Science, society and the perplexed physician

Lord Turnberg

ABSTRACT — In a time of changing attitudes to science and medicine, Lord Turnberg asks whether there is a future for the physician. The population has never been healthier, but, paradoxically, the public seems to be more afraid than ever of death and illness. As more information becomes available in the public arena, anxious patients want certainty when choices almost always have to be offered in the absence of certainty. The author speculates that in this brave new world the need for physicians will increase rather than the reverse. However, physicians must recognise that effective communication, empathy, and compassion are as essential to their role as scientific knowledge and understanding.

Imagine it is the year 1600, just four hundred years ago today. Elizabeth I is on the Throne, Cromwell is one year old, Shakespeare has just written Hamlet, the population of England and Ireland is around five-and-a-half million people, and William Harvey, twenty-two years old, is studying in Padua for his Doctorate. It is there that the great anatomists were revealing the structure of the human body, and there that the mysteries of the heart and circulation were beginning to take Harvey’s attention. By 1615 he had all the evidence he needed to demonstrate the way the blood circulates around the body, pumped by the heart.

But about thirteen years later, when he ‘rushed’ into print, his discoveries were greeted with some indifference and it took many years for his ideas to be accepted.

Part of this indifference was of course due to the fact that there were no obvious practical, beneficial, outcomes from his findings. Neither Harvey nor anyone else had any idea about the manifestations of heart failure and it was to be another hundred years before it became possible for anyone even to measure blood pressure, and over two hundred years before the clinical value of his findings became clear.

So it seems that scientific discovery — profound as it may be, and which nowadays would be heralded as a breakthrough — is often initially handicapped by surrounding ignorance, limiting our ability to understand and take advantage of those findings. So when I look at what the future holds for doctors and patients, as I intend to do, I hope you will understand why I do not put a time scale on the sort of predictions I will make.

The title of this Oration includes the phrase ‘the perplexed physician’. Perplexity seems to characterise the state of mind of many of my beleaguered colleagues — not only here in the UK but elsewhere around the world — and derives from the rate of change in the climate in which we work. The need to cope with the expanding fields of science and information technology at a time when society itself is also changing rapidly, in ways which are not always beneficial, is stressful for many.

This is not a novel concept. In 1856 Karl Marx wrote:

on the one hand there have started ... industrial and scientific forces which no epoch of ... former human history had ever expected. On the other hand, there exist symptoms of decay far surpassing the horrors recorded of the latter times of the Roman Empire. In our days everything seems pregnant with its contrary.

Do patients need physicians?

The changes are influencing the tools of medicine, the drugs and technology, but also the ways in which it is practised. All of this, coupled with the fact that physicians are never far from the firing line and criticism of almost everything we do seems rife, has led to a sense that we have lost control, if ever we had it, and not just of what we do for patients. As patients have increasing access to home diagnostic, near-patient, tests, and the Internet provides them with all they will ever need to know about their diagnosis and treatment, who will need physicians? Is it beyond belief that physicians will become largely redundant before the end of this century? I hope here to offer a little reassurance that physicians will continue to have roles to play — perhaps not the same roles as now, but important and distinctive ones nevertheless. However, the fact that I feel obliged to even raise this spectre suggests that there is little room for complacency.

I intend to discuss the impact — on patients and on doctors — of the remarkable advances in science on the one hand and, on the other, the no less remarkable effects of the shifts in society, and how these simultaneous changes are likely to affect patients’ need for physicians.

I hope that advanced thinkers will forgive me for using such an archaic term as ‘patient’. I do so only because I perceive a clear difference between patients and clients — customers or mere users of the service. The word ‘patient’ suggests a certain vulnerability which is missing from the customer/supplier relationship and poses an extra
requirement from that relationship. I shall return to this because it seems to me that, paradoxically, the more information there is available in the public arena, the more vulnerable and anxious people have become.

So my thesis will be that doctors will turn back to the basic characteristics which have always been required of them: to be caring individuals with a broad-based knowledge of human behaviour, both physiological and psychological, and who know how to weigh all the evidence in the balance in which a specific patient sits right at the fulcrum. Let me explore why it is possible to reach this rather less than revolutionary conclusion by examining the two major forces, scientific progress and societal change, which are having such an impact on physicians and our activities.

I happened recently to be sitting on a platform with a prominent politician who was saying some rather less than complimentary things about scientists for one or other of the many reasons for which they are so frequently berated. Then, noticing that I was sitting next to him, he kindly said: 'Oh, of course he's alright, he's a doctor.' I was not quite sure whether to take this as a compliment for not being a scientist, but I suppose, like most politicians' remarks, you can take them to mean what you want them to mean. But the serious question is: where will the doctor sit in relation to the march of science?

**New science**

Of course making predictions in the medical sciences has always been fraught. Who would have thought twenty or thirty years ago that duodenal ulcers were caused by an infection in the stomach and that you could cure them with a short course of an antibiotic? At the time I graduated, to have predicted that we would be able to eradicate polio from much of the world, to transplant organs, to replace joints with prostheses, or to implant hearing devices in the cochlea, would have required extraordinary perception. So predicting what medical science will bring us in the next twenty, thirty or forty years must be equally fraught. I think Kierkergaard got it right when he said: 'Life has to be lived forward but can only be understood backward.'

Nevertheless, the direction of change is clear and the scientific community is eagerly anticipating the fallout from the human genome project, which was announced with such a beating of drums earlier this year. I suspect that, like me, you have heard more than enough about the marvels this project is going to bring us, so I will not dwell on them but highlight some of the more realistic aspects in so far as they are likely to impinge on the need for physicians.

An understanding of individual genetic variability, derived from knowledge of the complete human genome, will enable us to understand the genetic basis of disease. Leaving aside the defects in obvious single gene diseases — cystic fibrosis, Huntington's disease and the like — knowledge about the multiple genes, which increase susceptibility to many common diseases, will become available; these diseases include diabetes, cardiovascular disease, hypertension, cancers and mental illness as well as immunological and even infectious diseases. It is becoming increasingly clear that there may be an infective basis for a number of common diseases, including some cancers and cardiovascular disease. Genetic susceptibility to infection and reaction to infection is a fascinating and potentially rewarding area of work.

In addition, the genetic basis of behavioural and psychiatric disease might also become clearer.

That type of information about the anatomy of the human genome provides us with a basis for diagnostic and therapeutic targets. The pharmaceutical industry is investing heavily in pharmacogenomics, not only in a search for these new targets but also to explore the genetic basis of the variability in patients' responses to drugs. Hitherto, major advances in therapeutics have been achieved by utilising what is known of receptors on cell surfaces, and designing drugs which either stimulate or block the actions of those receptors. There are several hundred types of receptors, but this figure pales beside the several thousand different peptide or protein products of specific genes which are themselves potential new drug targets. This enormous expansion in the potential for therapeutics is stirring the dovecotes of the pharmaceutical industry. The new sciences of post-genomics and so-called proteomics are opening up as it is increasingly recognised that knowledge of the genes themselves is but the first step. We have ahead of us years of scientific endeavour as we try to understand what these genes actually do, what proteins they code for and how they in turn work.

Understanding the genetic basis for variability in responsiveness to drugs will allow us to target drugs to those who are likely to respond best — and of course avoid giving those drugs to patients who are genetically predisposed to suffer adverse reactions. Knowledge of the relevant genes in the population at large would then allow the very focused prescription of drugs to specific individuals within that population.

If we now combine this type of information with advances in microchip and information technology we have an extraordinarily powerful set of tools. Microchip technology has advanced at an awesome pace and it is now possible to utilise it in a range of genetic and diagnostic tests. On the diagnostic front, a GP faced with a patient with a sore throat will be able to tell immediately whether or not it is due to a streptococcal infection by using a simple test strip placed in the saliva and, furthermore, will know what subtype it is and its antibiotic sensitivity. It will soon be possible to test patients with a febrile illness to see whether they have influenza or not by using a simple bedside test.

Near-patient testing will undoubtedly advance rapidly over the next few years and, as a result, the sort of work pathology laboratories will be asked to do is likely to change radically.

These developments will place remarkable diagnostic and
therapeutic tools into the hands not only of doctors, but also of pharmacists and corner shop keepers, and will be available from outlets in railway stations, supermarkets and to patients at work and in their homes.

A single mouth wash contains enough DNA to test for all the genes of interest. It is now possible to send off a mouth wash sample to a laboratory to have it tested, and then receive the result the next day. There are apparently laboratories offering this service already—a woman with a family history of breast cancer can test herself in this way to see if she carries a gene for that disease. Furthermore, it will not be too long before the diagnostic technology is so automated and affordable that it will be available in GPs' surgeries.

What then will be the role of doctors when everyone can make their own diagnosis? It is possible to imagine a time when we will have within ourselves the capacity to delete errors—to self correct diseases—rather like space shuttles seem to do. I understand that top range Mercedes Benz cars can electronically detect their own little errors, diagnose them and correct them while they are being driven. It does not seem beyond the powers of imagination to envisage a situation in which individuals carry with them a data card, containing information about their genetic variations which make them susceptible to certain illnesses, their proclivity to adverse drug reactions and their need to restrict their lifestyles to avoid activities which are particularly risky to them. It is also possible to imagine a situation in which an annual 'ten thousand miles service' will be possible, with a battery of diagnostic tests applied: any detected defects will be managed at a pre-symptomatic stage by relevant adjustments or drugs which by then will be capable of switching genes on or off, obviating the need for improved techniques of gene replacement. This might be thought rather fanciful, but it does not require an enormous leap of the imagination to anticipate such a scenario.

New communication

Then there is the Internet. We now have vast amounts of background information available to everyone, about every illness from which we are likely to suffer. There are now available large numbers of reliable—and many more unreliable—sources of information about the nature of specific illness, the meaning of diagnostic tests and the therapeutic options.

It may not be easy to know which are the best sources of such information, but no doubt in time this too will become clear. At present only the computer literate—admittedly an increasing proportion of the population—have access to it, but there seems no reason why it will not become universally available in the not too distant future, as the means of its delivery becomes simpler and requires less computer know-how. We are also beginning to see commercial concerns providing medical consultations and advice on the web, and it seems likely that this Internet advice will grow in popularity.

So what does all this mean to the man on the top of the space-age Clapham Omnibus? Will he feel secure in the fact that he knows his genetic make up, his susceptibilities, his behavioural characteristics, that he has the ability to detect disorder himself in the fine workings of his body and mind, and furthermore has ready access to information technology which will allow him to take corrective action? And what does it do to the physician who even now feels threatened as the mystique of medicine is lost, and patients, who, armed already with computer printouts, will also have all their test results, diagnostic possibilities and therapeutic options in their hands as they come through the door? Furthermore, a patient will be more intimately and personally interested in the details of his/her health problems and may well have done more research on it than the doctor can possibly hope to match. The ready access to so much information about their illness and its treatment places in the hands of patients a considerable power of self-determination. Hence my question: is there a need for physicians in this brave new world?

I recently asked a group of patients whether they thought there would be a need for doctors in light of these potential developments. They thought for a moment, then one of them said 'Well, I suppose we will always need a second opinion.' I have taken advantage in this lecture of a number of other helpful comments they made. There may also be some hope for physicians because, while this scientific revolution is going on, changes are occurring in society at large which may increase rather than decrease the need for physicians to provide guidance in the role of mentors.

Changing attitudes

Apart from a population which is becoming increasingly knowledgeable, there are two other closely linked societal changes that have the potential to make life difficult for the perplexed physician, and indeed for a perplexed population. Firstly, the trust and confidence of the public in science in general, and in doctors in particular, has been sorely shaken and is at low ebb—at least according to the media. I will discuss later the reasons why the public at large, the silent majority, do not necessarily share this mistrust to the extent that the media would have us believe. Secondly, the public is becoming increasingly averse to risk and, paradoxically, increasingly concerned about its health at a time when it has never been healthier.

It seems that trust in doctors is inversely related to the scientific basis of our practice. We were accorded most authority when we least deserved it. The rising interest in complementary medicine, of which much of the scientific basis is somewhat sketchy, attests to the lack of correlation between public trust and the scientific evidence for what we do. Doctors and drugs can damage your health—so 'magic bullets' are out and 'mystic medicine' is in. Suspicion and mistrust are reflected in the rising number of cases of litigation against doctors, regularly inflamed by the media. Figures from the Medical Insurance Agencies show a steady rise in both the numbers and costs of such cases.
Close examination of the reasons why patients enter into litigation reveals that they focus more on failures of communication than on technical practice. It seems that many complaints would not have materialised if only the doctors had spent more time listening and talking to their patients and showing empathy. Cases of complaint brought to the GMC show dramatic rises over the last five years. It is interesting to note that as numbers of such cases have risen in the wake of the Shipman case, the proportion of doctors found not guilty has also risen, suggesting that the public complains more readily as it becomes more anxious. Of course, high profile cases such as Shipman do not do much to enhance public trust in doctors. On the other hand, if one looks at the annual figures for consultations between doctors and patients and compares these with the number of complaints, the ratio is very high indeed. Table 1 shows the number of consultations in primary care and hospital practice compared with the number of complaints. The ratio is one which I suspect most commercial concerns would be pleased to see.

Furthermore, the public at large seems to recognise this because every poll of the population consistently shows doctors to be top of the pops. The most recent took place after the Shipman affair, and showed that while the media tend to portray medical disasters as small tips of very large icebergs, people who are patients by and large seem to be content with their doctors. Table 2 shows data from the MORI Poll, published early in 1999; they reveal the trust showed by a proportion of a sample population for various professions and groups.

It is important to be aware of the difference in views between patients, the public and the media and not to confuse their attitudes to doctors. Even amongst patients, views differ; those with minimal symptoms or no symptoms at all seem to be the most critical whilst the more serious their illness the more trusting they tend to become. Fit people have the time and can afford the luxury of not caring about the impact of their criticisms, whilst patients who are in pain or desperate for help are vulnerable and anxious to hand over responsibility for their cares and woes to their now trusted medical attendants.

None of this should be taken as grounds for complacency, however. There is no room for that. The recent Channel 4 series on doctors' errors was a balanced but sobering examination of the nature and frequency of errors in hospitals. They are too common for comfort. There is no doubt that some doctors behave badly and others perform sub-optimally, and most of the rest of us are mere mortals who make occasional mistakes. And while the proportion of bad doctors may be relatively small there are certainly sufficient numbers of bad doctors for the media to express their interest and for the rest of us to feel the prick of shame. But all of this has to be kept in perspective. Meanwhile we have to look harder at ways to ensure that we deserve the trust our patients continue to have in us.

Leaving trust and confidence aside, a rather more interesting change is occurring in the public's attitude to risk and safety, illness and death. According to Theodore Dalrymple who wrote that marvellous book, *Mass listeria* 1, the healthier we are the more we fear the risk of ill health, and the longer we live the more we fear death. He suggests that the phrase 'the worried well' characterises modern society. Let me quote:

Death is an anomaly which requires an explanation. It is an injustice. So indeed is illness. Illness strikes without regard to the virtue of its victim and if life turns out to be unfair as it always does, human benevolence must be to blame. Death these days is someone's fault...

When men are responsible for everything, even the existence of death, there is no room for sadness, only bitterness.

He goes on to point out that the universal declaration of human rights suggests that everyone has a right to perfect health.

The WHO definition of health is not merely the absence of sickness but the presence of a state of well-being. The natural state of man, in other words, is not only to be alive but also to be healthy.

**New health risks**

Of course the problem is that we all fall short of that. No one seems to be really healthy. The statistics from the United States are frightening. If you add up all the diseases from which Americans are said to suffer, as in Harry Glassener's book *The culture of fear*, you find that out of a population of 266 million Americans some 543 million have some serious disease — that is, nearly twice as many Americans have diseases as there are Americans. As new

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**Table 1. Incidence of official complaints about NHS doctors**

|                     | Consultations or inpatient episodes (No.) | Complaints (No.) |
|---------------------|-------------------------------------------|------------------|
| GPs                 | 300,000,000                               | 38,000           |
| Hospital doctors    | 67,000,000                                | 86,000           |

Source: NHS Complaints Procedures, 1998

**Table 2. Public perception of the trustworthiness of different professions**

| Profession     | Will tell the truth (%) | Not tell the truth (%) |
|----------------|-------------------------|------------------------|
| Doctors        | 91                      | 7                      |
| Judges         | 77                      | 16                     |
| Scientists     | 63                      | 27                     |
| Business leaders | 28                    | 6                      |
| Politicians    | 23                      | 72                     |
| Journalists    | 15                      | 79                     |

Source: Mori Poll, 1999
risks seem to spring up, so new diseases with new diagnoses come along. Apparently one in eight children in New York is handicapped in one way or another. When they are obese they are suffering from an eating disorder. When they are shy they have a social phobia. When they get poor grades in school they have an academic achievement disorder. Have you noticed the way in which the new disease of sex addiction has reared its head? Apparently 10–15% of Americans suffer from it – if they can be said to suffer. You may not think that this is a serious issue, but the point about having a name for a condition suggests that there must be some cause; there must also be a diagnostic test and some treatment. Everywhere there appear to be risks, dangers and hazards which, despite the evidence seem to be increasing rather than the reverse. Frank Furedi in his book which is also, interestingly, entitled Culture of fear, suggests that risks are everywhere, from listeria in cheese, heavy metals in fish, salmonella in chicken, insecticides and fungicides on vegetables and fruit, hormones in meat, to holes in the ozone layer and GM foods. Conventional crops are being contaminated with GM pollens and organic foods doused in faecal organisms. Where then should we turn to for food?

A survey about people's eating habits carried out first in 1947 and then again in 1996, showed that, while in 1947 80% said they could eat what they liked, by 1996 this figure had dropped to 58%, and the number who said that they had to take care with what they ate doubled from 20% to 41%. Now the chattering classes would not dream of drinking tap water; who knows what is in it? The growth of the bottled water industry speaks volumes.

The safety business is a growth industry. Schools and hospitals increasingly resemble minimum-security establishments. It is difficult to know how we manage to survive. As Ulrich Beck has said: ‘The sources of danger are no longer ignorance but knowledge’. Or as Theodore Dalrymple put it: ‘Information without perspective is just a higher level of ignorance’. Yet somehow we do manage to survive – average lifespans are increasing all the time.

Figure 1 shows the expected lifespan of Britons at birth throughout the past century, and as can be seen, it has risen gratifyingly. One interesting sidelight on this increase in life expectancy was cast by John Bunker: he demonstrated that about five years of the extra life gained by the population has been the result of improvements in medical care, and most of that has occurred since 1950.

What the risk-averse population sees, however, is not long survival but the potential for death. Death rates remain, despite all our efforts, persistently at exactly one hundred percent.

Table 3 gives a list of the major causes of death in the UK, with cardiovascular disease and cancer heading the list. But it is the figure at the bottom, the total, which will always be one hundred percent. The difficulty is that if we somehow manage to cure or prevent cardiovascular disease or cancer, then it is inevitable that the proportion of the other causes of death will rise and perhaps create more anxiety about the apparent growth of these risks.

![Figure 1. Life expectancy at birth, England.](Source: Government Actuary's Department.)

You may ask from where do I derive this idea of a public consumed by anxiety and worry. Well, from the newspapers of course; where else? The reasons why provocative headlines appear are not difficult to understand, since they sell newspapers; that is why newspapers are in business. As newspapers have become highly commercial and competitive they have developed a culture of reporting in terms of ‘the biggest’, ‘the best’ or ‘the worst ever’ – either disaster or breakthrough. A cause for panic sells papers while a cause for peace of mind does not.

Do the media reflect the views of the public at large, the silent majority? Whenever there is a poll of public opinion the results suggest something else, and you will remember that journalists figure pretty near the bottom of the list of people who are trusted (Table 2) – although I do not speak here about responsible medical or scientific journalism. This is not to say that the public is not confused but rather that it tends to reserve judgement and remain uncertain.

**Absence of certainty**

In summary, I can pose a series of paradoxes which form the twin horns of the dilemma facing the perplexed physician. The public is more knowledgeable but more
confused, more informed but more worried, more independent but more reliant on others. People are living longer but are increasingly worried about dying, they are healthier but more concerned about ill health. The environment is cleaner but the public seems increasingly anxious about environmental hazards.

The more they hear about science the less confidence they place in it. The public is ever anxious to utilise the fruits of scientific endeavour in general, and in particular where it leads to new treatments and cures, but they are increasingly mistrustful of science and scientists. The more evidence-based medicine becomes, the more the public turns to complementary and alternative medicine, much of which is not evidence-based. They are more dependent on experts but less trusting of them. The public wants certainty when choices almost always have to be made in the absence of certainty.

Does all this then suggest that there is less need for physicians? I cannot help but believe that, in the face of a confused population, increasingly concerned about their health, the need for physicians will increase rather than the reverse. But what sort of physicians should we become? The sort of patients I have described will require many characteristics of physicians which are unlikely to seem novel. Physicians will certainly need to have a wide range of abilities. Indeed, the major requirements for future physicians will be their ability to bring not only a perspective from an in-depth understanding of their own specialist area, but also, and increasingly, a broader view of medicine and society. One of the chief characteristics will be an ability to assimilate and analyse information and, importantly, to make decisions and offer choices in the absence of certainty. For all those reasons, it is my firm belief that we will need to continue to attract into medicine the brightest young men and women. They will have to be able to sustain the very long training programmes through undergraduate and postgraduate careers to gain the necessary degree of breadth and perspective and a full understanding of the scientific basis of medicine — we are likely to need more, not fewer, of them.

These attributes, though essential, are however not sufficient. It is equally important that physicians are responsive to their patients' needs through communication, empathy, compassion and a sense of partnership, so that patients feel that they have some control of the relationship with their physician. The increasingly confused population, bombarded with vast amounts of information, is likely to need more of those characteristics rather than less. They are equally essential to a deep understanding of the scientific bases of medicine and currently we may be falling short of that ideal, largely I believe because of lack of time. But that is another story.

There is another unique role for physicians: to explain and promote the value of scientific research to a sceptical public. One of the lessons learned from the GM food debacle is that the public is much more likely to accept the ideas of science if they can perceive an obvious benefit to them; in the absence of benefit they would rather not subject themselves to risk, no matter how small that risk is. Much medical research is devoted to offering better treatments or cures for human suffering and can easily be cast in a beneficial light by doctors who, by and large, are trusted more than 'scientists'. Physicians could and should play an important part in helping the broader public to understand the value of science.

Perhaps I could also say one or two words about the 'partnership' between physicians and patients, which is spoken of so glibly. To me this partnership is clearly one of unequals in a number of respects. The doctor, no matter how empathic, cannot fully appreciate the patient's symptoms or suffering, and the patient cannot have acquired that perspective which is in the hands of the doctor. You may remember that great American physician Franz Ingelfinger, the late Editor of the New England Journal of Medicine, who gave a marvellous lecture, published in that journal and entitled 'Arrogance', in which he pointed out that physicians cannot afford to be arrogant simply on the basis of their presumed superior knowledge. But he also pointed out that the greater arrogance was that of the ignorant, who feel that they can pontificate despite a lack of knowledge. He also suggested that, while it is important to be able to offer patients choices in their treatments, a physician could not devolve responsibility for advising on what she or he thinks might be best for a patient. Not proposing what is the best in his or her educated opinion from amongst a series of options would be a derogation of professional responsibility.

But there is another point about arrogance, and that is the assumption that no one else can do anything that the physicians do. It is pretty obvious that many health professionals can do most of the things that physicians do, from offering advice on specific aspects of care to practical clinical procedures; it would be foolish to suggest otherwise. Of course many health professionals also bring their own particular expertise to patient care. I feel quite unthreatened by the prospect of increasing 'skill mix' and 'team working'. Indeed that must be the way forward.

New physicians

But if you are seeking the unique role of the physician, you will have to look at the breadth and depth of the knowledge which allows physicians to bring an overall perspective to individual patient care. This is achieved only through a lengthy and rigorous training programme. Such are the physicians in whom patients will be most likely to place their trust and confidence. If we fail in our knowledge base and if we fail in our ability to communicate in terms that are important to patients, we will certainly lose that trust and confidence. I do not mean here simply an application of what is now termed as 'evidence-based medicine'. There is something missing from that phrase, although the alternative, 'ignorance-based medicine', does not appeal either. The problem with evidence-based medicine is that it ignores the
particulars and the complexities of an individual patient. Sir Theodore Fox, who gave the Harveian Oration in 1965, said 'the human race does not need a doctor but human beings do'. I much prefer the phrase 'evidence-based care': this encompasses rather more of the application of evidence to the complexities of an individual patient and their problems as well as what he or she wants in terms of physiological and social well-being, as much as the physical relief of symptoms. This is certainly not an argument against the use of evidence. It is more the incorporation of quality of life measures which patients recognise and especially the placing of evidence in the perspective of the individual patient.

My conclusion is this: that we will need more rather than fewer physicians in the future, and that the characteristics we have long prized – of combining compassion and empathy on the one hand, with a strong basis in scientific understanding on the other – will need to be encouraged rather than discouraged. Only in this way will it be possible to meet the needs of an informed but anxious population of patients who need help and support as they seek to live longer and healthier lives.

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ROYAL MEDICAL BENEVOLENT FUND

Christmas Appeal

A message from Rodney Sweetnam, President of the Royal Medical Benevolent Fund

Now the season of Christmas is almost upon us and all without regard to race or creed look forward to one of the happiest times of the year – not so for all. Those of us connected with the Royal Medical Benevolent Fund know only too well the sadness that follows unexpected tragedy in our profession. The hardship that may follow seems magnified at this time of year; all the more poignant when young children are involved.

The generosity of JRCPL's readers last Christmas helped your Fund to distribute additional seasonal support of £75,000 to help bring some semblance of happiness and dignity to those doctors less fortunate than ourselves, and particularly their bereaved families. Each year our general grants total well over £800,000.

The Fund always seeks to give this extra help at Christmas with gifts to the children involved. May I therefore ask for your support again this Christmas. The RMBF is very much your fund and for this reason I am taking this opportunity to write to all doctors. I do hope that this Christmas you will decide to contribute to our appeal. Our ability to help depends upon your generosity. To those of you who are already members and all the other doctors who have helped during the year – thank you. On this occasion I particularly thank those of you who send us a cheque for the first time this Christmas.

Contributions marked 'Christmas Appeal' may be sent to the Chief Executive Officer of the RMBF at 24 King's Road, Wimbledon, London SW19 9QN or to the Treasurer of your local guild of this Fund

Thank you