

**Doctors in the new millennium:  
Hippocrates or Hypocrites?**

**Rajan Madhok**

**Milroy Lecture  
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**Abstract (submitted at the time of selection in July 2001)****Doctors in the new millennium: Hippocrates or Hypocrites?**

Medical practice has come under intense scrutiny over the last few years. The British media has given extensive coverage to incidents involving the murderer Dr Shipman, the errant gynaecologists Rodney Ledward and Richard Neale and, the case of the middle aged man who had nearly 20 consultations before his throat cancer was diagnosed, for example.

A recent report from the Chief Medical Officer in England suggests that every year, amongst other things:

- 400 people die or are seriously injured in adverse events involving medical devices
- nearly 10,000 people experience serious adverse reactions to drugs
- NHS pays out £400 million in settlement of clinical negligence claims and has a potential liability of around £2.4 billion.

So, has modern medicine once hailed as the greatest benefit to mankind become a dangerous activity? Have doctors turned bad? Become uncaring, only interested in money, professionals? Closed ranks and started covering for each other? Forgotten their vocation, become hypocrites pretending to be true to the Hippocratic Oath?

There is no denying that there are grains of truth in all these statements. Some doctors have continued to use outmoded practices, have not been self-critical and made repeated mistakes. Some have been arrogant and not respected patients' wishes or indeed the law. Some have done things for money. There have been cover-ups too.

What, however, is not correct is that all doctors have turned bad and that the profession as a whole has closed ranks.

Clearly, there is a problem: medical mishaps are a serious public health concern. With the growth in designer drugs and cosmetic surgery the public and professionals have become cavalier in their approach to medical practice. As long as the public will push for a 'pill for every ill' and 'surgery on demand' some professionals will provide it. Given the inherent uncertainty in medicine this is a recipe for suffering.

Overall, if society is to have comprehensive and affordable medical care then we need to restore doctors' pride and support them and at the same time gain patients' and policy makers' confidence. This is the challenge that Dr Milroy would have wanted doctors to rise to. This presentation will expand on the subject and analyse the contributory causes and explore solutions, both of which are linked to wider societal changes and with profound implications for state medicine in the UK.

## About the Lecturer

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He graduated from the University of Delhi, India and came to the UK in 1980. Since originally training in orthopaedic surgery he has held increasingly senior public health leadership positions in the NHS. His association with the Mayo Clinic, USA in 1991, stimulated his interest in health care quality and orthopaedic epidemiology and he has pursued these actively since then.

Rajan is a Visiting Professor at the University of Teesside, an Honorary Professor at the University of Hull and a Fellow at the University of Edinburgh. He was made a Companion Fellow of the British Orthopaedic Association in 2001. He is an active researcher who has secured grants, authored three book chapters and over 100 publications, and presented his work at various conferences. He is a founding Editor of the Cochrane Musculo-Skeletal Injuries Group and has served in editorial capacities for the three main publications of his specialty of public health medicine.

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## **About Milroy Lecture**

The Milroy Lecturer is appointed by Council of the Royal College of Physicians, London, after inviting applications. The Lecture should be on a subject of relevance to state medicine and public hygiene, although the interpretation of this can be broad. In summary, Dr Milroy's intention was to "promote the advancement of medical science along with the interests of philanthropic benevolence and of social welfare". A copy of Dr Milroy's suggestions on the subject of his bequest and a list of recent lectures may be obtained on request from the Conference Department at the College.

### ***Dr Gavin Milroy***

A silversmith's son, Gavin Milroy spent his schooldays at the Royal High School, Edinburgh, and studied medicine at the University. He was a founder-member of the Hunterian Society of Edinburgh. After qualifying as L.R.C.S. of Edinburgh in 1824 and before settling in general practice in London, he enlisted for a time as a medical officer in the Government Packet Service to the West Indies and the Mediterranean. On his return, he was attracted to medical journalism and acted, from 1844 to 1847, as co-editor of the *Medico-Chirurgical Review*. A detailed commentary by Milroy on a French report on plague and quarantine, published in the *Review* of October 1846, in which he advocated the diminution or abolition of quarantine, led to his further specialisation. As an acknowledged authority on epidemiology, he was henceforth employed on several official commissions and committees. For two periods, 1849 – 50 and 1853 – 55, he acted as a superintending medical inspector of the General Board of Health, and in 1852 he was sent by the Colonial Office to Jamaica to investigate a cholera epidemic and afterwards presented a report.

From 1855 to 1856, he served with Sutherland on the Sanitary Commission in the Crimean War. Their reports, although issued too late to deserve credit for the current improvement in conditions, exposed the causes of the earlier troubles and influenced subsequent reforms. Milroy was honorary secretary of a committee appointed by the Social Science Association in 1858 to enquire into the question of quarantine. Its findings were incorporated in three parliamentary papers in 1860 – 61. He was also a member of the committee of the Royal College of Physicians chosen to examine the spread of leprosy and wrote comments on its report printed in 1867. His name is especially remembered by the college for his bequest of £ 2,000 to found the Milroy Lectureship on state medicine and public health. The Epidemiological Society owed much to his keen support, and he was its secretary in 1862-64 and its president in 1864-66. The Government awarded Milroy a civil list pension in 1871. His wife was Miss Sophia Chapman; they had no children.

(Dr Milroy's biography supplied by the Royal College of Physicians, London)

## Introduction

The saying about this period being the best of times and the worst of times does not resonate much with the doctors in September 2003. Even though general practitioners (GP) have voted in favour of their contract and there is the possibility of a breakthrough in the deadlock over the consultants contract, the overwhelming mood is that of frustration. Increasing demands and distorted priorities because of the culture of targets are causing anxiety and stress. Having to do more with less and faster is not their idea of modernisation. The much needed and hard won extra investment of money in the NHS seems to be being wasted on 'political' imperatives and increasing bureaucracy. So it seems from within the doctors camp. As far as my colleagues are concerned this Lecture is a 'No Brainer' – who is being a hypocrite here? Surely not doctors who are working harder and longer? It is the politicians who are messing it up and the public is too demanding. We have never had it so bad, NHS is a shambles, doctors are counting days to retirement and, surely it is the worst of times.

This is against the backdrop of high media interest with continuing stories about 'poorly performing doctors' since the high profile cases involving Harold Shipman, Rodney Ledward and Richard Neale and the oft quoted figures from the Chief Medical Officer's report: 'An Organisation with a Memory', which suggested that every year, in England, amongst other things:

- 400 people die or are seriously injured in adverse events involving medical devices
- nearly 10,000 people experience serious adverse reactions to drugs
- NHS pays out £400 million in settlement of clinical negligence claims and has a potential liability of around £2.4 billion.

What exactly is going on? Has modern medicine once hailed as the greatest benefit to mankind become a dangerous activity? Have doctors turned bad? Become uncaring, only interested in money, professionals? Closed ranks and started covering for each other? Forgotten their vocation, become hypocrites pretending to be true to the Hippocratic Oath?

Is it the doctors' fault and more importantly, what can doctors do to turn things around?

These are the questions I wish to explore with you today. My talk is in four parts, as follows:

1. Part One: What are the charges against doctors?
2. Part two: Where is the proof?
3. Part Three: What is the verdict?
4. Part Four: Where next?

For reasons that should become apparent as we go along I will devote more time to Parts Three and Four.

## Part One: What are the charges against doctors?

### *Hypocrites?*

Basically, that doctors are hypocrites. Hardly a day goes by without some shocking report about doctors in the press – the GMC has been portrayed as the Gentle Men's Club until recently and the BMA seems like the British Murderers Association. Not many reports out there defending doctors at present.

Going by the media portrayal the main charges against doctors can be categorised as follows:

1. Doctors kill patients – deaths due to medical errors are the 8<sup>th</sup> leading cause of death and account for more deaths than due to motor vehicle accidents, breast cancer or AIDS each year according to studies in USA; in the UK, Harold Shipman alone has killed over 200 patients.
2. Doctors cause harm – when they are not actually killing patients they continue to do harm: 1 in 10 hospital admissions is associated with an adverse outcome and, medication errors and hospital acquired infections are the most common causes.
3. Doctors are only interested in money – Nye Bevan had to stuff their mouths with gold, Kenneth Clarke noted them reaching for their wallets during the 1980s reforms and the recent debacle with GP and consultants contract has been about remuneration and private practice.
4. Doctors are not good researchers – with the pressures to Publish or Perish good quality and important research is being compromised.
5. Doctors cannot teach – the See One, Do One, Teach One method of teaching has gone on for too long.
6. Doctors obstruct reforms – implementing best practice and modernisation of the NHS is being blocked and if not actively resisting, few doctors are actively promoting the modernisation agenda. Doctors have become the disablers not enablers.
7. Doctors discriminate against fellow doctors – the Old Boys network continues and manifests itself in discriminations in appointments and merit awards and against women and ethnic minorities doctors.
8. Doctors are not good team players – they do not always acknowledge the important contributions of other clinicians and the divide between doctors and managers seems to be getting wider day by day.
9. Doctors are not self-critical – they tend to blame everyone else for the shortcomings of the health services.
10. Doctors are a closed tribe – they collude when the going gets tough and protect each other. Things do not seem to have changed much from George Bernard Shaw's time in this regard: *The truth is, there would never be any public agreement among doctors if they did not agree to agree on the main point of the doctor being always in the right.*

## **Part Two: Where is the proof? *Hippocrates or hypocrites?***

Why is medicine on the back foot? The history of medicine shows increasingly successful examples of work by generations of doctors, particularly in the last five centuries. Starting in the sixteenth century with the understanding of human anatomy to better knowledge about the disease processes in the eighteenth century to better methods of physical examination and finally leading to better treatments in the more recent times. Have people forgotten the misery and immense human toll due to infectious diseases and most of which are history, at least in the UK, due to advances in immunisation and antibiotics? Do we need further reminders about the benefits of total hip replacements, kidney transplants, cataract surgery and management of many chronic diseases, for example?

And is not this why more money is going into the NHS – from c£56 billion in 2002/3 to c£90 billion in 2007/8. Why would we do so if doctors are bad and doing harm – unless we, the public, are masochist or foolish? What is the basis of the charges – give us the proof, you challenge.

When I had submitted the abstract in 2001, I had this idea that I would undertake research into the subject. Two things happened. First, I could not negotiate any serious time off to prepare for the Lecture and second, as I started reading up on, and talking to some people about, the subject I realised that it was very difficult to collect the proof. Basically, it is a value judgement. Depending on your stance: whether you are the defender or the prosecutor, you can find evidence to support your viewpoint.

Here are some examples.

So, you can point to the role of the doctors in combating infections, from John Snow's work on cholera to Semmelweiss' work on infection control during childbirth to Fleming's discovery of Penicillin, all the way to the present day work on SARS where Dr Carlo Urbani who discovered the virus died from the disease.

Or, you could point to the continuing controversy about MMR jabs and the profiteering by some doctors from this controversy or, the role of the doctors in creating resistant bugs through indiscriminate prescribing of antibiotics or, spread of infection through lack of observation of basic hygienic measures including hand washing.

You could point to John Charnely who did painstaking work over many years to produce a good quality product for total hip replacement and then only released it to people who received proper training in the use of his technique and product. Or you could point to the many doctors who came after him who rushed in subsequently with their versions of not just hip replacement implants but also for replacement of many other joints and some of which failed spectacularly with tremendous human and societal costs. Doctors keep giving in to commercial interest/pressures. As one surgeon, on bumping into a colleague at a conference, said: "See you later. I have to go and 'whore' for my company."



In terms of research, there is evidence to show that doctors have conducted unethical research – the Tuskegee Syphilis Study and the atrocities committed by doctors during the Nazi regime are prime examples; falsified data and assumed authorships without doing (or even examining it) the work. Doctors have distorted research priorities – and seemed to have learnt nothing from the experience with managing infections, research funding for which became very limited in the last 2-3 decades due to complacency about it not being a developed world problem. And now all hopes are pinned on genomics – if you do not do genomics you are a nobody. And doctors have played into the hands of the industry and continue to conduct trials of ‘Me Toos’ to give the (often more expensive) products legitimacy.

On the other hand, you could point to people like Archie Cochrane, Iain Chalmers, and Chris Silagy, among many others, for their selfless dedication to promoting evidence based practice, and to Belding Scribner, the inventor of renal shunt, who abhorred the ‘contaminating effects of profit motive on health care’ and lobbied hard for access to dialysis and generally promoted the idea of single payer health system in the US. Incidentally, Scribner has also been credited with helping to establish the modern field of bioethics.

Hippocrates and hypocrisy can co-exist – the case of William McBride is an example. McBride, an Australian obstetrician, was among the first to describe the teratogenic effects of thalidomide and was subsequently given governmental funding to set up a research institution. First challenged by one of his researchers about discrepancies between the published results and original data in 1982, he was finally brought to justice in 1991 and admitted to publishing false and misleading data. He was struck off the Medical Register in 1993. A sad fate for a doctor who had prevented untold damage by alerting the authorities to the harmful effects of a drug; not an easy task given the enormous influence of the pharmaceutical industry.

Whilst many doctors are in the forefront of driving improvements in quality of, including access to, services, both at macro and micro level, there are instances where they have been slow to change or blocked progress. One example of my personal experience in regard to the latter concerns care of patients with low back pain. Nurse led services for such patients, a relatively simple and effective measure, took enormous amount of time and effort – the model first established in Middlesbrough in 1993 did not get implemented in South Tyneside until 1996 and in Hull until 2000. And is still not universal approach to providing care for these patients in the country.

John Yates’ work on waiting lists shows how less is being done with more and how waiting times could be easily slashed with just an increase of one extra session of operating time. And it is ironic that John Yates, not the most admired figure amongst doctors (mainly surgeons) for his thorough and pointed analysis of productivity in health care, counts doctors as the people who with their hard work, integrity and scientific approaches, influenced him the most; he could only recount one manager who impressed him but could name several doctors!

Finally, time after time doctors have been found to be discriminatory – discriminatory to women, by barring entry to medicine overall to restricting progression in many specialties to personal discrimination as in the case of Dr Wendy Savage; and to

ethnic minorities doctors, who face similar, and may be worse, disadvantages. The current situation with Staff and Associate Specialists is another sad reflection of the discrimination against fellow colleagues – most SAS doctors are experienced and can work up to consultant levels – and yet are not recognised as such at a time when the shortage of consultants is compounding the problems of access to services.

On the other hand you could point to the great humanitarian doctor: William Osler and the serious efforts being made by many doctors to tackle discriminations presently.

And I could keep going like this against all of the charges levelled at doctors. But, it would not be the best use of Dr Milroy's endowment – he would have wanted us to move on.

### **Part Three: What is the verdict? Hippocrates and hypocrites?**

So, are doctors Hippocrates or hypocrites?

Ambrose Bierce (quoted in Lantos) defined the physician as “one upon whom we set our hopes when ill and our dogs when well”. Is it because the doctors have worked hard over the last century and vastly improved the quality of life of people suffering from acute and chronic conditions and some people in society resent the successful status of doctors and want to bring them down?

Or is it that doctors have fooled themselves into thinking that they were accepted and respectable people in society whilst the reality is that the public has never trusted them and George Bernard Shaw’s comment still holds:

*“All that can be said for medical popularity is that until there is a practicable alternative to blind trust in doctor, the truth about doctor is so terrible that we dare not face it. Moliere saw through doctors; but he had to call them just the same. Napoleon had no illusions about them; but he had to die under their treatment just as much as the most credulous ignoramus that ever paid six pence for a bottle of strong medicine. In this predicament most people, to save themselves from unbearable mistrust and misery, or from being driven by their conscience into actual conflict with the law, fall back on the old rule that if you cannot have what you believe in you must believe in what you have. When your child is ill or your wife dying, and you happen to be very fond of them, or even when, if you are not fond of them, you are human enough to forget every personal grudge before the spectacle of a fellow creature in pain or peril, what you want is comfort, reassurance, something to clutch at, were it but a straw. This the doctor brings you. You have a wildly urgent feeling that something must be done; and the doctor does something. Sometimes what he does kills the patient; but you do not know that; and the doctor assures you that all that human skill could do has been done.”*

The current situation reminds me of the saying by Epictetus:

*“Appearances to the mind are of four kinds.  
Things are either what they appear to be;  
Or they neither are, nor appear to be;  
Or they are, and do not appear to be;  
Or they are not, yet appear to be.  
Rightly to aim in all these cases  
Is the wise man’s task.”*

It seems to me that there are enough wise ‘men’ out there already who think that they are aiming rightly; and may be that is the problem now. Too many people judging doctors. But do they know the context within which doctors work - are there any extenuating factors that need to be taken into account, given that the evidence is not clear cut? Two important issues for me are:

1. is it bad medicine or bad doctors? And
2. is it the system or the individual?

### ***Bad medicine or bad doctors?***

Medicine is not an exact science. There are inherent uncertainties and consequent risks. To confuse these risks with errors is unhelpful to doctors just as condoning errors because of risks jeopardises people's lives.

Take an everyday occurrence in the health service – something that happens millions of times every week if not every day. A patient receives a test: it may be a blood test, a cervical smear, an X-ray or any other investigation.

There are four possible outcomes following this test. Two of these: True Positive, when the patient has the disease and the test shows it and the converse, True Negative, are what doctors and patients would like to know. However, there will be instances when the test results are False Positive, that is the test is positive but the patient does not have the disease, or in the reverse case – False Negative. Much of the time doctors do not accurately know which category the test results belong to. They rely on mathematical estimates of probabilities, not always from well conducted scientific studies and, on intuition and experience.

Furthermore, the test result is only one step in the management of the patient's condition. There are many others, either leading up to ordering of the test, such as when to order the test, which test, how to do it, for example or subsequently. Thus, should the doctor act on the result straight away or order another test, and in any case which treatment and how? It has been estimated that there are 65 steps within a hospital once the GP refers the patient to an ENT department and their eventual discharge. All such steps in the patient's journey through the medical system have their uncertainties.

This uncertainty in medicine creates an underlying risky situation to which patients are exposed whenever they receive medical care.

It is also difficult to guarantee the continuing and life long safety of many procedures; the history of medicine is full of instances where procedures done in good faith or on the basis of contemporary knowledge proved to be ineffective or harmful subsequently for various reasons including scientific and technological advances.

Finally, despite best intentions and efforts, things do go wrong in medicine. Almost all medications have side effects, even everyday remedies like aspirin and paracetamol. An average of 500 paracetamol related deaths occurred in England and Wales each year during the mid 1990s. Nearly one in 20 patients requires readmission within 28 days of everyday operations like appendicectomy and hip replacements.

Not everyone appreciates the inherent uncertainties and risks. For various reasons not all doctors have the latest knowledge or are willing to accept the best evidence. Furthermore, they may not communicate the important risks to, or share uncertainties with, the patients. Equally, patients may take a passive role or choose to go against the advice being given. Two common clinical situations illustrate this.

Antibiotics for common colds are unnecessary but many doctors still prescribe them and many patients are unhappy if their doctors do not prescribe them. Grommet insertions are not always necessary but many surgeons continue to perform them and many patients are unwilling to accept the advice about watchful waiting – they do not want to wait and feel that they are being fobbed off by such expert advice.

And if things were to go wrong – for example, a nasty side effect due to the antibiotic or a complication due to surgery were to occur then where does the fault lie?

### **System or individual?**

Although they may not always integrate well and work in teams, doctors do not practice in splendid isolation either. There are systems that shape doctors throughout their training and careers. And it starts with their education: undergraduate and post-graduate. Melvin Konner, an anthropologist, in his account of medical training in USA, wrote:

*“I still sympathise with the plight of the doctor especially today when the doctor is under siege. But medical schools have failed, and continue to fail, to produce graduates who are capable of humane as well as merely scientific medical care. It is this failure more than anything else that has put the modern doctor so thoroughly on the defensive. Today’s physicians- the medical students of the seventies and eighties- have lost the public trust because they have not cared enough about their patients. Is it surprising that their patients no longer care about them?”*

Samuel Shem, writing a new introduction to his classic, *The House of God*, ten years after it was first published, stood by all he had written:

*“No, friends, I did not coin the word gomer (Get Out of My Emergency Room – used by tired ER residents, for older people brought in from nursing homes), nor did I invent the cruelty towards those with that label. Neither did I create the sexist way that women were treated in hospitals at that time. A promising change since then has been the numerical parity of women in medicine. Yet, I hear that in many ways, medical training may now be even worse”.*

Jed Mercurio, writing more recently, echoes these sentiments.

Medicine is a highly stressful profession. Most doctors worry about and many have difficulty in dealing with medical errors in the culture of perfection. Many doctors develop stress related symptoms: nearly one in 20 GP has been known to suffer from anxiety. Nearly one in four GP and hospital doctor had increased their alcohol consumption due to stress according to a recent study. Deaths due to alcohol related disorders are almost three times as high as in the general population and almost the same rate as seen in bar staff. The suicide rate for UK doctors is two to three times that of the general population.

Compared with doctors in other developed countries and in comparison to higher paid employees generally in the UK, medical remuneration is falling behind. Not all doctors have merit awards or huge private practices. To make matters worse, the average medical student loan is approaching £15000.

Doctors face genuine difficulties in addressing errors many of which have their roots in the inadequate system in which they practice. Most enquiries of medical errors show a failure of the system rather than an individual – the infrastructure of the NHS is poor, both in terms of physical buildings and manpower. The work place has changed dramatically over the last two decades especially with the impact of globalisation and whilst many businesses have been transformed with the modern technologies, the NHS is still playing catch up. Not many businesses would run a corner shop the way we run some of our hospitals – with poor administrative systems. There is the almost daily struggle of finding beds to admit patients and then place them in inappropriate accommodation in Nightingale wards or mixed wards. The intense politicisation of the NHS and the blaming of doctors by politicians seems ironic given that whilst doctors may not always have helped the public they have certainly helped the Exchequer by colluding with implicit ‘rationing’ and by working in sometimes appalling conditions over the last few decades.

Doctors today are also paying the price for the deeds of their predecessors – a case of Fathers’ sins being visited upon the children. Doctors had to fight to protect the health of the public, root out quackery and raise standards of the profession and this is what the last century was about. Of course like everything else in medicine there was a side-effect of this zealous attempt to reform services - the social iatrogenesis described by Ivan Illich. Doctors ended up dominating life but does that mean today’s doctors want that sort of control? I suggest not. Today’s medicine is different and today’s doctors are different. Most doctors today have realised the limitations of medicine – most of the time the work is repetitive and hardly like the excitement of TV dramas. As the saying goes, you are bored 90% of the time and scared to death 10% of the time. They do want to change and indeed have been changing. Doctors today know that they are not gods and do not wish to be responsible for people’s lives.

We have a vicious cycle whereby doctors over the generations have been socialised into a system – they are poorly or ill treated during training, put into rather impossible positions whereby they are required to be not just clinicians but also administrators, economist, researchers, teachers and of course they can not do all this, and certainly not do all these well - and end up perpetuating the bad system.

Cynics amongst you might say: here we go again; another doctor defending the profession and blaming everyone else except the doctors themselves.

I do not wish to exonerate doctors completely. I think doctors have a lot to answer for the current predicament and a lot to do to restore trust – trust with the public, the media and the politicians.

I believe that doctors have not reciprocated the goodwill shown to them by the NHS; the creation of the NHS gave doctors the much needed security of tenure, status and money. One would be hard pressed to think up of a better alternative to organising health care than the NHS but where has been the holistic GP, focussing on prevention, and where has been the consultant, as the guide of the GP. I have a story from the time when I first came to the UK. An older consultant pointed out that he started all his letters to the GPs by thanking them for asking him to see their

patient (the patient belonged to the GP and he was there to be consulted) and when he went to the wards, he took the ward sister's permission to enter her ward to see the GP's patient.

In my naivety, few years ago at the Local Medical Committee (LMC) meeting, I had suggested that routine pre-admission assessment for fitness for elective surgery at hospital was unnecessary in the NHS since the GP, as the holistic carer, should have the information and also is best placed to do this. Why did we therefore need to invest in such services and indeed inconvenience patients. It was months before I regained any credibility.

This was not helped by the fact that I had also undertaken some analysis and argued for common (pooled) waiting lists rather than surgeon specific lists for routine procedures – a practice which is still not mainstream.

And that to me was the essence of the NHS – a holistic doctor, the GP, supported by the consultant and patients cared for by nurses who ran the wards, and working together in teams.

Alas, this was a mirage, as I discovered subsequently. The primary: secondary care divide between GPs and consultants has been a major fault line in the NHS. Indeed, with the growth in specialisation, the divide has further deepened. Sometimes I feel that doctors are busy 'fighting' each other across this chasm rather than joining forces to overcome other elements that are also slowing down progress in the NHS.

Overall, in pronouncing their verdict I would like the judges to bear in mind two rules:

1. Let you who is without sin cast the first stone – If ever I could afford indiscretion I could tell harrowing stories about managers and politicians, for example. Indeed, most of the charges against doctors are similar to the charges made against many other providers of welfare and professionals like teachers, police, lawyers etc. Are doctors really that bad? Or is it just a general trend, and not just in the UK but worldwide?
2. Pass proportionate sentence and rehabilitate the offender. This is a crucial point because I do not believe that the question is whether we need doctors; we have always had 'doctors' and will always need them. Because at the heart of being a doctor is 'helping'. Lantos in his remarkable book tells it like this –

*Medicine today is facing many problems, many changes. Doctors fifty years from now will do things that we can not imagine, just as we do things that our forebears would have found miraculous. There may not even be doctors as we know them today. And yet, doctors today do some of the same things that doctors have always done and will always do. That permanence, it seems to me, has nothing to do with science, nothing to do with technology, nothing to do with whether we work in fee-for-service solo practices, HMOs, the British NHS, or the Veterans Administration. It doesn't have much to do with tort reform, managed care, or 'safe havens' from conflict of interest legislation. And, oddly enough, it doesn't even have much to do with whether what we do works or doesn't work. Instead, it has to do with whether,*

*like William Carlos Williams, we nurture the capacity to respond to “the haunted news” we get from “some obscure patient’s eyes.” No matter how good our science gets or how our health system is organized, someone will always have to do that.*

In passing judgement, we must make sure that we do not destroy this capacity to respond – we do not alienate doctors too much, there is enough ‘haunted news’ in society.

If I was asked about my verdict, I would say that judging whether doctors are Hippocrates or hypocrites is a futile exercise - there have always been and always will be good and bad doctors.

Doctors are ultimately both: Hippocrates and hypocrites. And this is because they are both: victims and perpetrators. They are victims of a less than perfect science and a societal system that demands zero risk and zero tolerance. They are perpetrators of the ‘crimes’ charged against them. Although things are beginning to change, doctors generally are not yet sufficiently patient centred. There is a long way to go before quality improvements, good communication and tolerance become hallmarks of the profession as a whole. But that can not happen without changing the system – doctors and society are inextricably linked; each informs the other.



## Part Four: Where next? Hippocrates?

How can we then meet the challenge posed by Dr Milroy - To promote the advancement of medical science along with the interests of philanthropic benevolence and of social welfare? Where do we go from here? What do we need to do and who should do it?

Given that doctors and society are inter-dependent, a useful start may be to understand what is happening in society. Clearly this is the information-age, we are all part of the global village, technology and scientific advances are occurring at break-neck speed, and the gap between the rich and the poor is widening. Globalisation is taking its toll in environmental changes. Social support systems, particularly the family structure, are disappearing. All in all - too much change and too fast.

However, despite all these, it seems to me that the underlying societal context over the millennia has remained remarkably constant and it is that:

1. Society needs doctors. In any profession there will always be 'bad apples' – and doctors are not alone. Perhaps the distribution is a bell shaped curve with the two extremes being the 'bad' and 'great' while the middle is good enough.
2. Social and health Inequalities are inevitable – the poor have always been with us. Almost all graphs in health show inequalities and apart from the rare conditions, which have been largely eradicated, there are gaps because of some characteristics: socio-economic grouping or ethnicity for example
3. People have a tendency to 'self harm' through 'recreational' agents – opium, tobacco, drugs and alcohol at various times in the last few centuries have been labelled the culprits. But the products are only the superficial manifestation of the underlying tendency.
4. Powerful interest groups will try and dominate people – monarchs or despots, religion, business, politicians or professional groups will try and dictate terms. Doctors have been very powerful in this regard in the last century and were at the forefront of medicalisation of life.
5. Those who have will want more and faster – some may blame Margaret Thatcher for the breakdown of society, and exposing greed, in Britain, but all she did was anticipate where we were headed, and maybe speeded it along. At heart, human beings are competitive and look after number one.
6. Overall resources will always be limited and choices have to be made and different people will make different choices – we do not all value health the same - I am not victim blaming and do acknowledge that circumstances play a part.
7. Professional group behaviour is different to individual behaviour – organised medicine is about protecting turf and wants changes on its terms; it will also generally fight what it will see as its 'rogue' elements. Semmelweiss and Codman are two examples of doctors who were ostracised by their peers.

8. Our behaviour and standards change over time – biological warfare despised by the western world now was practised by it only a few centuries ago. Sir Jeffrey Amherst, commander in chief of the British forces fighting a North American Indian uprising wrote to Colonel Bouquet “*Could it not be contrived to send the smallpox among those disaffected tribes of Indians?*” And as Lantos observes, sitting in his hotel room in California, how times have changed: “*You can watch porno in your hotel room but may have to go into an alley to smoke a cigarette!*”
9. In the end there are only a finite number of permutations and combinations when it comes to providing health care, and we can keep going around in circles. The debate about the DTCs and the private sector is not new – the Victorian health care system was just that, does ‘skill mix’ bring back memories of apothecaries?
10. And most importantly, as time goes, we do make progress although breakthroughs happen infrequently. The human spirit of enquiry coupled with a desire to help fellow human beings keeps the world going. Things have improved in many areas of medicine: medical education and training, research governance, emphasis on quality are all examples of improvements and, often driven by doctors.

Of course I am generalising but it is important to look at these trends without getting into details of specifics. And therefore it seems to me that our calls for less ‘political’ interference, some stability, enough funding and public’s understanding etc will go unheeded. Politicians will keep pushing, the public will keep demanding and the media will keep probing and, we are in for a very turbulent time.

There is a conundrum now – how to reconcile aspirations of the society with the aspirations of doctors and how to reconcile rhetoric with reality. The society, and that includes us, aspires to a 24/7 service where doctors work in teams, provide risk free and affordable health care and are held accountable. Doctors, on the other hand, are also seduced by the life beyond work phenomenon and want Monday to Friday 9-5 jobs, want to provide personal care, want society to understand the uncertainty in medicine and give appropriate financial reward and have professional autonomy.

Einstein is supposed to have said “*The thinking that got you into this mess is not going to get you out of it*” and “*Knowledge without imagination is useless*” .

And we can see the evidence of the latter. Take technology for example, there have been relatively few new basic discoveries: the genetic revolution is building on Watson and Crick’s work in the 1950s and the information technology is based on the computer chip and web which were available decades ago. What is different, however, is that entrepreneurs have combined this basic knowledge with their imagination.

The big question facing us now is: how can people become and remain healthy? Health as defined by the WHO - a complete state of physical, social and mental well being and not merely an absence of disease or infirmity - is not just due to health care but is dependent on a range of factors: education, employment, housing, transport, policing for example.

In the global village the division is no longer between developing and developed countries; rather the division is between those who have and those who do not have. Those who have are the go-getters, the sophisticated and who can find their way whilst those who do not have rely on others, the state, to look after them. And the thing that makes the difference is education – if we are really serious about health inequalities we would ask for more money to go into education. As big business and the media try and control our minds more and more – to dumb down the masses – proper education, not schooling, to discern right from wrong and to help decide what is important for the individual will be crucial.

And here is my bombshell: I believe that the NHS itself is in danger of becoming the cause of health inequalities. Consider this for a moment: the extra money coming into the NHS is at the cost of depriving other public sectors. As a citizen I see the lack of such disinvestment everywhere: in dirty streets, crime and fear of crime, lack of educational infrastructure, poor quality housing and inadequate public transport. At the same time, I am not convinced that everything that we do in the NHS is justified. The current organisation of the NHS is less than satisfactory – I am not into manager (or any one else) bashing, most of whom also work hard - but how is it that we took down 100 health authorities and created over 300 PCTs (along the same lines) and have gone from 9 regions to 28 SHAs, in England? Not to mention the plethora of national agencies. Of necessity, the bureaucracy has increased. At a recent meeting to discuss management of a serious clinical incident involving a review of thousands of case notes, I noticed four communications people and not a single analyst who could help put together an incident management system!

And rather than get in there and inform discussions, doctors are becoming disillusioned and disengaged. Kazuo Ishiguro in his book 'The remains of the day' describes the perfect butler who remains focussed on his job, oblivious to everything else around him, and totally unable to engage meaningfully with the housekeeper. Can it be that doctors have become that butler? Can it be that like the butler who 'fights' off all advances from the house keeper, doctors are unable to work with others including managers and form more productive relationships, and have fulfilling lives?

Of course, the system distorts 'priorities' but not all of them; there is still a lot that doctors can influence in terms of service provision and quality improvement. Doctors can inform better use of the limited resources. I am not sure how much I should labour the point about lack of evidence (I acknowledge that lack of evidence does not mean lack of effectiveness) for most of what doctors do – medicine is as prone to fashions as any other profession and doctors have often done things because they can be done rather than that they need to be done. My favourite example concerns tonsillectomy. In a survey in New York in 1935, 1000 school children were examined, 61% already had a tonsillectomy. The remainder 39% were examined by a group of doctors and 45% were advised tonsillectomy. The remainder were examined by another group of doctors and 46% were advised tonsillectomy and this happened a third time. By then only 65 children were left who had not been advised the operation. The researchers ran out of doctors to send these children to for re-examination and stopped the study! At a recent meeting of orthopaedic surgeons, delegates were asked why surgeons had abandoned Charnley prosthesis (one of the best and a very cost-effective implant for hip replacement); 48% said 'victims of

fashion' and 19% said: 'surgeons repeat mistakes of history'. Another meeting concluded that 'quality control of surgeon may be more important than that of the implant'. Skrabanek and McCormick and Fido's books on the subject are very sobering reads about how prone doctors are to fashions.

Doctors write about technology abuse – the most recent example in the BMJ being the debate on VOMIT (victims of modern imaging technology) - but seem unable to control its frightening march.

Doctors can stop resisting attempts to measure and improve quality – two recent Endpieces from the BMJ are very sobering in this regard.

*Recertification of doctors in 931*

*"After the sensational death in 931 of a patient in a Baghdad hospital all 860 medical practitioners in that city were re-examined; 100 failed."*

*Hospital League Tables 1830*

*"Were such reports of the various hospitals throughout Great Britain annually published, and the amount of expenditure given, a comparison of them would produce economy in several departments. It might induce the medical officers to be more anxious to dismiss patients, as soon as compatible with the strength of the convalescents, and to be more scrupulous in admitting slighter cases of disease, while the comparison of the expenditure for each patient would produce enquiry into the causes of its being higher in one hospital than another, and the administration of hospitals would thus be conducted on better defined principles than at present."*  
*From Thirty fifth annual report of the Glasgow Royal Infirmary for 1829.*

Millenia later we are still fighting revalidation and centuries later there is limited attempt by doctors to engage in value for money discussions and in matching resources and needs – it is somebody's else's problem.

I disagree. I believe that doctors have a responsibility to sort out the current problems facing the health care system. They should not be passive recipients of what the NHS through politicians and managers dishes out, they must actively steer the agenda and not wring hands or pass judgements from the sidelines. After all, we helped to create this situation – the medicalisation of life that occurred over the twentieth century was driven by doctors.

As Illich wrote *"Medicine has the authority to label one man's complaint a legitimate illness, to declare a second man sick though he himself does not complain, and to refuse a third social recognition of his pain, his disability, and even his death. It is medicine which stamps some pain as 'merely subjective', some impairment as malingering, and some deaths - though not others - as suicide. "*

He went on to write *"Like all other major rituals of industrial society, medicine in practice takes the form of a game. The chief function of the physician becomes that of an umpire. He is the agent or representative of the social body, with the duty to make sure that everyone plays the game according to the rules. The rules, of course, forbid leaving the game and dying in any fashion that has not been specified by the*

*umpire. Death no longer occurs except as the self-fulfilling prophecy of the medicine man."*

Doctors need to undo the wrong doings of the last century, they need to create new rules – rules that ensure medical advancement as well as social welfare. Some of it is already happening as younger doctors are recognising the limitations of medicine, making sure that they also have a work:life balance and because it is becoming personal now. We are now feeling the shortcomings of medicine and the NHS as we need care for our families and friends and find it wanting. Most of the people I talk to can relate stories of neglect. Almost every issue of the BMJ has something personal in it that confirms how short we fall of the standards we want for ourselves. Bill Kirkup in a Personal View column in the BMJ in August 2003, described the treatment given to his mother and wrote:

*"I can't help feeling that we have lost something of the art of medicine in a headlong rush to embrace the science. .... But quality of care in this instance could so easily have been improved significantly at no cost – in fact with a clear saving of time and money. If this tale really is commonplace across the NHS the implications must be considerable. I hope that it is not too late to listen to this particular patient."*

Many of us are worried about end of life decisions – as citizens we want more control over what happens to ours and us.

We are currently in a vicious cycle whereby relentless advances (advances do not always mean better or needed) in medicine and technology are widening inequalities and reinforcing the dependency of people. The more medicine we give the more people will take, and need, it. There is an infinite demand and we are heading towards a pill for every 'ill' and surgery on demand. We need to break this cycle, for the sake of our patients and for our own sake.

Maybe the time has come to define limits to health care. When the NHS was set up we did not have the plethora of interventions that we have today. Is the current NHS relevant in the new millennium. Will modernisation and public-private partnerships solve the problems? I think not, unless we redefine the meaning of health care and its limits especially in a state funded system. Let me share my thinking like this. Surely, in a civilised society, we can all agree that everyone should get bread and not go hungry. But bread comes in different varieties, you can get a 10p loaf or a £2 brioche. Now how do we decide which sort of bread everyone should get – should it be that the basic loaf is the societal responsibility but beyond that it is up to the individual? Why should everyone be entitled to the most expensive especially as more and more health care is about managing expectations? What is the purpose of the NHS: Is it to ensure that people are healthy or happy? Why do not we establish what are the most essential elements of health care – a basic package of care – and ensure their universal availability, and leave the rest for people to choose? Different people want to make different choices about their quality of life and what makes them happy after all.

We make this into a highly emotive issue by talking about Rationing – Bread or Brioche is not rationing in its strictest sense, bread is about life, brioche is happiness.

Of course, with further advances in science and technology, especially genetics, tissue reengineering and nano technologies, we will come to rationing.

Richard Dawkins has coined the term 'meme', by analogy with gene, to describe a selfish, self-replicating idea, one that survives and evolves through generations. Could it be that today's society has a meme, which keeps promoting this idea that more medicine means more health? Would more money into NHS really improve health? Could it be that More is Less is the new breakthrough and doctors need to point out the fallacy?

This is a defining moment and history will judge us by what we do. It is important that we stop and consider whether what we are doing is relevant now. We need to move from the *Primum non nocere* (First, do no harm) mode to *Primum bonum faceri* (First, do good) mode. If we keep practising medicine as we have been doing we are creating more harm to society generally, by taking away individual responsibility and creating dependency and depriving people of other essential services. Doing good means being imaginative, thinking differently and getting involved. It also means being passionate –passionate for change and continuous improvements. Being a doctor is a very privileged position and comes with responsibilities – we must take the heat just as we take the good times – and work for a better society.

Doctors in the last millennium are remembered for major discoveries and advances in science and technology. Doctors in the new millennium should be remembered for their leadership, their humanity and for enabling people to achieve and maintain health. Let us rise to the challenge – Dr Milroy would have expected nothing less.

## Conclusion

Since being selected I have often wondered how to add value to the discussions about health care provision and the role of the doctors and whether the timing is right. There is too much talk already. Looking at the recent list of lectures at the College there have been at least two on the same theme and the general mood is rather militant. I also feel that what may be coming across as apathy or arrogance from the profession is perhaps the increasing self doubt amongst doctors and the feeling of injustice – may be the society has pushed doctors too far and needs to back off. After all, many doctors are already promoting major reforms in various fields of medicine. Surely the job must be to support these people and find ways of speeding up the changes rather than create further antagonism. It is important therefore to keep things in perspective and provide a balanced account.

If I have given some sense of being critical of doctors then it is partly because I feel it is deserved and partly because of a feeling of responsibility. Lest I am accused of casting stones I should admit to making my share of mistakes during my career, not all of which I can blame on the system or on others. By way of an apology, I should mention that I have not forgotten the mistakes, the price of being a doctor sometimes is too high in terms of recurring nightmares. I also believe that despite the media portrayal the public still trusts doctors and doctors can and should provide leadership in a world that seems to be spinning out of control.

Regarding the timing issue, at the start of the new millennium, we are at the crossroads. On the one hand, advances in science and technology have the potential to help people live longer and enjoy a better quality of life. On the other hand, globalisation has taken its toll: societal and health inequalities are widening and health care costs are rising. Events of September 11, 2001 perhaps have underscored the cross roads and serve as a reminder to do what we have postponed for some time. And that is, to reflect on where we are going as a society and how to improve health and ensure good quality health care provision in the new millennium. So the timing is right.

Whilst preparing for the Lecture I was advised to say how I saw, and felt, things and not to sit on the fence and, if I got it wrong I should apologise. Well, I have certainly done the first one and in case I got it wrong I also apologise.

Thank you for the honour to give this year's Milroy Lecture.

## **Acknowledgements**

The Milroy Lecture was an opportunity to seriously review the subject and whilst I could not devote as much time as I would have liked I also realised that there will never be enough time to study the subject, the volume of material available is vast.

I am very grateful to many people for their help with this Lecture and at the risk of forgetting to mention some people, for which I apologise, I would like to thank the following: Julie Anderson, Ian Bogle, Roger Burrows, Graeme Catto, Iain Chalmers, Michele Cossey, Don Detmer and Amber Batata and their colleagues, James Le Fanu, Bill Gillespie, Dick Heller and his colleagues, David Johnson, Alan Maynard, Joe Neary, Sarah Nettleton, Trevor Sheldon, Karen Smith, Michael Worboys, and John Yates. None of them is responsible for any shortcomings in this paper; that fault is mine alone. My PA, Gail Addinall, has been a pillar of strength at work.

I dedicate this Lecture to my wife, Lisa, for her love and support over the years and to our children, Tara, Aaron and Ryan – sorry guys for not being there very often.



## Further reading

The following is a list of the various books that have influenced my thinking. I have not included any of the official reports like the Kennedy Report on the Bristol Incident, for example, or many other published papers, especially in the BMJ and JAMA, that have also influenced me over the last decade.

Ernest Codman was rather sceptical of publications by doctors and called them advertisements. On the other hand, I feel that some publications can give important insights into the person. So, for those who wish to know more about my philosophy, you may like to review my Professorial Lecture: "From Hips to Handles – The Quest for Better Orthopaedic Care"; it can also be downloaded from [www.emusk.tees.ac.uk](http://www.emusk.tees.ac.uk)

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