

Inspiring Doctors. Episode 12: Nick Black

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Martin

Welcome to Inspiring Doctors, a podcast series brought to you by the British Medical Association. I'm Martin McKee, a professor of public health and the president of the BMA. In this series, I'm joined by people who I see as role models. They've successfully taken their medical knowledge to a wider audience in creative ways.

So what inspired their work? What lessons have they learned? And what advice do they have for young doctors who may want to follow in their footsteps? There is something magical about the confluence of medicine and communication. My interviewees are only some of the role models who do this work, but they are all people who have inspired me. I hope that our conversations will in turn inspire you.

My guest today is Sir Nick Black. Nick trained in medicine at the University of Birmingham and worked initially in paediatrics, including a period in Nepal with Save the Children. He then moved into public health in the Oxford region before working at the Open University, where he designed a highly praised course on health and disease. In 1985, when I first met him, he moved to the London School of Hygiene and Tropical Medicine.

He's perhaps best known for his leadership in the field of health services research, contributing in many ways to its emergence as a distinct area of scholarship. But he also has a keen interest in history, which is what we will talk about today. This interest stimulated him to write a fascinating guidebook entitled *Walking London's Medical History*, and more recently his first novel, *The Honourable Doctor*, a tale based on a true story of intrigue and nepotism in the medical establishment in 19th-century England.

Welcome, Nick.

Nick

Hello.

Martin

I'd like to start with a question that is always asked of people who move into public health. You could have stayed in paediatrics, but you didn't. What was it that led you to change direction?

Nick

Well, I've often thought about this, and I think there are two things to say. The first is that as a medical student, I was fortunate to go to Birmingham University in the last few years that Tom McKeown, the great doyen of public health, was teaching. And after all the clinical teaching we'd heard, McKeown turned up and completely turned the tables and suggested radically different interpretations apply.

The health of the population had improved so dramatically, particularly throughout the 20th century, and I find this fascinating as to the contrast from the almost universal view we'd had

from our clinical teachers. And that, I suppose, was probably working on my own natural iconoclasm and questioning.

And then it all came together when I went, as you mentioned, to work for Save the Children Fund in Nepal for 18 months. I found myself thrust into the position of running a project with about 30 staff, mostly local people. And essentially what I was doing was management and policy making. And looking back, it was actually about transformation of services. I was trying to shift the emphasis from the central clinic out into the villages. I also did a survey, epidemiological survey of child health.

And at some point I had to make the decision – do I come back and go into paediatrics, for which I had a job offer? But by then I realised what I really needed to do was to learn to do what I'd been doing, but properly. So I was sort of teaching myself epidemiology, management, policy making, and I recognised that this was a little bit reckless. I ought to go and get myself properly trained.

So I came back and I made the life-changing decision to switch from clinical, which I'd always enjoyed – I would have been happy being a paediatrician, I'm sure – to public health and then specifically into health services.

Martin

Yes it's strange, isn't it? Because I can remember being a medical registrar and reorganising clinics and, again, making use of many of the techniques that I would later learn about from our mutual colleague Colin Sanderson. But of course I didn't know about queuing theory and operational research at that time, but I was sort of struggling to apply it, and it was only when I came to the school with you that I really understood what I was actually doing.

Well, you once said that the person you'd like to thank most was someone called Peter Watkins, your history teacher at school. Can you say more about how history has influenced your approach to medicine? And here I'd make reference maybe to your teaching, because you have often brought a historical element into it.

Nick

Yes. Peter Watkins' effect on me, again with hindsight, as a 16-year-old during O-level American history – I wasn't aware of the changes that I was experiencing intellectually, and it was a bit like the McKeown effect on me, because what this inspirational teacher taught us was that there was a very different view that could be taken interpreting the past.

Just one example. What was actually the cause of the American Civil War? Well, like everybody else, certainly at that time, it was about the good guys who were against slavery and the bad guys in the South who wanted to maintain slavery. Well, what he showed us was that, in fact, it wasn't... That was part of it, but the main thing was the southern states wanted to retain their independence of Washington, and the northern states wanted a federal approach.

You might notice some similarities with Brexit discussions there. But actually that's what really lay behind it. The slavery issue was obviously of vital importance too. And so, looking back, I think what I got from Peter Watkins was my very first exposure to social science. It wasn't

called that; it was called history. I imagine social science may actually be labelled and taught in schools today, but back in the 1960s it wasn't.

So from then on I always had an interest in history. And coming more up to date, I think it was the realisation that whilst we accept that if you want to understand and improve healthcare and health systems, there are many disciplines that need to be brought to bear. But I was conscious there was rather little attention paid to the contribution of history.

Martin

And of course we always have that famous quotation from Santayana, 'Those who ignore history are doomed to repeat it.'

But your first major foray into writing was, I think, at the Open University, and it was in the early 1980s when multidisciplinary work was much less common than it is now. How well do you think that your medical training prepared you for that experience?

Nick

I don't think my undergraduate medical training contributed much. I don't say that critically, because I think undergraduate medical training... the task is to take a lot of, usually, young people who want to be doctors – and we as a society want them to be doctors – and they need to focus on the pre-clinical subjects and then clinical medicine. And that's fine. I'm not somebody who advocates that undergraduates should be exposed to a lot more about management and policy. I think that comes later.

But my postgraduate education absolutely expanded my horizons. So with this background of having worked for Save the Children Fund, and become aware of how there's a lot more to providing good healthcare than what we might call, narrowly, medicine and medical knowledge – I didn't know much about those other areas, and my public health training provided me with my first understanding of the other key disciplines such as economics, sociology and so on.

And I was really fortunate as a... now called a specialist registrar in public health, to be attached and spent three years in with the department of what was then called community medicine in Oxford, which was stuffed full of brilliant people from different disciplines. And just having the privilege, as a young researcher setting out, to be exposed to those people was incredibly important for the rest of my career.

Martin

When you were at the Open University, of course you were working with some remarkable people. I'm thinking of people like Phil Strong, for example, who I know had a major influence on your life. So I was wondering if you could help us to understand how that engagement with people from a broader range of disciplines has shaped your work subsequently?

Nick

Yes, and again, I keep going back to McKeown, to Watkins, my history teacher. These are all people who disrupted me, and shook me out of the certainty. I mean, when we're training

doctors, medical students, we have to impart a high degree of certainty. Because you can't function and be useful to patients if you can't be pretty certain.

That's not to mean you're not thoughtful; it doesn't mean you become... we shouldn't become arrogant. But doctors are no use if they spend a lot of time worrying for hours about what's the right diagnosis. They have to be taught how to make quick decisions. Most obviously in an area such as an emergency department. Obviously in other areas – thinking things like psychiatry or care of the elderly – one can spend much longer thinking about a patient's problems and understanding them.

But what people like Phil Strong and Alastair Gray, the economist, and Steven Rose, a biologist – these were the people I worked with at the Open University – what they did was to shake me out of any certainty I might have brought to the table from a background in medicine.

Particularly sociology – I remember I started going to the Medical Sociology Association meetings and I was almost drowning, because of what I was hearing, trying to make sense of it. At that time – this was sort of the height of feminist sociology... Fine, that was great, but the high degree of relativism was the polar opposite to the certainty of the sort of positivist medicine. I'm trying to come to terms with this and understand, how does this work? How can we bring these things together?

I suppose some people might have just walked away and said, 'It's a load of nonsense, I'm having nothing to do with it. I'm interested in healthcare.' To me, I wanted to understand it and see how it could be brought together and brought to bear on healthcare, because I could see that it actually had answers.

So for example, when I did my doctorate in Oxford, where I was looking at the epidemic of surgery for glue ear in children – which had become the commonest operation in children – it provided me with the framework to actually start by questioning, what is glue ear? Not to the point of 'does it exist', because I know it does exist, but what is going on here? Why are so many more children being diagnosed with it? Where is this need coming from? To what extent is it a social construct?

So it's very different from the medical view of my ENT colleagues who I was working with, and actually very different from the patients' parents who saw it absolutely as a medical condition in black and white. And in fact, my doctorate, what I then tried to show was actually it was very uncertain what was going on.

Martin

And of course, that reminds us that all knowledge is contingent; it's constantly changing. But also, so often in our everyday engagement with other people, we find that we're using words in a particular way and they're using it in a different way, and we're often talking past one another.

Nick

It was also, going back to history, it was also the first time I did any historical research. When I looked back at this term 'glue ear' – which is quite a good one because it's very graphic, it

gives the idea that there is a gluey-like substance in the middle ear, which is quite a good description of what's happening – what I couldn't understand is the clinicians, generally, they believed this was a relatively new condition that had appeared in perhaps the 1950s and was getting more and more common. So the classic, almost clinical, epidemiological view.

But when I looked back through endless ENT textbooks, going back to William Wilde's *Diseases of the ear* – Oscar Wilde's father, who also had a turn of phrase, you can see where Oscar got it from – what I found was, I think I came up with, I forget exactly, but something like 60 different names. When you looked at what the symptoms were, this was the same condition! This was not a new condition. That was completely socially constructed, by those who wanted to believe it was something new, but it had been there from way back, since the start of medical textbooks in the mid-19th century.

And so that fascinated me as well, that a condition could change names so often. And each time it was then believed it was a new condition.

Martin

This reminds me of my favourite philosopher, Lewis Carroll, who famously had Humpty Dumpty say, 'Words mean what I choose them to mean, neither more or less.'

I'd like to move on to your book on walking London's medical history. What stimulated you to write it, and why did you choose the unusual format, perhaps for a doctor, of guided walks as opposed to a more traditional history book?

Nick

Well, this was about 20 years ago, and I'm fortunate to have the privilege of academia, having a sabbatical. At that point, I'd become more and more convinced that the discipline that could help contemporary policy-making and reimagining healthcare was history – that it played virtually no part in shaping contemporary thinking.

And I thought, well, I'm not a historian, and also I don't want to write... there have been lots of books on the history of medicine. Obviously I was interested in healthcare, but some of those so-called books of history of medicine were actually a history of healthcare – they're much wider than what doctors have contributed, but doctors have dominated the story. And I didn't feel I had the right background to write a history of healthcare policy.

But also I thought – with all respect to historian colleagues – another worthy book, to gather some nice reviews and then gather dust on the shelves. All the way through my career I suppose the underlying theme has been wanting to increase public understanding of healthcare, because I firmly believe the more the public understand the nature of health and disease, and what healthcare can and can't do, the easier it will be to create the sorts of healthcare systems I believe we ought to have.

So, how do you communicate with the public? They don't want to read a rather worthy but dull historical account. And that's when I hit upon the idea – and it was only about three months into the data gathering – of doing it as a series of walks.

The other reason behind it was, I had a long-standing interest in both the history of London and the architecture of London. So this allowed me, because it was going to look at all the buildings where key events took place. It was fantastic. It meant that I had licence to spend my life in archives, looking at old maps, walking around London, exploring parts of London I'd never been to, finding – to my delight – buildings that nobody else seemed to know.

For instance, one example, the Middlesex Hospital recently demolished – that's the building people will think of, which was actually about the second or third generation of the building on that site. The Middlesex Hospital didn't start on that site. It started in a small road which runs just off Tottenham Court Road, and it was in three Georgian houses.

But what's so exciting is two of the houses still exist. There is no indication on those buildings that that was the original Middlesex Hospital. People walk past it all the time and have no idea. And I found that just... it was like finding hidden treasure.

Martin

So are you now going to be spending your time nailing blue plaques to walls?

Nick

I'll leave that to others!

Martin

You write about London in your guidebook as being at the centre of many of the debates that have shaped healthcare today. But you also cite a long list of influences from elsewhere in Europe – voluntary hospitals from France, including the first one in London, the French Huguenot hospital opened in 1718; the medical societies from Italy; postgraduate training from Vienna; and nursing sisterhoods from Germany.

You discuss this rich exchange of ideas at a time when foreign travel was much less common than today. In fact, I think it was Disraeli who was the first prime minister ever to actually leave the country during his term of office. And it was a time when we didn't have the internet or even the telephone.

So how do you think that our own health policy is currently shaped by international developments and innovation? Do you think that our politicians have enough awareness of what's happening elsewhere?

Nick

I think the answer is yes and no. I'll explain why. At times I feel their attention to what is going on in other countries has proved quite harmful. I'm thinking particularly of a period, for instance, during the 1990s it probably was, when we had governments of both the main parties who were besotted by American healthcare, promoted by big private management consultancies. Secretaries of state became convinced that here was the answer, and we're going to ship it in from Minnesota or California or wherever.

My personal view is that that not only contributed very little or nothing, it actually was quite harmful and slowed things down in the direction they should have been going. So in that sense, attention abroad, you could say, has actually been too much.

It's also very selective, the way it's used. So, frequently – and this still goes on and I'm sure it'll go on in the coming years – somebody, a secretary of state or shadow secretary of state for health, will stand up in Parliament and extol the virtues of the French healthcare system. Now, there are many good things about the French healthcare system, but what they won't probably acknowledge is that in certainly the last 12 months, doctors in France have been on strike.

Now, if you said that to most politicians, let alone the public – they are blissfully unaware of that, and for the same reasons that we've got junior doctor strikes here today over terms and conditions and pay and so on. So that... it's had too much attention.

On the other hand, the other side of it is, much more considered knowledge and understanding of how things are done in other countries can be – has been, but probably a lot more *could* be – beneficial to our own healthcare policy thinking. But it needs to be more sophisticated and also, of course, understanding the context. Because what works in France or Germany or Italy won't necessarily work here.

Martin

Well, that's certainly true, and something that's kept me going for many years. I'm often reminded of the case of a British secretary of state who went to Spain and came back thinking that what he saw in the Abril report there was a great idea, except that his Spanish colleagues said, well, yes, indeed, it is a good idea, but we actually got it from you. The only difference is that for us, the trade unions have got a much greater role.

I was struck with so many parallels with the present in your guidebook. We've mentioned the Middlesex Hospital already, how it reduced the rations of its staff and cut back on the number of leeches that were used during the financial problems that England was experiencing during the Napoleonic Wars. Now, its problems were partially alleviated by immigrants – in that case, the French clerics who were fleeing the terror and paying for their care here.

So I wondered if there are other examples that you felt from your walks around London that were especially prescient today.

Nick

I think there were lots, and if you go back and look at that book, almost on every page there is something. I mean, you mention the leeches. The other interesting thing with that example, the Napoleonic Wars had closed the English Channel, basically. And for some reason – I've never come across the explanation – we depended here in Britain on French leeches. I never quite understood why we didn't breed our own leeches, but perhaps somebody can enlighten me. Anyway, that's how it was.

So it was this lack of leeches. It wasn't just financial problems. But one of the solutions was the reuse of leeches. Up until the Napoleonic Wars and the supply being cut off, leeches were

single use. They'd be used, they'd suck the blood out of somebody, and then they'd be destroyed. Which seems extraordinary, why that was the policy. Well, with a lack of it, suddenly, overnight: oh, it was alright, you could actually just let the leech digest the blood, and then – I don't know how long it would take, hours or days – before it was ready to be reused. This was pre-germ theory, but there wouldn't have been any great danger of infection.

And that, to me, tells me something that is very pertinent today. We've seen examples during the pandemic that in extreme times... yes, they are very testing for healthcare and health services – everybody's aware of that over the last few years – but it's also a wonderful opportunity, because the system can really be disrupted at these moments.

So, for instance, we've seen this from the last few years with the much greater use of remote consultations. Now of course, for some patients, particularly some elderly patients, face-to-face consultations in general practice are highly valued and are beneficial. But until the pandemic, what we were being told by our clinical colleagues was, 'oh, the highest we could go was 20%' or something. And suddenly overnight we're doing 80% and the sky wasn't falling in. Now, what the right percentage is, we can discuss.

So I think the leeches were a great example of: take advantage of these moments of crisis, because that's when you can shake the place up and disrupt and introduce radically new ways of doing things.

Martin

And in this series, we will be talking to Dom Pimenta and Rachel Clarke, both of whom have written books about their experience in the pandemic, and who have some very good examples of this. In Dom's case, he set up a charity to source PPE, but also addressed this issue of the reuse of PPE, a lot of which was being used and then discarded.

Now you also write in your guidebook – and I really can't recommend it highly enough, it's a fantastic resource – but you talk about how healthcare is and always has been an industry, and in that case, in the historical episodes, you pointed to unscrupulous clerics who were running medieval hospitals, the masters of private mad houses, and the proprietors of private anatomy theatres. Looking at that more unscrupulous, dubious behaviour, I wonder what lessons we can draw today from what you observed in those less well-regulated times?

Nick

Yes. Those are fairly extreme examples, but I think what's much more widespread is the sense that very often, in management of healthcare and trying to improve its quality, we run up against intransigence and a reluctance to change and improve.

I think what we can learn, what I have learnt – and I say this as somebody who's spent the best part of 30 years working in the area of better ways of assessing quality of doctors and hospitals and health centres, with a view to then holding those providers accountable through quantitative measures of quality – is that whilst those approaches have clearly had quite a lot of benefit, and one can point to some really great improvements in quality, at the end of the day the only way that we're going to have high-quality care is if the professions, and medicine in particular – though not exclusively, the other professions have a responsibility as well – if

they adhere to a strong ethos, and their motivation is first and foremost to the patient and to doing what is best for the patient.

So I take those unscrupulous people running private mad houses as the extreme of non-professional behaviour, and I'm not for a moment suggesting that that sort of behaviour is widespread in modern healthcare. But what is very common is something far less extreme, but actually is the impediment to achieving.

At the end of the day, however clever we are in measuring quality, in quality improvement measures brought in, in incentives, in regulation – all sorts of things that we do to try and improve quality – the reason that it's only ever going to be limited is because we'll only get improvements in quality if the people delivering the service want to deliver high quality, and that depends on that professional ethos.

Martin

Indeed.

Before we move on to your latest novel, which I will do in a minute, I just wanted to ask you one question about the resources that you use. You drew very extensively on the archives of many medical organisations – and I have to say I've got great admiration for your ability to find these archives – but I just wonder if we value archivists enough.

Nick

No, of course we don't. But I'd also say there's a contrast, from my experience, between this country and the USA. Whatever one might think about the US – and everybody's got their opinions, I'm well aware that not everybody is a huge fan of America – I have to say their academic support for archives and historical records is fantastic.

Take a simple example. If you want to read *The Lancet*, going back to 1823, for free – Elsevier won't thank me for this – you do not have to buy each article at whatever they charge. There's a thing called the HathiTrust. You'll find it on the internet, and it will give you free access to every volume. And you can turn the pages and you can look at everything, and you can then extract articles, whatever you want. I'm not sure who pays, who the HathiTrust is, but there it is. It's somewhere in the academic firmament in the US.

American universities are incredibly generous with their digitisation of British books – it's not just American sources. There's virtually nothing in this country that comes free, which is sort of ironic, given the, you know, the big political difference between the two countries. You'd have thought that this country would have been more generous.

Instead... going back to your question about the archivists, the actual individuals. Well, anybody who's gone looking for hospital archives, you know where you'll find them. You'll find them in an unlit basement, with all the old books piled high to the ceiling, dusty, and you'll have to go digging away. And with the best will in the world... the archivists do their best, but they're not particularly well supported.

I'd say the other thing is, of course, the sort of research I did for the history walks book, and then more recently, has all been in the 21st century. Go back before 2000, or go back to no internet or the early days of the internet – you wouldn't get very far. You'd have to literally go and visit all these buildings. Whereas now you can virtually just sit at home and get every historical source you want. There's very little that you actually need to go out and go to archives for.

Martin

And there are so many gems. I'll always remember one article from *The Lancet* from the 1850s when I was doing some work on outpatient clinics, and they described a situation in which hundreds of people were seen each morning, dispensed a dose of doubtful physic almost at random, if I remember the quotation, and one wondered if much had actually changed.

I really want to turn to your new novel, the book *The Honourable Doctor*. And for those who haven't read it – and again, I can highly recommend it – it's based on the true story of a young apothecary apprentice, James Lambert. James travelled from the Fens to London to serve his time as a medical pupil at the Borough hospitals. He's shocked by the actions of one of the pillars of the medical establishment and decides that he can't remain silent.

Now, I'm not going to spoil the plot for those of you who haven't read it, but I think we can say that it doesn't end very well for James.

Now, when you wrote it, you had to imagine a lot of dialogue that I suspect wasn't present in the archive. There's the obviously personal talk, such as that with his girlfriend and later wife Eliza, but also the political discussions that his uncle engaged with his friends about, and much of that refers to contemporary issues like the Corn Laws. So how did you come up with that dialogue?

Nick

I see this as almost the – well, not the final, but my latest – step in... going back to what I was saying about trying to improve public understanding of healthcare. I see it as a progression from the Open University health and disease course, which obviously was for highly selected people who chose to take that course as undergraduates at the Open University, but a very wide number, and tens of thousands took it over the years. Then through to the history walks books, which was another step, but explicitly about healthcare policy.

And then I felt, well, perhaps one needs to go further to engage some members of the public, and move into fiction, but based on true events. So the novel, as you say, all the events are true, but they have to be interpreted and strung together. And that's the imagination.

So it is fiction – not everything in it is absolutely true. I'll give you one example, without giving anything away, but Thomas Wakley, the founding editor of *The Lancet*, I actually have him smoking a pipe and drinking. He was actually rather abstemious and he neither smoked nor drank. So don't take it all as gospel, but it's for effect and to create a sort of atmosphere. In fact, most people did smoke. Most men did smoke pipes and drink.

The key thing with historical fiction – and I only learned this as I did it – is that you are asking the reader both to accept it's a novel and it's fictional, to an extent made up, but also you're telling them it's a true story, in the sense it's based on true events. You've got to earn the credibility on that.

And the way you do that – from reading about historical fiction, I learnt this – is by having very accurate historical context. That's what gives the novel the credibility. So things like what was going on with the Corn Laws, what was going on with Peterloo, and the uprising of the mill workers, and so on.

So to do the book, I learnt quite quickly, the way I did it was I did all the research on the story, which is largely from the archive records of the Middlesex Hospital, from *The Lancet*, and so on. So I had the story of James – which I still find an incredible story, that nobody has ever heard of James Lambert. I hadn't; I've never met anybody who's ever heard of him. And yet he was, I believe, a really important character in the history of modernising healthcare.

Then I realised, to put it into context, I've got to learn about the Regency period. The Regency period is fascinating. It's really the start of the modern state. Before the Regency period – we're talking sort of 1810s, '20s – government, society, is quite different from the modern state. But something recognisable to us today starts in about 1820s, 1830. It has been referred to as the Regency revolution.

And it's not just in governance and in healthcare. It's in science, it's in road building and engineering, it's in literature, it's in fine art. You know, whether it's John Constable or Jane Austen, it was an extraordinary period, and it affected healthcare as well. And this doesn't seem to have been paid attention to.

So that's how I... just by extensive reading. I didn't – like you, you may know more about it than I did – but, of course I'd heard of the Corn Laws, I was aware that they were highly controversial, but I didn't actually understand exactly who was arguing for what. And it was actually very complicated, as to who were the beneficiaries and who had the adverse effect of the Corn Laws. So I had to read a lot about that period, before I could put the healthcare story of James Lambert in context.

Martin

It is certainly very complicated, with the names of political parties changing and with splits in political parties. So I don't envy you that. In fact, Richard Horton in one of our previous episodes in this series – and of course he is the current editor-in-chief of *The Lancet* – pointed out to me that they pronounce him 'Wak-ley' rather than 'Wake-ley', because I had pronounced him 'Wake-ley' up until then.

Nick

Well, I pronounced it 'Wak-ley' until recently. But I've been doing some more research on him and he doesn't actually have any direct descendants. But there are some descendants from Thomas Wakley's siblings, and they call themselves 'Wake-ley' – they are adamant about it. Now that doesn't mean that Thomas pronounced it that way back in the 1810s, '20s, but the descendants of the family are adamant it's 'Wake-ley', not 'Wak-ley'.

Martin

We have already identified a medical controversy in this series. I was going to say that you're not the first person to attribute bad habits to somebody falsely, because in the movie *A Beautiful Mind*, the mathematician John Nash smokes throughout it. But in fact, he was quite a militant anti-smoker, and once reputedly threw somebody out of his windows for smoking in his room.

Now, among the many characters and organisations in your novel, we had a lot of coverage of the Society of Apothecaries, and it doesn't really come out of the story particularly well. Today the General Medical Council has also faced considerable criticism, and here I have to declare an interest as I've written rather critically about its accountability, and it's made a number of decisions that have provoked considerable controversy. So, does your story hold lessons for the regulators of today?

Nick

Yes, but I think they are ones that a lot of people already recognise. I should declare an interest here as well, that I am not a great fan of regulation as a means of either assuring or improving quality of care. The evidence just is not there that it works. This is true of other sectors as well; of course we've seen the dreadful consequences with Ofsted recently in the education sector.

That's not to say that I'm against all regulation. I think you can't let anybody just set up and say 'I'm a doctor' or 'I'm a nurse', so clearly there's got to be some professional regulation on entry. But the idea that you can improve care through regulation is very attractive to particularly politicians, and to parts of the media and to the public. But there's little evidence of its value.

So I would go for very light-touch regulation, minimal regulation, to make sure that the public is actually protected from mountebanks and charlatans! But I don't think that we've actually moved on very much. If anything, there's more regulation today than there was then. Strictly, the Society of Apothecaries was equivalent to a royal college – its job was to set an exam and control entry, in that case to apothecaries, and you had the surgeons and physicians as well. So strictly they weren't a regulator in the modern sense.

But, yes, so I think minimal regulation, and the royal colleges who do sometimes stray into those areas should really focus on establishing what is good quality.

Martin

And building professionalism, which you've already talked about – the professional ethos to always try to do better.

Nick

Indeed, yes.

Martin

Now, James Lambert is one of many doctors who've suffered for speaking out against injustices. A classic example for many of us is Henrik Ibsen's Dr Thomas Stockmann, and he

spoke out about the contamination of the water in the spa town in Norway in which he lived, and he was driven out of town for doing so. The mob attacked his house, broke the windows.

Is there a moral in your book, given what happened to James Lambert? Should we as doctors speak out or should we remain silent?

Nick

Well, you won't be surprised that I think we should speak out. Having said that, I would not encourage all doctors to do that. Doctors need – and this would be true for any of the professions, not just doctors – it takes a lot of courage. You need to really think carefully. And if you are somebody who is quite risk averse, then be very careful.

Also, never rush into speaking out. It's a bit like email – the basic rule, don't send the email at night. Sleep on it and send it the next day, particularly if it's a resignation. So, think hard, think through what the likely consequences might be. Obviously discuss it with a confidant, somebody who's perhaps a little older, seen more, more experienced. But in the end, it's got to be your decision.

I think the other thing I would say is that I make a distinction between what have come to be known as whistleblowers, and somebody like James Lambert, who was not a whistleblower.

Why do I say that? Well, if I look at whistleblowers – and there are absolutely some dreadful experiences people have had in the last 10, 20 years, well documented by Phil Hammond and others – usually what they are saying is the care here that I am observing and am expected to be part of, I do not believe is safe. I am not comfortable being part of it. We do not have enough nurses, doctors, whatever it might be; I'm being made to discharge a patient prematurely; all those things.

In other words, what they are saying is... they are not standing up and saying, I think we should transform the system. They're actually quite conservative. They're saying the system needs to be... as it is, the status quo needs to be better. More resources, more staff. Fine; that's okay. But that's very different from somebody like Thomas Stockmann, you mentioned from the Ibsen play – he wasn't saying that. What he was standing up and saying is we need change.

What Lambert – when you read the novel, as I hope you all will – is saying is we need change. What Thomas Wakley was saying is we need change. They were not arguing for more for their bit of the service. They weren't whistleblowers. They were reformers. And reformers actually have a very different mindset. Equally risky, because on the whole, people don't like it and those in power don't like it. So again, be very careful. But if we don't have a certain number of doctors, nurses and others speaking out, then there's little hope for change.

Martin

Indeed.

So I'm going to end with two questions that I've been asking everyone. The first is a very personal question. We're talking about doctors as a role models. You, for many people, myself included, are a role model. But who are the ones that have inspired you, and why?

Nick

Well, the one who comes to mind is Jonathan Miller. For younger listeners, Jonathan Miller was a doctor, a Cambridge graduate, and he was one of the four members of a revue, satirical revue, called *Beyond the Fringe*, which is seminal. It transformed more than just comedy. It was quite revolutionary at its time, and it's still very funny if you can find it. I'm sure it's on YouTube or somewhere. It was Peter Cook, Dudley Moore, Alan Bennett and Jonathan Miller – four incredibly talented people, Cambridge Footlight undergraduates.

And as a 17-year-old heading through A-levels towards medicine, what I actually really wanted to do was be a film director. A thing called the National Film School had just opened; this is 1968, around about that. But my parents, very wisely I think, said, well, do medicine first, rather than the high-risk world of filmmaking. And the person they pointed to – knowing my weak spot, as it were – was, 'well, Jonathan Miller did medicine and now look what he's doing'. Of course that was before he went on to direct opera, but he also pursued clinical work in neurology.

So I think that kept me on the straight and narrow, which I have no regrets about. So I would say Jonathan Miller was probably the person. Years later I had the good fortune to meet him, and I told him this and he was just acutely embarrassed I think, that he had had this responsibility.

Martin

I can identify with that. I wanted to do politics, philosophy and economics; my parents also said 'do medicine first', and in a way I've hopefully managed to combine the two in some way.

My very last question, what advice would you give to someone who's just graduated in medicine and would like to follow in your footsteps?

Nick

I think, have the courage of your convictions. But it does come with risks. So, you're in a very privileged position as a doctor. It may not feel like it, amongst a lot of the junior doctors today; they may not feel terribly privileged, but they are. That's not to say they haven't got a good case for improvements in their lot. But use that privileged position very judiciously. Think hard before acting, but once you're convinced of the rightness of what it is you want to do, then I'd encourage you to go for it and do it.

Martin

Nick Black, thank you very much.

Nick

Thank you.