB Yes. I think it's still absolutely all right at the coalface. I think, you know, the failure of morale starts when people begin politicising about it. I mean, I'm, you know, distressed in a rather controlled way – because I control my distress whenever possible – at the way in which various things have become political footballs whereas they should really be common national objectives. I've had a certain amount of interest from time to time in inequalities in health and it really is a source of regret to me that that's become a polarised football – to mix the metaphors absolutely thoroughly – whereas it should really be something that concerns us all, but not, let me hasten to say, to the exclusion of all else. I mean, it's not, you know, the biggest health problem but it is an important one, this unequal division of resources and so on, both between regions and between classes.

GW Yes, I'd like you to develop that a bit more in a moment, but before you do, do you think that at any time it would have been possible to get this at least one removed from political party manoeuvrings, because it is after all a vast expenditure for the country? Is there any way in which it could have been governed, shall we say, by an independent body like the UGC [University Grants Committee] in the old days?

DB People often raise this question. They make various analogies like the UGC, like the BBC. I think it's a lost cause. In fact, it's a non-existent cause because I think exactly as you said, Gordon, the finance is just so massive that no government whatever it's political complexion is going to let that amount of public money escape its control. I think it would be helpful to the Service if they devolved a little bit more than they do, but in a way it's, again, they have... I should go back to the... I think it was Keith Joseph's time and they did take quite a significant step in devolving responsibility to regional health authorities rather than keeping it all central. They achieved this objective in an interesting way politically because what they did was they said 'We'll study this matter and we'll take advice.' And the advice they took was from chairmen of regional hospital authorities and it wasn't entirely surprising that the advice they got was 'Give us more power, please.' And they've done it again, of course, more recently, the present administration, because seeking some way of introducing management into the health service, they got a manager to have a look at this and, surprise surprise, up he comes with the idea of what we want is management. And I think that management is very important in businesses, but I'm not sure that a strong managerial thrust is exactly the way to manage a health service where, after all, the real action is in the community or in hospitals at the place where the patient, or the

possible patient, actually meets the health professional who is qualified to give them advice. They don't need to take it but, you know, advice should be given and that's where the real action is to me, not in the sort of area echelon.

GW No, that's true but the people who are at the coalface and so on, they are part of, and very conscious of being part of, a national scheme under a central government. Do you think that the regions could in any way – and we have a government which encourages competition – could there have been a role for regions to have sufficient autonomy to actually be capable of producing perhaps better results than the neighbouring regions? I mean, if that were... on morbidity and mortality?

GB I think that's a splendid idea and is one of the really neglected opportunities of a National Health Service because, you know, there are so many things where the answer isn't known what is the best form of organisation. It would seem so commonsensical to have one region or one district even doing one thing and some another. Now, this was mooted in some issue a few years ago by Henry Yellowlees² when he was in the Department and the thing failed not because it was in any way impossible, but because of the political local pressures, because if something's done it's automatically assumed to be a good thing whether proven or not, and immediately the howl goes round from the control district 'Why on earth aren't we receiving this obvious benefit,' and it's almost politically impossible to do the sort of trials for which common sense shrieks aloud.

GW Coming back to what is known as the 'Black Report',³ what was the remit you were given on that occasion?

DB Well, that was given us by David Ennals,⁴ of course, which is a long time ago, about 1973 or '4 even, I think, and we had a three-fold remit. The first was to gather information and we certainly gathered information, you know, massively. And the other thing was to speculate on causes and, again, we did that. As they say in testimonial style 'to our own satisfaction', but seldom to anyone else's. And the third thing was to suggest, you know, steps that could be taken. I think the fundamental thing that came out of that was really how important social factors are as compared to health service provision. Health Service provision, tremendously important but not the major factor. Actually, I think in the report, which is, after all, ten years ago, we went almost overboard because I had sociologists with me and I think we undervalued the contribution of health services. In the intervening decade, information has come along from various countries in Europe that those diseases for which there is effective treatment, there has been a much more striking fall in mortality, as indeed one would expect, in those amenable diseases than ones for which there is no treatment. That is just common sense, but it does rather go against the idea that, you know, what happens in the health service is marginal and that it's all to be put down to social causes. These remain important, but I think the health service was undervalued in our report to an extent.

² Henry Yellowlees, Deputy Chief Medical Officer, 1967-72, Second Chief Medical Officer, 1972-73, Department of Health and Social Security.

³ The report of the working group on inequalities in health, chaired by Sir Douglas Black, was not published by HMSO in the usual way, but was made available in August 1980 on request to the Department of Health and Social Security. In 1982 it was published by Pelican books.

⁴ David Ennals, Minister of State, Department of Health and Social Security, 1968-70.

GW That's very interesting. When you first were assembling your facts, were you expecting to find differences according to social class in the morbidity rate?

DB Oh yes. I positively clear, my colleagues and myself, of any imputation that we made a great discovery, this was all really well known before. I think that we put in a lot of what, I think, W S Gilbert would have called 'corroborative detail' in a fairly massive form, but this was no surprise to anyone and, you know, sometimes when I talk about this, people say 'Yes, but you know, what's all the fuss about? It's bound to happen that you get poorer health experience if you're poor.' But, this would be a valid argument if there was actually nothing you could do about it, but since there are things you can do about it, some of which are not being done, then I'm prepared to go on being a sort of low key agitator, which is my general role in this matter, I think.

GW You don't feel that this is an extension of medicine which is perhaps peculiar to yourself and a few others? I can remember Lord Brock⁵ years ago saying – who was a most caring individual and did great work and so on – nevertheless he said that in his view all these political factors... that poverty, social class and everything else, these were for politicians and for other people, sociologists, and not for medical men at all. I've never held this view myself. I've always felt that if a medical man accepted conditions which he knew were contributing to ill health, he ought to say so and he ought to try and do something about it.

DB You know, from a great distance below I take as my model, Rudolph Virchow, who not only laid the foundations of cellular pathology, but also said, you know, doctors should be the natural advocates of the poor. Now, that's a role that doctors haven't invariably fulfilled entirely, but nevertheless I think it's one that I'm, you know, not ashamed of being conscious of, however far short I may fall of doing anything useful about it. So, I'm unrepentant about the Black Report.

GW Yes, in a discussion on behalf of the College, I perhaps shouldn't remind you, also that the famous William Rose case of the apothecaries in 1703, the advocate of the apothecaries, did say that he was for the poor people of England and it was that that won the case against all the legal arguments of the time, there being no provision for the poor at that time other than going to an apothecary or as you might go to a chemist shop now rather than a doctor.

DB This is a little similar to what my professor of medicine, Adam Patrick, in Dundee said just before our final exam, he said 'When there's doubt, we always give the benefit of the doubt,' and then he paused and went on and said 'to the patient.'

GW Still on the rather governmental aspects of medicine, but now turning more to research, you were the... I think you were, the first Chief Scientist,⁶ were you not?

DB Well, Dick Cohen⁷ did it for about six months and he set up the organisation actually, and then all I had to do was to go in and operate it, which I rather failed to do,

⁵ Russell Claude Brock, Lord Brock of Wimbledon (1903-1980).

⁶ Sir Douglas Black was Chief Scientist at the Department of Health and Social Security from 1973 to 1977.

⁷ Dr Richard Cohen, Chief Scientist at the Department of Health and Social Security, 1972-73.

but I think that was because it was inoperable.

GW Yes. Now, you didn't think so obviously when you accepted the appointment?

DB No, I hesitated a little, but I thought well, we'll have a go.

GW But, did you think on taking the appointment that there was an opportunity for you to influence the way that research was funded?

DB Yes, I think that I had inherent sympathy with the objective of the Rothschild Report⁸ which was what started this all off. I had absolutely no sympathy with the mechanism proposed because, you know, Brian Windeyer, who preceded me as Chairman of the Clinical Research Board, and I wrote at the time saying that this mechanism will never work and in the end it didn't work. And Jim Gowans'⁹ honesty was the major factor in preventing it from being perpetuated against all common sense, because there really was the most curious system of triple counting. Every pound that was spent had to be accounted for by the department and its budget, by the MRC [Medical Research Council] and their budget and by a separate budget for what was called 'transferred funds'. You see, Rothschild's idea basically was that the MRC couldn't be trusted to do socially organised, social type research, and therefore that wise body, the DHSS [Department of Health and Social Security], should be, you know, put there as overlords. And the reason why it didn't work was that the Department really didn't know any better than the MRC what should be done, in fact, rather worse. And again, it was the MRC, which was an organisation with a long and creditable history with a very considerable staff, against that of a department with a fluid body of people, because with civil servants there was no such thing as a career in research management; they have to go in and out for career advancement. I sound like someone making endless excuses, but actually I think the thing was inherently unworkable. I tried to work it really quite hard.

GW This is an instance where politicians think that a department of government is in a position to exercise judgement across an area of, to some extent, technological expertise as well as social consequences, and in a way all the parties continue really to do this, don't they, in many ways? I mean, the departmental view, even with the great epidemic of AIDS we have now, the experts say one thing but the departments are seizing on some particular expert or some line of policy and there doesn't seem to be any body or any group of people whom the country could trust to direct things in the most desirable way.

DB Gordon, I've always maintained that the Department has a role but it's a role in information gathering because they have the tremendous nation-wide facilities, ready access to OPCS [Office of Population Censuses and Surveys] and so on for getting information. And equally they are quite good, on the basis of that information, on stating the priorities, but where they are weak is in the scientific expertise to know what desirable objective is in fact achievable and what in the present state of the art isn't, and that's where they fall down. It would really be silly for them to try to duplicate the Research Council expertise. It could be done. I mean, they could have their own panel

⁸ A Framework for Government Research and Development. Cm 4814 November 1971 by Lord Rothschild (Head of the Central Policy Review).

⁹ Sir James Gowans, Secretary of the Medical Research Council, 1977-87.

of experts and indeed the CMO, the Chief Medical Officer, does have advisers covering the whole range of medicine, but in a way it's a duplication and who's to say that one group of advisers is better than another. I mean, they might say themselves that they are better than the other but that wouldn't necessarily be convincing outside.

GW And they might have vested interests with their own...

DB They could, yes. That's right.

GW A somewhat parallel development it seems to me in the last twenty or thirty years to this, so to speak, political, if you like, I would say almost arrogance, in regard to specialised subjects, not only medical, is this whole development of the alternative medicine or complementary medicine. This for the general public has become something of enormous importance and, on the whole, I think the public at the moment if there was a referendum would be inclined to put their money on the alternative or holistic so-called medicine. How do you think that this has come to develop because it's so foreign to everything that we thought of as medicine anyway up to the war, I would say? I mean, no one dreamt that they were not practising holistic medicine I would have said up to the war. The compassion may have been paternalistic to a great degree and perhaps that had its serious faults but somehow, and I wonder if the health service and the NHS has had anything to do with this, the doctors have become increasingly regarded as technical experts who, for some unknown reason, are then presumed not to have the other dimension of kindness, courtesy, compassion and so on. How do you think this has come to develop so strongly?

DB Well, you are in danger, of course, of mounting one of my hobby horses, that we are beset by false antitheses, and one of my false antitheses is between technical expertise and compassion. And my example, be it from my own past experience, of course, is kidney disease, when the highly technical business of dialysis came in and later transplantation with the technical backup that that requires came in, and it really did not make renal physicians and surgeons less compassionate, on the whole it made them more compassionate. And I think that if I knew as much about other fields like cardiology and so on, I would probably be tempted to make the same observation. Obviously, you know, there are as many different kinds of people as there are doctors and nurses, as it were. Doctors, you see, don't in fact do a lot of the technical side. I mean, if you go into a coronary care unit all the monitors are being watched by nurses and they probably know far more about it than the house physician who comes along three or four times a day. Certainly, any young doctor should, you know, learn from the ward sister, in the days when there were ward sisters – they are now NOs [nursing officers] something or other, but that again is another sore as it were. But, I don't think there is really any antithesis between high technology and compassion. I mean, people like Bryan Jennett, steeped in computer technology, head surgery technology and so on, among the most compassionate of men.

GW But how do you think that the public has come to accept this view?

DB Well, it's the public plus the heir to the throne, of course. I think he's been fairly influential in this regard and I think tremendously sincere in his views. I mean, I have every respect. And, you know, in my book anything that can do patients good is good. The only reservation I would make, or at least one important reservation I would

make, is that it is sensible to go through the diagnostic screening before you seek therapy in all directions rather than not, I think that's common sense. But in the BMA [British Medical Association] we got a lot of stick for our report on alternative medicine, it was uncaring and so on, and I must admit to partial responsibility for this because I was in the working party, but I am, you know, so fearful of the very real therapeutic opportunity being neglected because of some curious phoney medicine standing as a barrier between the patient and the doctor or surgeon who can really help them.

GW I remember vividly such cases, even as a student. But, we have this weight of opinion. Do you think it would be fair to say that those who have entered medicine in the last thirty-five years and so on have been in because they've been chosen on examination proficiency more than anything else, that this has in any way given colour to the public idea that doctors are not so caring as they ought to be?

DB Again, this is often said. I am a slight defender of two very challenged propositions: one is that you shouldn't worry about exam results and the other that you shouldn't give any preference to children of doctors. The defence of these things is a separate one obviously. At the end of the road, they do have to pass an awful lot of exams and I'm sure that if the public were faced with the proposition, well, let's have a medical course without exams and then everyone would be really caring, I don't honestly think you'd welcome that proposition very much, so I am a defender of taking some account of exams. With regard to the children of doctors, they do at least know what the medical life is like and you are not going to have, I think, the terribly sad spectacle of someone making their way through five or six years of a medical course and then, you know, discovering that they're in a vocation which isn't their vocation.

GW And yet medicine offers almost every vocation...

DB Oh, you can do almost anything, yes.

GW ...almost anything afterwards.

DB Yes.

GW But, that certainly has become institutionalised almost. There almost is a rival body almost, isn't there, for parts of orthodox medical...

DB Yes. Well, that's to be welcomed if the bodies like osteopaths, if they themselves introduce higher standards of examination and produce a register and so on, that does tend to protect the public, but I think it doesn't protect them from the total danger which is of, you know, going along some very unverified path when there might be an orthodox, in quotes, path that would actually do them more good. I'm terribly aware, you know, that medicine is not a cure-all for everything and it's in the... I remember surprising a television producer once, he said, you know, in what proportion of diseases do you think medicine makes a critical difference and my guess was 10 per cent and that seemed to surprise him, but I think it's, you know, near the truth. But when I first qualified I thought, as I have so often said before, it was about 1 per cent, so you know we are heading the right way in medicine. To me it's a paradox that there is so much interest in, you know, alternatives, they don't now call them alternatives so

much, they call them complementary medicine. That again, I think, is a step in the right direction, you know. Let's call the – difficult to get a word that doesn't imply a pejorative – alternative, the ones who... the responsible practitioners of alternative medicine and people with a strong interest in it from within so-called orthodox medicine; they are very keen on the idea that the two things work together and it's not, you know, a rigid one or other and I think that's all to the good.

GW Your remark about how effective medicine, I mean, how much it has changed in our time... I remember George Pickering saying that, I mean, the first duty in his day of a physician was to be a, I think, a 'placebo reactor' or some word of that kind...

DB That's still there, of course.

GW And, of course, it's still there. But, by implication, you are also saying that if 10 per cent of medicine really makes the difference, it means that there is still a very great deal to be done in the way of research, doesn't it?

DB Oh yes.

GW And the strange thing is that it is frequently said by the public, I think, or the media on their behalf, that they can't see the necessity for this further research. I mean, antibiotics and everything have done marvels and wonder drugs and so forth. There is an ethical side to this and you are now chairman of the ethical committee [of the Royal College of Physicians] and I wondered if you are finding that people who practise a form of medicine which, to some extent, denies the scientific basis of medicine, have any of them been challenged on ethical grounds?

DB I don't think so. I think that they have very often been challenged in the courts on financial grounds – that's another matter – and you know false claims, and there is consumer protection legislation, but as far as I know, people haven't been challenged purely on the lack of a scientific base to their claims. I should put in a minor correction on my 10 per cent, what I had in mind there, of course, was things that make a critical difference between ill-health and good health, even in the 90 per cent I think doctors obviously have a strong duty of care, often devolved on nurses, often...

GW And they influence the outcome of the illness without it being a very critical...

DB And I think with life and death situations, or else the difference between complete recovery and on-going disability.

GW Continuing on the ethical problem side and on more general issues, I'm thinking of problems where the public feeling about drugs and drug safety and the pharmaceutical industry and so on, there are major ethical problems are there not in the approach to this. I don't only mean relations between the medical profession and the pharmaceutical industry, but in a public that wants no risk and yet is endlessly calling and demands, in fact, and is amazed if they haven't got an effective drug in response to an appropriate illness.

DB Yes. I think that the worst thing that anyone promulgating, whether it's a drug or a course of action or a means of obtaining energy, if they start off by saying there's

no risk they really have lost the first battle and probably also lost the war. I mean, I think that we in our profession have been rather guilty of, you know, undervaluing the risks and overvaluing the benefits for a host of good reasons. I mean, you know it's no good saying to a patient, 'Well, I'll give you this medicine but it'll probably do you more harm than good.' That's neither the way to succeed in your profession nor in helping the patient, and I don't think we have an obligation to share all our grievous doubts and anxieties with the patient. I think that's, you know, positively unethical, but again, I think that we shouldn't neglect, you know, the obvious risks. I think people have every right... I get worried about the phrase 'informed consent', whether it's to research or to operation because completely informed consent is an impossibility. I mean, a computer that was completely and perfectly programmed might just about manage it and the end result of that would be that nothing would ever get done at all, probably. You know, there was this rather tragic Sidaway case where a surgeon operated to help relieve, to give relief, to a cervical spine condition, and the sad outcome of this was very extensive paralysis and this case was taken up in court and the unfortunate lady said 'If I had known the outcome of this operation, I wouldn't have had it.' But, again, neither would the surgeon, in fact, have done it, quite clearly, and yet if he had mentioned this as a very rare possibility, it... you know, I don't think it was necessarily part of his duty to go into the really rare outcomes and yet it's the outcome that the patient is interested in, naturally.

GW Yes. In these days of computers, of course, it is possible, theoretically anyway, for all the rarest possible consequences to be printed out, but as you say, if one were to do that, what progress, what treatment would ever be undertaken. Certainly, surgical treatment would be at a full stop.

DB Yes. You see, the way in which people assess risk is really almost divided logic because, you know, people go for long car journeys and yet be frightened of flying short distances, and the actual risk of a long car journey is probably actually greater than that of a short flight. Admittedly, the aircraft...- this is getting off medicine – you know, the aircraft companies, as anyone in their position probably would, make the very best of it by counting it in miles rather than on take offs and landings, which is where the real major risk appears to lie, short of terrorism and so on. But, of course, I got very interested in all this risk assessment business in the Sellafield¹⁰ context, which has been another preoccupation of mine.

GW Yes. This is exactly what I wanted to talk about. Let's talk a little bit about that because I think the public – again I keep on taking a sort of public view this morning – but I think the public felt very worried that when you say that there is not evidence of an increased incidence of leukaemia or whatever within a certain region, or that this appears not to be part of the expression of a geographical situation near to a nuclear power [plant], that you are saying something scientifically correct because that is what you have found, but the public wants, again, something more than this. They're wanting a guarantee that there will be no case of leukaemia which could conceivably be attributed to it, but background radiation and all the other factors are virtually unknown to the general public.

DB Well, it's a difficult area and in self-defence I have said that I never get into that

¹⁰ Sellafield, Cumbria. Site of nuclear power plant and nuclear fuel reprocessing plant.

kind of area unless I'm asked to be put in it.

GW Yes, because you're frequently asked!

DB Yes, having got into it, two things stood out a mile really. One, that, very probably, there was a population increase in incidence, that's the sort of thing that's measured by the Poisson approach, there is a very high probability that there is something in the neighbourhood of Sellafield to worry about. The other thing that stood out a mile, and I think it was really Donald Acheson who directed my attention to this, was that the actual number of cases involved was really very small, spread over a long period of time. No way does that diminish the individual tragedy of each of them, that's another matter, but putting the two things together, you know, there is a reason for why and this has been compounded by somewhat similar things being found at Doonray, but it's silly to consider a risk in isolation and not compare the risks of whatever alternative procedure. And there are two alternatives in my view to the use of nuclear power for energy. One is to do without the energy and, you know, sort of have old people freezing as it were, which I find distasteful, and the other thing is, you know, go to coal and oil and these have hazards which are different, but on the usual estimates, rather in excess of those from nuclear power. There are, you know, more far out things. We could, I suppose, make Britain into a sort of coral island with gaps in the reef and turbines buzzing around with them or we could put up windmills like the Dutch Masters used to paint, but I don't see those as real viable alternatives and the sort of Greenpeace approach, well, you know, let's use half as much energy as we do, I think this would, you know, lead to hardship, quite honestly.

GW Yes, immense hardship.

DB So, I am an advocate of nuclear power as a source of civilian energy, obviously, on all occasions except those when Lord Marshall¹¹ is trying to persuade them to say it's completely safe and then I have a gut reaction which says no way! Because it's obviously not completely safe, nor is anything, like crossing the road, like being born, and as George Godber used to say the most dangerous thing ever to do is to be born, you're sure to die, you know. So, this sounds very callous and hard-hearted but I think one is considering a balance of risks and not risks in the absolute.

GW In your capacity as chairman of the ethical committee for the College, are you being faced with actual situations or are you supposed to be a sort of upper house that is looking at general issues?

DB Well, a little of both. I mean, one major preoccupation with this is that in no way are we substitutes or surrogates, to use a word that has got other ethical connotations, are we in any sense substitutes for the local, whether they're district or regional, ethical committees, that's not our function. Our function is to look at general problems, but equally we are very open to receive, you know, specific requests for guidance.

GW So, a thing like surrogacy of motherhood, I mean, and so on?

¹¹ Walter Charles Marshall, Lord Marshall of Goring, Chairman of the Central Electricity Generating Board, 1982-89.

DB Well, that's right. I mean, that seems to be being dealt with in other ways, but, you know, queries do keep coming in. I mean, the most recent one is that some local health authority has raised the question at their own ethics committee of what happens when a lot of samples have been taken for a completely different purpose, who owns them and can they be used to do AIDS tests. I don't think there is an established College policy and that's why I'm driven to quote BMA policy, which is as long as they're anonymised – it's a horrible word, you know – but as long as they can't be attributed to any one individual, then it's ethical and legitimate to use them for epidemiological purposes. One of the fascinating things about ethics, of course, is again like risks there is never a yes or no, because some people if they happen to have AIDS and their sample showed as positive, it would be a positive dis-benefit to them for them to know about it. On the other hand, there are some people who it would be a positive advantage to them, particularly to their social contacts and families, for them to know about it, and this is why counselling is so important in that particular context. I mean, in some ways, I think we are running scared of AIDS, you know; it's not the first plague that's overtaken our sad human state, as it were, but I think it is a major problem. But what I worry about is, you know, resources being transferred from other things which might be more profitable in terms of lives saved.

GW Yes. Exactly what I was going to ask you next. When you said 'I' there, you were talking individually?

DB Yes.

GW I mean, but does your committee look at problems where resources, if you like... dialysis, let's take a familiar subject, there are ethical issues, aren't there, if resources will not run to people being given the opportunity to have that treatment?

DB There are problems in what ethics committees are supposed to do and what type of evidence it is supposed to take into account and personally I'm a syncitial type in that I see a continuity between ethics, economics and scientific validity. Now, ethics committees ought to have a strong lay and nursing representation as well as a medical one, and that equips them well to look at the ethics issues in my view. It equips them less well to deal with resources other than science, but at the same time I very much defend their right to take even a layman's look at those other two aspects and take in appropriate advice to deal with them. There is often a saving situation where a grant is sufficiently important to be looked at both by, say, a grants committee of the MRC and by a local ethics committee, and I think there an ethics committee would be entitled to say that if a grants committee had passed its subject to ethics approval they could probably take it that the science was all right, but at the end of the road they might know something, you know, about the local scientist; it might then say, well, you know, he's fooled the MRC grants committee but he's not going to fool us, and that to me would be perfectly legitimate grounds for turning it down if they knew that this chap was, you know, unlikely to produce good honest science as they might do from other evidence. I would have hesitated to say that, I think, twenty years ago but there have been so many worrying things in the last decade of people pirating work, pirating actual papers that one can no longer assume what I think I had been innocent enough to assume twenty years ago that, you know, scientists were honest people. Most scientists, almost all scientists, are honest, straightforward people but, you know, there's the occasional shyster.

GW Yes. Some twenty years ago, I came up against a few very, very sad instances.

DB Still, that's a diversion.

GW But, there's always also a sort of muddy area between ethics and moral problems and what one might regard as, I always feel the word etiquette is far too trifling, but nevertheless, one of the things that came up in many a case at the Professional Conduct Committee of the GMC [General Medical Council] is really more a question of lack of kindness, lack of consideration, thoughtlessness and so on. And this frequently does actually injure the patient or injures the family in regard to the treatment of a particular patient to a degree that one must say is unethical, or a failure to come to see a child that's ill and so on, when a doctor often may have every excuse, but nevertheless if his general pattern of behaviour is one that he doesn't get up in the night, or he doesn't make an extra effort to do something, it's a very difficult area, isn't it, to comment on?

DB Exactly. One shouldn't, you know, react on individual things but I think it was in yesterday's *Times* that there was a rather sad letter from a woman who'd had a breast removed about twenty years ago and the surgeon who did it said 'We've taken out 7lbs of meat.' And that I mentioned because we were talking earlier about, you know, is this business of selecting medical students on exams and so on producing a lack of caring. Well, you could hardly have a greater lack of caring than that thing and yet that woman, in the marvellous way that patients have, was very grateful to this chap. She thought he could have put it better and she wrote indeed to say so, but nevertheless she expressed her gratitude for the twenty years of life that she'd enjoyed. And I honestly think that partly because of the intervention of the media, which we often curse, and sociology and so on, I think that doctors on the whole are becoming better rather than worse, but, you know, I'm a congenital optimist. I mean, I can remember awful things in the old days of people, often out of shyness, even... I remember a very caring physician whom I won't name being so embarrassed when a patient with gangrene of the foot had to have an amputation that the way in which he could, in quotes, break it to the patient was to go up to him and say, 'I'm sorry so-and-so, this leg of yours is no good to you. We'll have to have it off.' And, you know, that was the way that... I don't think I would break that kind of thing, I'd hope not.

GW No. I think there were very many instances of, in our early days, of that sort of... there was a lot of talking around the bed and using 'ca' [cancer] and various other things...

DB With transparent disguises, yes.

GW ...and where the public was regarded as incapable of understanding...

DB I'm a great lover of American medicine, Gordon, but one thing that creases me is those awful so-called grand rounds where chaps talking away to their audience all the time and the patient sort of wheeled in and wheeled out again and nobody addresses a word to the unfortunate man or woman and you could really have a statue or a dummy for all the good of having a patient there is. Robert Platt was always tremendously annoyed if someone presenting a case at one of our modest little meetings didn't start

with the patient and thank the patient and so on, and I hope I didn't have to learn courtesy from him, but I certainly would have done if I had had to.

GW Well, they had courtesy but there was also a lack of understanding, I think, of what the patient could guess at or might suspect and sometimes quite wrongly suspect.

DB Again, having mentioned Robert Platt, you see, he was an extraordinarily caring man because in the Manchester Royal Infirmary where he worked, he was the man who got the hairdresser to go regularly around the female wards and this, you know, made a tremendous difference to morale. And I think that it's [William] Blake who says that if you want to do good you must do it in minute particulars, and I take that as an example of the minute particular which Robert was doing good on that occasion.

GW That's a splendid story. We did discuss a little bit of the aspects of admission of students, the kind of student being admitted to medicine, if we move over altogether to medical education for a while, if you were asked to be dean of a newly establishing medical school with a very free hand, no committee, are there any major radical changes from what is being done at the present that you would wish to see achieved?

DB Two things by way of introduction, Gordon. First of all, to the extent that I have succeeded in medicine, and I suppose in a way I have, I have attributed very largely by never having been a dean, you know, I have seen men spoilt by being deans, it's just, I've seen men being spoilt by becoming professor of medicine. I once used an unwise phrase 'as a professor of medicine you have the stultifying effect of a medical chair,' and one can sometimes see it. Secondly, I am tremendously conservative with a very tiny 'c' and I think that we've not got at all a bad medical course. I think, and everyone who talks about medical education says this, I think that due to a lot of pruning and, of course, the pruning is always in someone else's subject, you know. When I was in Manchester I sat on the curriculum committee for twenty or thirty years and we were very responsive to student needs, which meant that we acted like a pendulum, you know. They said 'We have far too many exams, one every year, you know, we can never really get down to study.' And we boiled down the exams to two, one at the end of three years and one at the end of six and they came back the very next year and pleaded with us 'there's just so much of this material that we have to remember, we can't possibly carry it for three years.' I think that in terms of radical innovation, I think that my most radical innovation would probably be to have a real honours year and this you will not be surprised to hear is not original, it's an idea I had from Jonas Kellgrun. When he was professor of rheumatology at Manchester, he pointed out that, you know, for most of the medical students it's really a struggle to keep up with the work as it were and they need relief by seeing patients, but you get the odd number like 10 per cent who could really... they are being held back by the slow speed of the major convoy and they could do honours type work throughout the course, and these could be the future, you know, research workers and so on. And I think that's basically a good idea however much it tars one with the black brush of elitism, but, you know, I am a non-ashamed elitist. I think that in this country we are over-populated if anything, we've got to live by our wits and I think that we should be, you know, encouraging talent rather than holding it back in the interests of education equality, again just to show how unbiased I am in this equality business. Equality of opportunity, yes: compulsory equality, no. But, again, to come back to your question, I think that certainly now if I were told you're to be dean of the medical school, I'd

probably run away about a hundred miles.

GW I don't know. I would be happy to be a student if you were to become dean.

DB If I hadn't run away.

GW Just another, one more aspect of education and this is in post-graduate, this is really the question of re-certification or at least some kind of hurdle for periodic assessment through professional life. This has been tried, of course, in various places in the States particularly. I gather in most places it hasn't worked for human reasons of, say, a wish to sign on when you don't actually remain for the course or whatever, but would you feel that there is a good case to be made out for some kind of pressure throughout one's career to keep up to date?

DB Yes. I am very much a carrot man rather than a stick man and I think that I would be much more in favour of giving very positive encouragement, even amounting to compulsion, for re-education but I wouldn't myself go as far as re-certification except I think that we do need more than we have got to deal with the doctor who, for a variety of reasons, becomes incompetent. We have mechanisms. We have got the three wise men, we have got the GMC Health Committee and I've paid great tribute to the GMC for, you know, setting up an organisation that really took account of the difference between a doctor who's sick and a doctor who's...

GW Yes, we needed it very badly.

DB ...who's not, you know, not... but let me go back a bit, the Health Committee is a great advance and equally one has to take account with the odd doctor who's unscrupulous, careless, even a rogue, and these unfortunately do exist, but the gap remains something to do about the doctor who, let's say, is honestly incompetent, who doesn't keep up with his subject. I think that there are some situations which one would want him to, you know, take up a less exacting branch of the profession, even retire from it, but it's terribly difficult to devise a mechanism that is fair both to the patient and to the doctor. At the moment, I think our bias is towards being fair to the doctor too much and less to... but I don't honestly think that re-certification would be the real answer because as our dear friend and colleague, David Pyke,¹² has pointed out, most of the things that happen are not due to lack of knowledge, which is what alone you can study by re-certification, but it's due to bad attitudes and I think re-certification wouldn't do anything for that, and I think the really dangerous things don't come from lack of knowledge, though of course there are areas in which lack of knowledge is critical and culpable, but I think most of the bad things that happen come from lack of sensitivity and lack of a good attitude towards both pride in one's profession because I think that's important and also I think, even more so, one's moral duty to one's patient.

GW Well finally, what would you see as the role of the College itself in influencing the graduate education of the future?

DB Well, I think that the College has a tremendous asset in enjoying by and large

¹² David Pyke, Registrar, Royal College of Physicians, 1975-92.

the confidence of physicians and to give a concrete example, I think that's enabled them to do something about audit under Cyril Clarke's wise guidance and [Allan] George Whitfield in a way in which, you know, wouldn't have been nearly as readily accepted from any other agency. And again I think it's good that the College has now set up a standing committee on ethics aspects and I think that these are two activities in which the College is in a very good and strong position. I think their postgraduate activities on the positive side, education, are very important and very acceptable again to physicians both in training and qualified, and again, although it has difficulties, the JCHMT [Joint Committee on Higher Medical Training] organisation, of course, is the creature of the four colleges – one must never forget Dublin, at one's peril as they say – that again is providing a great stimulus, I think, to health authorities to provide the *milieu* in which people can persist with both training and with continuing education and I think these are the roles where I see the College as being important in and giving advice to government, of course, in many ways.

GW That clearly is, for the foreseeable future, a very important role continuing for the College. Douglas, thank you very much indeed – I am losing my own voice.

DB It's been a pleasure.

GW ...and I'm delighted and I'm very grateful to you for being so patient in talking again about things that one is always obliging you to talk about but to do it so freshly and with such interest.

DB All new stuff, as they say.

GW Thank you very much.