The conclusions and recommendations offered by Professor Maynard and Dr Bloor in their weighty article (November 2003 JRSM1) do not follow at all from the arguments adduced, being contrary to reason.

The authors begin with a plausible account of the efficiency of an informal exchange process based on trust between purchaser and provider and typified by the ideal practice of medicine, wherein to a large extent the doctor acts as agent for his patient. They then argue that the trust between parties that is required for such a process to function has broken down and conclude that it must be replaced by measurable contractual obligations—in brief, by a surrender of medical practice to managerial and political control. These three stages are very much of the nature of a syllogism, and the argument suffers from that frequent fault of syllogisms, the undistributed middle; so let us begin by discussing that ‘middle term’, common to the two premises.

Is it true that trust has broken down? Certainly it has been assaulted by the journalistic media and by politicians, but broken? Surely not. The only direct comment on this question made by Maynard and Bloor subverts their argument because it points in exactly the opposite direction - to whit, that people ‘continue to trust doctors more than most other professional groups’ (perhaps an understatement anyway, since surely we should read ‘any’ instead of ‘most’). Thus in respect of trust accorded by patients as individuals to doctors as persons the second premise is simply untrue, by the authors' own account, and if their related conclusions prove to be false that should be no surprise to anyone.

A greater part of the authors' concern is with another aspect of trust - that between the funders of medical care (here meaning the public purse) and the people who deliver it. In other words, doctors in the public service have not been doing as well as they might and government intends to put that right by regulating medical practice, seemingly without reference to whether doctors are their employees or not. What evidence is cited? Note that the first two items are from about 150 years ago, so of dubious relevance today, and comments are added in each case.

Nosocomial bacterial infection was not dealt with properly until after bacteria were discovered. Semmelweis indeed made sensible recommendations on the basis of an astute observational study, though it proved hard to convince colleagues of the necessity for change until all the necessary facts had been obtained—and note that it was not governments, managers, lawyers, politicians or health economists who made the original observations, nor they who discovered the existence and pathogenicity of bacteria.

Florence Nightingale measured outcomes. But then so also did the official military medical service, and that is how we know that their seemingly inefficient, crude and heartless approach during the Crimean War produced rather better results than Nightingale's, and that is why she changed her methods to those we knew fifty years ago and which have been abandoned recently in favour of a more patient-friendly approach, complete with failures of hygiene.

Medications kill a lot of people in the over-medicated USA. Lack of medication kills a lot more people in other parts of the world.

Medical errors occur during perhaps 5% of hospital admissions, depending on who you read (not distinguishing between error and serious harm and certainly less frequent than driver

errors during bus rides, which similarly do not often kill people).

In several recent cases of bad medical practice or downright evil, someone, and we must presume the authors mean the General Medical Council, showed ‘failure to act on evidence’. In the Shipman case it was the police and the judiciary who failed to act when they clearly should have, and nothing done by the GMC could possibly have detected the man's murderous intentions, nor will regulation help in this kind of situation in future - stupid to think that it might. Anyway, the GMC is not a ‘professional’ but a statutory body. Criticism pertinent to the GMC should be directed at the legislators and regulators rather than at practising doctors.

NHS surgeons vary in how much work they do for their money. The conclusion from the figures presented is that 85% of the surgeons are covered by a mere three-fold variation, which seems staggeringly small considering how imprecise these data evidently are. A cursory inspection suggests that 5% of the surgeons did no work at all, self-evidently due to the inclusion of confounding data.

On this evidence, together with prejudices better suited to demagogic politicians, Maynard and Bloor reach the conclusion that practitioners, whether paid from the public purse or not, ‘should’ have data to describe what services they provide, how much activity relative to their peers, how they provide care including the evidence base, and to whom they deliver care relative to socioeconomic class and population need.

From the evidence presented it would be more nearly justified to conclude that the individual practitioner should do no such thing, since it will occupy far too much of his time for no known benefit. And what about ‘innocent until proven guilty’? And why is private medical practice anything to do with government apart from simple regulation and updating of qualifications? And what about government collecting information in whatever detail it wishes, and charging the expense of doing that to the central budget since it is government that wants the information and not anyone else?

On this evidence the School of Health Economics at the University of York, on which governments have relied heavily for advice, lacks objectivity. Why don't we set out to measure the outputs of managers, lawyers and politicians first—doctors afterwards, when the methods have been fairly tested in those simpler environments?

In addition to all that, Maynard and Bloor refer to doctors' irresponsible insistence on clinical freedoms; make unsupported criticisms of the performance of the Royal Colleges, which they think should be reduced in number to three (but do not explain why they choose three instead of one, nor why we do not combine with the Royal College of Nursing); accuse doctors generally of having no idea of the need for prioritization, cost-effectiveness and ‘rationing’ in medicine, whereas of course that is half of the business of every practitioner; and quote with approval a finding that it was prosperity and public health that improved life expectancies between 1800 and 1950 rather than anything to do with the activities of medical practitioners. That last point, a truism of public health teaching for a century at least, is just beginning to look unsound for the first time in history.

Medicine is concerned with the relief and control of sickness, often but not necessarily with cure; with the individual patient or with society, depending on which hat we are wearing and

often that is two hats together; with precise diagnosis and exactly aimed treatment wherever possible, emotional support and the avoidance of harm where it is not, and with innovation. How on earth do you expect to lump all those things together, with all that they imply, so as to make them controllable by half-witted officials, and why would you want to?

I recommend a system of fast-track entry to medical degree courses, though with examinations of full rigour, for these and all other irrational critics of the profession and its doings. We need them to understand us.

1. Maynard A, Bloor K. Trust and performance management in the medical marketplace. J R Soc Med 2003;96: 532-9 [PMC free article] [PubMed]