that had stopped the problem being confronted. In the case of a gynaecologist, Rodney Ledward, whose poor standards of care and arrogant behaviour led to his being struck off the Medical Register by the General Medical Council, the subsequent independent enquiry catalogued the wrongdoing but also pointed to deep-seated cultural problems and described doctors as behaving as ‘gods’. Many other incidents of poor practice around this time were characterized by a seeming reluctance to bring the problems to the surface and deal with them. Problems of poor practice often presented with a major adverse event but when the chronology was clear, there were earlier concerns that had been ignored or inadequately addressed.

Shaw made little attempt to sympathize with, or understand a profession which sought to protect its ‘bad apples’. He tarred all with the brush of conspiracy. In reality, whilst closing ranks was part of the reason that poor clinical practice continued to be so badly dealt with even with the advent of the NHS, there were human and bureaucratic factors at work as well. In the small closed social world of a local hospital or practice, concerns about a doctor’s standards of practice create great conflict for those involved which they can find difficult to reconcile. The instinct to think the best of a professional colleague, the wish not to appear vindictive, and the thought that, ‘there but for the grace of God, go I’ are often reasons to hesitate rather than to blow the whistle. Inflexible and daunting disciplinary procedures have also been a barrier to action.

The medical scandals in the British NHS in the late 20th century did not amount to a conspiracy to hide shortcomings but they certainly were a watershed in professional and public attitudes to poor practice. They put the concept of professional self-regulation under the microscope. They forced reform of the traditional NHS approach to weak clinical performance. They led to a widespread acceptance within the medical profession that the power of the patient—the ‘laity’—must become the dominant one in the provision of health care.

If he sat in judgement today on these changes, Shaw might be impressed by the extent to which the medical profession and the health service has become much less tolerant of poor practice and much more open and pro-active in dealing with it. Moreover, the protection given to the ‘laity’ through clinical governance and the statutory duty of quality would perhaps have removed any lingering doubts he may have had about conspiracies. His logical and analytical mind would also surely have appreciated the evidence and the experience that demonstrates the much greater relevance of weak or dysfunctional systems in provoking medical errors and lapses in standards of care than the actions of individuals. He might also have approved of the major role that public health—the only strand of medical (as it was then) practice that he viewed benevolently—is playing in modern health services around the world.

References


Commentary: A very Fabian dilemma

Julian Tudor Hart

Alick West described George Bernard Shaw as ‘a good man fallen among Fabians’, a view well illustrated by the well-known but now seldom read preface to The Doctor’s Dilemma. It reveals both the best and foretastes of the worst of that eclectic philosophy, now being applied by a Prime Minister for whom Fabianism provides his only reputable historical reference.

The Fabians rejected systems analysis, believing that progress depended chiefly if not entirely on dripping sound advice into the ears of the powerful, seizing whatever opportunities for this that might arise. Though vaguely aware that the powerful attended these drippings into one ear only to the extent that
they heard hammering on the gates through the other, the most typical Fabians—certainly the Webbs—were always at pains so far as possible to diminish the alarming noises from hammering, so that their own reassuring whispers might be heard.

To his honor (we owe it to him to use his reformed spelling) George Bernard Shaw was never typical. He welcomed the hammering, was ready himself to shake the gates alongside anyone else willing to do it, and never shared either the snobbery of the Webbs or the self-importance of HG Wells. But though he admired systems analysis, and Karl Marx as the greatest analyst of all time, he never accepted a systems approach for himself, his penetrating criticism being fired always from an eclectic, opportunist standpoint, favoring wit over logic or consistency.

Through his activity from 1897 to 1906 first as Vestryman, later as Councillor in the London Borough of St Pancras, then as now a down-at-heel centre of railways and prostitution, Shaw learned a lot about real lives. Beavering away on its Health, Lighting, Housing and Drainage Committees alongside Methodist minister Ensor Walters, he strove to ‘push the rates up and keep the death rate down’.1 He had a close, unscholastic knowledge of poverty, and hated it with a constructive passion. The most interesting section of his preface to The Doctor’s Dilemma shows how Shaw, almost alone not only among his contemporaries but even among later observers right up to Collings2 in 1951, had a sympathetic and informed understanding of despised doctors serving despised populations in the inner cities, not as Mother Theresa or Albert Schweizer celebrities, but as perceived failures in their profession. This is missing from the parts quoted in this issue of the International Journal of Epidemiology, so here is its most important section, describing the relation between the scientific education received by medical students, and the constraints within which this had to be applied by working general practitioners (GPs) in the real conditions of 1911:

The only way [the GP] can preserve his self respect is by forgetting all he ever learnt of science, and clinging to such help as he can give without cost merely by being less ignorant and more accustomed to sick beds than his patients. Finally he acquires a certain skill at nursing cases under poverty-stricken domestic conditions, just as women who have been trained as domestic servants in some huge institution with lifts, vacuum cleaners, electric lighting, steam heating and machinery that turns the kitchen into a laboratory and engine-house combined, manage, when they are sent out into the world to drudge as general servants, to pick up their business in a new way, learning the slatternly habits and wretched makeshifts of homes where even bundles of kindling wood are luxuries to be anxiously economised.3 That paragraph describes accurately enough the situation I, and colleagues of my generation, found when we entered the National Health Service to serve inner city and industrial communities in the 1950s.

Shaw worked harder to acquire some scientific literacy than the immense majority even of his medical contemporaries, to say nothing of his literary colleagues. He was a close friend and assiduous student of Karl Pearson, founder of British medical statistics. Shaw’s judgement was often wildly wrong, as his polemics against bacteriology and immunization in the Preface amply show: but so, and more disastrously, was the judgement of Karl Pearson and other pioneers of imperial sociobiology, leading directly to the Eugenic policies of Germany, Sweden, Australia, and many States in US between the first and second world wars, and the attitudes I heard from most middle-class adults in my English childhood in the 1930s. Unlike these, he had enough personal concern and compassion for real people in real places to pause at the brink, and think again about where all this was leading. This shows in his useful advice on the difficulties of trusting to medical honor and conscience:

Doctors are just like other Englishmen: most of them have no honor and no conscience: what they commonly mistake for these is sentimentality and an intense dread of doing anything that everybody else does not do, or omitting to do anything that everyone else does.4

It might be more useful for British medical graduates to learn that paragraph by heart and consider how they personally intend to preserve their honor and critical, imaginative conscience against pressures merely to conform to current convention, than to recite whatever mutilated mistranslation of the Hippocratic oath their medical school may have chosen. And no student, nor any teacher, can be regarded as properly educated, who has not read and internally argued with Shaw’s Preface. Writing to his friend Mrs Patrick Campbell he described his play as a warning.5 We need it.

References

4 Ibid, p. 16.