'Trust me – I'm a philosopher...'

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Spring 2002 was made unusually bearable by the weekly, addictive dose of mellifluous and measured wisdom on the question of trust – the subject of this year's Reith Lectures. In the broadcasts and subsequent book Baroness O'Neill of Bengarve confronts the managerial and political ideology of our age, the undermining of public trust in institutions and organisations, mainly professional, and discusses how trust might be restored.[1] First, she reviews the evidence for a public flight from trust in institutions and professions. There is little evidence for this: the behaviour of individuals suggests that they still engage readily with professionals and services. Indeed, a society which has never been better educated should be more discerning than previously and more sophisticated in its dealing with institutions. However, the press and politicians tell us that public trust is evaporating (and they are in an excellent position to judge since public trust in themselves is limited) and that drastic remedies are required. Hence, the last decade has seen nationalisation of trust by stealth – the proliferation of regulatory, monitoring and watch dog bodies which bombard individuals and organisations with an endless amount of paperwork dealing with targets, outcomes and other statistics whose purpose appears more to bolster the self-regard and importance of the person announcing them than improvement of the service provided. A recent surgeon correspondent to a national newspaper listed 22 bodies he must report to; four of them cost the NHS £63 million annually. We have been led into a soviet and maternalistic system of centralisation, ruled by diktat, which is more likely to enfeeble and make dependent the users that the process is claimed to empower.

Authoritativeness is having a bad time. Medicine is not the only example – ask teachers, social workers, the police and any organisation, private or public, that is seen as an easy target. This atmosphere brings a reciprocal mistrust – of the new political/media establishment by the professions. For example, our profession has been slow to realise shifts in public opinion. It is not surprising that 1990s parents felt affronted that the practice of retaining their dead children's body parts was not explicit and that trust had been abused. Keeping tissues and organs was done – generally – with good intent and no malice. However, by today's standards the process was informal and implicit. When it became news, the reaction of those in positions of leadership was illuminating. Calm assessment, putting the matter in perspective, explanation and apology were needed. What we got was ministerial incandescence and mass referrals to the General Medical Council. Such unbalanced reactions, more characteristic of those incapable of distinguishing a paedophile from a paediatrician, were damaging to the relationship between doctors and politicians and undermined trust between them. Painstaking work (perhaps yet incomplete) was required to retrieve the situation. Trust can only exist in a culture where faults are acknowledged, followed by contrition and forgiveness. Rare commodities – along with statesmanship – today, sadly.

Let us take a more optimistic view. Public trust in the professions was formerly uncritical and unquestioned. Perhaps the postmodern public needs to renegotiate that relationship. Whereas patients used to trust doctors to do their best to heal them they now seek help in treating themselves in a partnership. What trust boils down to is a relationship between individuals. If I cannot be confident in placing my trust with my neighbour, how much more difficult it is to deal with larger organisations. Baroness O'Neill points out that in order to profit from trust one has to be a trustworthy individual oneself. The duties I owe to others are just as important (perhaps more so) as the rights I claim from them; indeed conscientious attention to my duties makes it more likely that my rights will be respected. This is the heart of the matter. If we all did as we would be done by, trust would be the true lubricant of society that it ought to be.

The book of the lectures is short (100 pages), readable and written in the rich style that is suggested by Baroness O'Neill's spoken voice: thankfully the lectures were free of italics and exclamation marks. (If you want a meatier text, try the book of her Gifford Lectures, which received a masterly review from Sir Douglas Black recently).[2,3] One of the delights of the lectures was the discussion afterwards. Unfortunately this is not published; it would have been a pleasure to read her assured dispatch of an NHS executive who challenged her questioning of accountability. She has no quibble with the principle, only some of the processes. She rounds off discussing how the media might be called to account for some of its excesses. Not much likelihood of that I suspect;

the only effective sanction would be to switch off the radio and television and not to read newspapers. Like the flavours in some junk foods, they possess habituating constituents – scandal, bad news – and their hold over the population is likely to increase. If they cannot curb themselves and promote further the credulousness and self-regarding selfishness of society they will destroy what they claim to champion. Baroness O'Neill has performed an important service for British society; its impact may be gradual and we must be patient. However, greater forces are marshalled against her. The House of Lords is being modernised – too independent, Oxbridge Colleges are too elitist, philosophers live on a different planet and medical royal colleges need taking into public ownership in the Postgraduaute Medical Education and Training Board. Nonetheless, when going into the jungle I know whom I – and most of the population – would wish to accompany us. Trust the people.

References

1 O'Neill O. *A question of trust: the BBC Reith Lectures 2002*. Cambridge: CUP, 2002.
2 O'Neill O. *Autonomy and trust in bioethics: the Gifford Lectures 2001*. Cambridge: CUP, 2002.
3 Black DAK. Book review, autonomy and trust in bioethics. *J R Soc Med* 2002;**95**:423–4.

letters TO THE EDITOR

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Are preventive drugs preventive enough

Editor – The study by Trewby *et al* (*Clin Med* November/December 2002, pp527–33) is a thought-provoking investigation of patients' expectation of benefit from preventive drugs. The authors demonstrate a mismatch with the actual benefit that can be calculated from the major clinical trials of cardioprotective drugs. However, it may be argued that it is not valid to compare the 'expected' and 'actual' benefit directly in this way.

Clinical trials are designed to determine whether a drug has any statistically significant benefit to the population in question. The statistical power of the trial increases with the number of subjects; the primary outcomes studied are usually the 'hard' statistics such as myocardial infarction and mortality. The absolute and relative risk reduction are derived figures that relate only to the outcome measure. However, absolute risk reduction may not 'answer the individual's main questions' as the authors assert.

In reality, benefit is not a binary outcome. A drug that lowers cholesterol and reduces the risk of myocardial infarction and death may well also reduce the risk of angina, cardiac failure, stroke, renal failure and many other outcomes which a patient may consider important. The risk of adverse effects is also important; for example, a statin would be less likely than a beta-blocker to produce the 'awful side effects' cited by one subject. A patient may summate all these potential benefits and adverse effects in a non-linear and highly individual way; to present a numerical 'benefit' relating to a single outcome is an oversimplification.

The populations studied in the large trials are heterogenous, and no trial has the power to provide reliable figures on the likelihood of all possible outcomes given any possible combination of relevant risk factors. However, in clinical decision-making a clinician combines quantitative with qualitative information to provide patients with recommendations that may be much stronger than figures derived from clinical trials may suggest.

'Taking the patient's views into account when prescribing' could also be misinterpreted by the patient as lack of conviction on the doctor's part. As doctors, our ethical responsibility is to advise our patients as best we can, clearly stating which measures will give the patient the best chance of health in the future. Whether the patient dislikes the idea of taking tablets is a separate issue; in fact, the patient holds the ultimate power in choosing whether or not to follow medical advice. It could be argued that medical paternalism and other power metaphors are less important in today's information-loaded society, and that the most important aspect of a patient-centred, evidence-based approach is to explain to the patient the scope and limitations of the evidence, rather than simply to provide the available data.

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Diagnosis and management of gastrointestinal causes of chest pain of uncertain origin – 'oesophageal angina'

Editor – The helpful account by Dr de Caestecker (*Clin Med* September/October 2002, pp402–5) draws attention to a