

## The 1980 Reith Lectures—some reactions

The 1980 Reith Lectures were the first ever given on medical ethics. They provoked widespread public interest and not a little medical hostility. Ian Kennedy, the London University lawyer who gave them, has agreed to respond, in this issue of the *Journal* to a variety of considered reactions to the series.

EDITOR

### Agreements and disagreements

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#### Editor's note

*The author, president of the Royal College of Physicians, finds much with which to agree and disagree in the 1980 Reith Lectures. The need to remedy inequalities of health care distribution is, of course, supported by this particular commentator. However, he takes major issue with Kennedy's criticism of scientific problem-solving as the basis of medicine and he rejects Kennedy's proposals for further safeguards to ensure medical accountability to the public. He summarises his 'essential difference' from Kennedy by saying that the doctor is a trained professional responding to the needs of individual patients – not, as Kennedy would have him be, an agent or a servant of society.*

*This paper is based largely on a lecture given at Green College, Oxford.*

As members of a liberal profession, it may be our duty to welcome the kind of scrutiny described in the well-known lines from *To a louse* by Robert Burns:

O wad some Pow'r the giftie gie us  
To see oursel's as others see us!  
It wad frae mony a blunder free us  
And foolish notion.

Opportunities of this kind for doctors have not been lacking in recent years, mainly from sociologists and from journalists in the various media; and in the 1980 Reith Lectures they were joined by the lawyer, Ian Kennedy, who has made a special study of the social and ethical aspects of medicine. His observations generally have been welcomed by 'the media'; but largely because of the style of the Lectures, designed to arrest attention and aimed at the concerned lay person, most medical commentators have reacted rather harshly, except for, perhaps, John Swales (1) who put forward a temperate and reasoned defence of scientific medicine.

My own position is, perhaps typically, intermediate and ambivalent. I see, on the one hand, a good deal of common ground between Kennedy and myself; but some of his statements are extreme, and give a misleading picture of medical practice as I know it. To take first of all the common ground,

Kennedy makes it plain in the book version of the lectures (2) that he is in the main following a path already trodden by Illich, McKeown, Cochrane and others; but this does not drain his presentation of originality, a criticism which has been made by others. Just as he recognises the value of many forms of clinical care, so I am fully prepared to admit the importance of lifestyle in relation to health, and the value of the preventive approach. After all, I am the president of a College which has published important reports on the dangers of cigarette smoking, the prevention of heart disease, the prevention of dental decay by fluoridation, and the medical aspects of dietary fibre. More personally, I have chaired the DHSS Working Parties on the prevention of spina bifida, and on the continuing inequalities in health between social classes.

As some will know, there was a change in administration between the setting up of the Working Party and the appearance of the *Inequalities in health* report (3). I was not greatly surprised that the foreword to the report was less than warm. Mr Kennedy describes the comment in the foreword as 'thoroughly anaemic'; I think I would prefer 'muted'. I have, in fact, been rather more surprised by the widespread interest shown in the report which is very lengthy and very detailed, and not always easy to obtain. This encourages me to hope that in the longer term the main recommendations of the report will gain acceptance and be put into effect. The current political polarisation is unfortunate, for these things should be a matter of concern for us all.

Some of the qualities of the report, and some of its appeal to Mr Kennedy, no doubt stem from the composition of the working party – two doctors (Professor J N Morris and myself) and two sociologists (Professor Peter Townsend and Dr Cyril Smith of the SSRC). With our varying official commitments, Cyril Smith and I were to some extent governors; and the engine got most of its steam from Professors Morris and Townsend. The report was, of course, a consensus, and I do not agree with everything in it, but I certainly fully agree with the main conclusions, and particularly with the stated objectives: to give children a better start in life; to encourage good health among a larger proportion of the population by preventive and educational action; and to improve the quality of life for disabled people [who are more prevalent in social classes IV and V]. Clearly then, I not only

agree with but positively welcome those parts of Mr Kennedy's 'blueprint' which run along the same general track as the *Inequalities* report (3); and here I need only reiterate our common emphasis on the importance of maternity services and services for child health, if we are looking to the future. I also welcome his explicit recognition, earlier in the same lecture, that, speaking of prevention and of the curative services, 'The debate should not be in terms of "either or".' To make a contrast between the prevention of disease and the care and cure of those who already suffer from it, is in my view, to make a false antithesis. Both are essential ingredients of good medicine.

When my predecessor at the Royal College of Physicians Sir Cyril Clarke honoured me by asking me to give the Harveian Oration I chose as my subject 'The purpose of medicine' (4) and came firmly to the conclusion that its central purpose is to serve not medical science, not the health professions, not society, but to serve patients – an objective with which Kennedy clearly agrees. I agree with him on a number of other matters, such as the general value of the National Health Service, by comparison with the overwhelmingly free-enterprise system in the USA and Europe; the inadequacy of litigation in assessing compensation for clinical misadventure, and his consequent advocacy of 'no fault' compensation; and that there is an important place for informed lay opinion to be expressed on the ethical and economic aspects of health care, such as already exists in the majority of hospital ethical committees. I share fully his concern for child health.

These are important areas of agreement; but I must now turn to our divergencies of view, which are far from trivial, since they concern the general orientation of medical education and practice. My own considerable experience in medical practice does not of course legitimate me as a judge in this case, but it surely entitles me to be a witness.

In his first lecture Kennedy suggests that, by reifying 'disease' and 'illness', doctors have arrogated to themselves a special area of power. I regard this, if it exists at all, as a greatness which has been thrust upon them, rather than one which they have set out to achieve. Most doctors are so busy mitigating the effects of illness that they spend little or no time in conceptualising it. When the inevitable ageing process drives them to philosophy they tend to adopt the same 'nominalist' point of view as does Kennedy, disclaiming the 'essentialist' or 'realist' view with equal fervour (5). These authors carried out a study to compare the perception of a number of conditions by doctors and laymen. They found that where a causal agent was known both groups favoured the idea of 'illness' but with conditions such as 'depression' doctors were more inclined to look on these as 'illnesses' than the lay people. The greater 'Yes-ness' of doctors is likely, however, to be related to their perception of a need for medical

intervention – an indication perhaps of a naive or pragmatic 'essentialism' rather than of any conscious conspiracy to deprive patients of their rights.

There seems to me to be two good reasons for maintaining a taxonomy of illnesses. At the individual level, the patient expects to be told 'what is wrong with him'. More important, from the preventive angle, it is not very helpful to relate environmental factors to something as vague as 'disease in general'. Concrete progress in clinical epidemiology comes from relating those factors to definable conditions, *eg* smoking and bronchial carcinoma, lead and encephalopathy. The frequent and difficult revisions of the WHO International Classification of Diseases indicate, truly, that taxonomy is imperfect; but also that it is something useful, worthy of every effort to improve it. Kennedy also criticises doctors for excessive preoccupation with the 'illness', to the neglect of the 'patient'. There is a real dilemma here – if on the one hand a doctor becomes totally involved with the patient and his family, this may get in the way of full development of skills which have been long and patiently acquired; if on the other hand he maintains a rigid professional detachment, he sacrifices the empathy which is an essential ingredient of good practice. I have to maintain, that if autocratic behaviour is not unknown among doctors, equally it is by no means peculiar to them. I would further admit that some doctors communicate less adequately with their patients than they would in an ideal situation, divorced from the time element. But in my experience, few patients exhibit any strong desire to become party to the doctor's dilemmas; they are 'hot for certainty', in Meredith's phrase, and often regard the temporising answer as distinctly dusty.

I come now to the central area of my divergence from Ian Kennedy. I agree with John Swales (6) that his views are likely to carry a great deal of weight, coming from a prestigious platform, and also following the current political tide. All the more important that they should be challenged, in the same temperate way that Swales has already done. I refer to his criticism of 'scientific problem-solving' which Kennedy clearly regards as a wrong direction for medicine to have taken; and he associates it with acute medicine, with hospitals, and with expensive technology. I see nothing wrong with 'scientific problem-solving'; which is of course just as much the basis of effective prevention as it is of curative medicine. Indeed, I see medical progress largely though not entirely as an extension of scientific problem-solving in areas of medical need into which it has only partially penetrated. Elsewhere I have expressed my surprise at the paradox that 'Whereas the potential of medical knowledge for preserving and restoring health has never been greater and is still increasing, the systems for applying it have never been so sharply criticised

(6). For a variety of reasons, public confidence in the benefits to be expected from the application of science has waned, and medicine has not been exempt from this form of mistrust, despite the glaring contrast between what was possible 100 years ago and today. It is the scientific aspect of medicine, together with the technology which may (not must) be associated with it, which Kennedy wants to see 'curbed', as part of his reorientation of health care. This suggestion must be seen as a threat to just that area of medicine whose benefits are most objectively demonstrable: and of course it completely ignores the vital role of acute medicine, at all ages, in the prevention of chronic disability. I believe that Kennedy's picture of acute hospital medicine is too gloomy. May not his view of what can be practically achieved by preventive measures be too rosy? There is still a good deal of uncertainty about what constitutes an optimum lifestyle; and even more uncertainty that advice which involves a radical change in lifestyle would actually be followed. Such evidence as there is may even suggest that advice on health matters is more likely to be followed by those who stand in least need of it. Some of Kennedy's expectations recall those of William Beveridge, that after a few difficult years of Health Service the cost would begin to fall, as the burden of illness began to decrease. This view ignores the limitations of our human condition; prevention may be a euphemism for postponement. Of course, sensible preventive measures remain worthwhile, and deserve encouragement; but I do not see them as diminishing the need for acute services.

It is easy to speak of a switch of resources but, while money can be diverted, facilities and skills cannot. Kennedy's argument would be that over an extended period there should be a shift of emphasis, with more doctors and other health staff specifically in the area of prevention, and all doctors imbued with the preventive outlook. My contention is that all good doctors are already concerned with the various forms of prevention; and that further cuts in hospital services would lead to increased waiting lists, and thus prolongation of misery from common and important conditions such as hernia and osteoarthritis. More radically, I regard 'prevention' and 'cure' not as antitheses, but as complementary activities essential in good medical practice.

Has the Health Service failed? And have doctors got too much power in it? Kennedy's answer to both these questions would seem to be 'Yes'. My answer to the first question would be a categorical 'No'. Before 1948, expert specialist care was almost confined to comparatively few large centres; whereas now standards have risen to an acceptable district hospital level throughout the country. Of course, great problems remain, particularly in the inner cities, and there is not always adequate access to the facilities which are available. The persistent inequalities in health are due to social and economic

factors at least as much as to any deficiency in Health Service provision. Clearly, I cannot speak from direct experience of the general practice sector; but thanks to both the Royal College of General Practitioners and to the British Medical Association, there has been a concern to raise standards; and soon vocational training will ensure that new entrants to general practice will have had the opportunity to acquire the important skills needed in this branch of the profession. Although I believe that the answer to the second question should also be 'No' I could of course be regarded as biased. Ascription of power and arrogance is perhaps most commonly made in relation to consultants; and I sometimes wonder if people in general realise the length of training and severity of selection which precede a consultant appointment in a popular speciality. After five years in medical school, three years in general training, four years of specialist training and possibly a series of interviews, the newly-appointed consultant might be forgiven for supposing that he knew something about his job. He will certainly learn more as the years pass. He will be very foolish if he thinks he knows, or will ever know everything; and he must always remember that, with the present explosion of medical information, someone far junior to him is quite likely to know things of which he is unaware. On the other hand, he has been trained, and is expected, to take decisions – not all of which will be correct. If he remembers all these things he will attain the difficult balance between confidence and humility. In my experience, the majority of consultants do just that.

After that defensive note, let me turn to someone who could scarcely be accused of a bias similar to mine. I refer to Professor W J M Mackenzie, a doyen of political science in this country, who was commissioned by the Nuffield Provincial Hospitals Trust to undertake a survey of the National Health Service as a political institution. His findings have now been published under the title 'Power and responsibility in health care' (7). Like Kennedy, he recognises the distinction between prevention (deified by the Greeks as Hygeia) and cure (deified as Asclepius); and he comments that 'Hygeia is at present fashionable among intellectuals, but Asclepius gets the cash'. The context shows that this is not a reflection on private practice, but a description of resource allocation in the NHS. But Mackenzie does not take sides on this. He notes that greater emphasis on community care, on prevention and on health education is approved policy; but also that more actually happens in the hospital sector, and he asks 'Why?'. His answer is 'There is one overriding reason: that hospitals cure people'. He does not of course mean either that there are no cures outside hospital, still less a certainty of cure within; but I believe that he is identifying a popular expectation, which was very strong a decade ago, but may be somewhat weaker because of improve-

ments in family practice, and the fashionable criticism of 'hospital medicine'.

Mackenzie does not see any single group within NHS as having anything approaching a monopoly of power – rather he sees a state of conflict between central authority, the professions, and the trade unions, which in his view must be replaced by a new myth, for the 'Them versus Us', which is gravely damaging the service. He defines the new myth in his final sentence – 'The necessary myth is one of reciprocity, that we are all in turn sufferers and servers, carers and curers; to each according to his need, from each according to his capacity'.

On the specific issue of 'doctor power', he notes that this was promoted by the 'functional' or 'professional' model of the doctor's role put forward by Talcott Parsons as a development of Max Weber's theory of society; but more recently, particularly among American sociologists 'a whole generation turned away from functional models in sociology and towards conflict models'. Together with the growth of consumerism in general, this change in sociological attitudes has weakened the influence of the professions in general, including medicine. Looking at the medical profession as a potential 'power block', Mackenzie sees the average doctor as 'politically rather naive', and the profession as a whole as fragmented by the diverse occupations within medicine, which lead to differing political interests. A general conclusion might be that while individual doctors exercise very substantial clinical power, the political power of the profession is tenuous – or would be, but for one thing – 'the doctors are weakly led, but they are indispensable'. Indispensable when it comes to the running of the service, but not powerful in a political sense – 'where medical power lies is at the level of clinical decisions'.

I believe that it is instinctive awareness, rather than any conscious recognition, that clinical decision-making is the central responsibility of their calling which makes doctors appear so obdurate to fair-sounding suggestions that yet further mechanisms, such as the ombudsman, should be invoked to question them. Of course, errors of judgment occur in clinical practice – where do they not? Absolute safety, especially in the context of illness, is not to be found; and exaggerated attempts to seek it can be counter-productive, leading to defensive medicine, which adds to the cost of treatments and saps the confidence of the doctor. I personally would put more trust in self-criticism, and in the criticism of colleagues, than in a proliferation of external agencies. A further point is the lack of any one-to-one relationship between mistakes and complaints. Many mistakes never lead to complaints; and there are certainly some complaints which have no basis in a mistake, but merely reflect the nature of the

illness. It was not a doctor who, speaking of complaints, said 'They can, however, be rancorous and persistent; political pressures have in the UK given a store of weapons to patients with which to attack the citadel of medicine' (8). Recourse to the Courts on grounds of negligence is open, as is legal aid in necessitous cases. For complaints relating to family practice, there are NHS tribunals, and the possibility of appeal to the Secretary of State. For complaints arising in hospitals, there are channels of complaint to the Health Authority, and ultimately to the Department. Patients can (and do) complain to their members of Parliament, and to the Health Commissioner. Patients' associations and community health councils will assess a complaint, and assist in its formulation and investigation. A further procedure is under discussion whereby independent consultants can be called in by the Regional Medical Officer to help to resolve those complaints on clinical matters which cannot be settled locally. The General Medical Council can suspend a doctor from practice, or remove his name from the register for a variety of reasons which may include malpractice; and the Council can now take account of dangers arising from illness in a doctor, who may not recognise his own state of incapacity. Against this background, the phrase 'double jeopardy' may seem almost an understatement.

Therefore my essential difference from Kennedy is this. He sees a doctor as an agent or servant of society, which in some not-too-clearly defined way can give him instructions – 'We must become masters of medicine not its servants'. I see the doctor as a trained professional, responding as best he can, and often as a member of a team, to the needs, expressed or unexpressed, of individual patients. I think that the second of these is what people want and need; but I agree that they must choose.

## References

- (1) Swales J D. Thoughts on the Reith Lectures. *Lancet* 1980; 2: 1348–1350.
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- (3) *Inequalities in health*. (The Black Report). London: DHSS, 1980.
- (4) Black D. Cui Bono? *British medical journal* 1977; 2: 1109–1114.
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- (6) Black D. The paradox of medical care. *Journal of the Royal College of Physicians* 1979; 13: 57–65.
- (7) Mackenzie W J M. *Power and responsibility in health care*. Oxford University Press for the Nuffield Provincial Hospital Trust, 1979.
- (8) Mackenzie W J M. See reference (7) p 35.