include editors of leading medical journals, will have to find their own ways to resolve this discomfort.

I was disappointed to see Morrell pulling out the old chestnut of "commitment." The danger in the current NHS culture, which knows the cost of everything but the value of nothing, is that commitment is free to the user but may be expensive, in more than simply monetary terms, to the provider.

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1 Smith R. Medicine's core values. *BMJ* 1994;309:1247-8.
(12 November.)

Are based on Christian ethics

EDITOR,—It is encouraging to see the profession discussing its core values, with the lead given by the chief medical officer¹ and the summit meeting reported by Richard Smith.² Coincidentally, the Sheffield group of the Christian Medical Fellowship held a day conference in the midlands on 5 November to discuss "foundations and the future." Many of the core values that we agreed were identical with those highlighted by Smith—namely, "caring, integrity, competence, confidentiality, and a high standard of ethics." We particularly identified with Professor David Morrell's plea that the doctor-patient relationship should be "a real human relationship based on love, caring, and sharing."

Our discussions, however, went one stage further: we asked where these core values come from and how they can be sustained in the future. Perhaps we have become so used to the Judaeo-Christian principles that have inspired our profession for centuries that we assume that they will always be there. These values do not arise from scientific medicine itself, nor are they the "natural" attributes of doctors, who are mere humans. If the clergy do "escape into a niche market," as Sir Maurice Stock suggested,² and we lose the unique inspiration of Christ's example of love and service the future could be very different. After all, we have experience in this century of how the abandonment of the Christian ethics led to the tragedies of Nazi Germany. It would be folly to rely on mere tradition or the naive assumption that doctors are somehow different from the rest of humanity.

To maintain the profession's core values in the future an inspiration and an ethic that can withstand the pressures ahead are needed. We, like many others, have found this in the Christian faith.

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1 Calman K. The profession of medicine. *BMJ* 1994;309:1140-3.
(29 October.)

2 Smith R. Medicine's core values. *BMJ* 1994;309:1247-8.
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Profession needs to open itself up

EDITOR,—The debate about core values in medicine reminds us that the profession is at an important crossroads.¹ As the demand for more openness in medical practice grows doctors, understandably, feel threatened. To add insult to injury, their field of work seems to be breaking up as others become involved in aspects of practice that were once their unique province.

How should the profession respond? It is disappointing, although hardly surprising, that a large section of it seems to wish to retreat into an ever smaller and more tightly defined core to

remain proof against further invasion by the uninitiated. The alternative is to accept that, to evolve and survive, medical practice needs not to withdraw into itself but to open itself up, to develop new models, to embrace new paradigms, and, importantly, to move away from the narrow biomedical focus on which our teaching has been, and largely still is, based.

This is difficult for clinicians whose working life revolves round a high pressure cycle of interactions with ill patients, but the alternative is to restrict medicine and those who practise it to a limited and ultimately shrinking role. Instead of defending the past the profession needs to create the medical practice of the future. The signs are that this will entail even closer scrutiny of what we do clinically; learning to cooperate with others in creating systems that allow us to practise effectively; and doing more than paying lip service to the idea of incorporating prevention and health promotion into mainstream clinical practice.

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Should include respect

EDITOR,—Richard Smith's editorial on the summit meeting on medicine's core values indicates a misunderstanding within the profession of the concept of respect.¹ The answer to the question "How . . . could doctors balance respecting each other with having to act to stop a colleague who might be harming patients?" is that no balancing is required. Genuine respect for a person (which must be earned rather than demanded) includes a respect for his or her integrity, desire to contribute, and ability to receive bad news and use it constructively. Thus respect for a colleague who may be harming patients requires not hiding the truth and devising complicated ways of working around it but gently but firmly breaking it. Indeed, withholding the truth in this situation would be an act of patronising cowardice, whereas genuine respect requires courage and humility. Perhaps it was this diminished perception of respect that led to its exclusion, and the exclusion of anything resembling it, from the final list of core values. This seems a pity because without it the list seems not to encompass some of the important points raised during the meeting.

It would be interesting to know what hard evidence there is to support the assertion that doctors and managers have value systems that are in fundamental conflict. As someone who is neither but who educates both, I find their values to be similar. They sometimes surprise each other, however, by discovering that members of neither group have two horns and a tail.

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(12 November.)

Statement of intent needed

EDITOR,—The debate about the core values of our profession seems to rest on a series of isolated notions and objectives.¹ Would it be helpful to attempt to draw these ideas together in a single statement of intent? If so, I offer my version of what such a statement should encompass in its description of a doctor's obligations and rights.

To care for sick, old, frail, and weak people. To respect their privacy and their dignity, to earn

their trust, and to help them understand what is happening around and within them. To encourage healthy behaviour and to manage preventive and screening programmes in the knowledge that the fruits of this work will not come as quickly or easily as some would suppose. To take part in debate about the proper allocation of resources for health in a civilised society and to ensure that those who report and comment on these matters acknowledge that ever increasing demands on health services cannot be met by efficiency savings alone and that responsibility for the dilemmas that confront clinicians and managers each day lies with the public as a whole. To build on working relationships with other health professionals and to acknowledge their skills and experience without apologising for our own hard earned skill. To develop a common language and understanding with managers, most of whom share our sense of vocation and commitment to health care. To take the lead in medical audit and continuing education for doctors so that the government and patients can be confident that they will be given care that is proved and effective. To point out from time to time that quality is by definition not susceptible to measurement and that performance should not be judged solely in terms of figures.

Finally, to remember that as well as having responsibilities to our patients we have a responsibility to ourselves and our families. To admit as a profession, and as individuals, that we sometimes feel unable to meet the demands that are placed on us. To make it clear that, while we cannot expect guarantees of comfort and security which are so manifestly denied to others in Britain and abroad, our patients should not be cared for by men and women who are exhausted and demoralised.

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(12 November.)

The right to speak out

EDITOR,—Kenneth Calman's article reflects his current view of the standing of the profession and gives us an insight into present thinking at the Department of Health.¹ The profession as a whole perceives itself as under great threat at present, so to have such a statement by the chief medical officer is valuable. The article seems to be soundly argued, and I suspect that much of it is common ground. One notable omission, however, I found disquieting—namely, the absence of any mention of our duty as medical practitioners to speak out to ensure that the highest possible standards are maintained when we believe them to be under threat. If we become afraid to do this then medicine in Britain is in danger indeed.

Although I am retired, inevitably I chance on past colleagues. Almost universally they admit to being afraid to speak plainly when they see standards slipping, for fear of losing their jobs. Whether their fears are well founded I find it difficult to judge, but their fears are real to them, and growing.

Recent examples of how dangerous this fear to protest can be are not far to seek: doctors in Iraq feared to speak out when called on to amputate limbs in the name of their country's law for fear of facing the severest consequences.² This is, of course, an extreme example, but nearer home surgeons have told me that they dare not complain when they find nursing levels on postoperative wards seriously inadequate. That is a grave charge that needs answering.

I am sorry that this point does not feature in Calman's article. The present climate of management surely has much to answer for if the urge to

make a legitimate protest without fear or favour is no longer considered wise.

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1 Calman K. The profession of medicine. *BMJ* 1994;309:1140-3. (29 October.)

2 Butt G. Iraqi doctors face climate of fear. *BMJ* 1994;309:898. (8 October.)

Unanimity in the profession

Don't pretend to be unanimous

EDITOR,—The first two editorials in the issue of 29 October sit strangely together. While the first, by Ian Morrison and Richard Smith, takes an imaginative view of the future,¹ the second, by Tony Grabham, is a fine example of the authoritarian and corporatist attitude that has characterised "doctors' leaders" for too long.² Morrison and Smith urge doctors to see themselves as part of a wider society, characterised by sophisticated consumers and shifts in the boundaries of health and medicine. Grabham, however, reminisces back to the days of Harold Wilson and Barbara Castle, when a display of professional unity apparently influenced government policy.

If the profession is unanimous then there is no point arguing for unanimity. If it is not then the pretence of unanimity is a deception. I reject the notion that breaking ranks and expressing a contrary view is wrong. It is about time that medical leaders (and the public) stopped regarding medicine as a professional island, unaffected by the tides of social change. On the contrary, as doctors we reflect the range of opinion present in the society from which we are drawn. Doctors therefore have every right to express personal views publicly, even when these are at variance with those of the ruling medical cabal. When I was a medical student in Johannesburg I marched in the streets in defence of academic freedom, and I will continue to oppose any threat to this principle, whether from the government or from professional leaders.

Policymakers are entitled not only to information on the majority view in the profession but also to the degree of unanimity and the reasons behind opposing medical viewpoints. Grabham is right that medical representatives are fragmented. An academy of medicine based on the royal colleges and elected representatives would form a useful point of contact between the government and the profession and a forum for reasoned argument, particularly in cases in which consensus is absent. Such an academy should not simply try to paper over the cracks of inevitable and healthy division of opinion.

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1 Morrison I, Smith R. The future of medicine. *BMJ* 1994;309:1099-100. (29 October.)

2 Grabham T. Divided we fall (yet again). *BMJ* 1994;309:1100-1. (29 October.)

Any academy should stay away from realpolitik

EDITOR,—When Tony Grabham confines himself to ethical issues (incidentally, I believe that performance related pay in medicine is primarily an ethical issue) I broadly agree with his view that the profession needs to present a united front.¹ The BMA's ethical committee has worked wonders over the past few years, but the BMA's council does not provide the ideal forum in which to debate

the broad issues: time for reasoned debate is rarely adequate, the adversarial presentation of amendments and riders is often too restrictive, and the council anyway is predominantly politically oriented. A policy forming body combining as its basis the views of the General Medical Council, the royal colleges, and the BMA would certainly be more authoritative and possibly more effective as well.

But the thought of such a body concerning itself with realpolitik is another matter. Firstly, the government would seize on it as the ultimate longstop, declining to make any important medicopolitical decisions until they had been referred to this particular committee; this would effectively emasculate the standing committees of the BMA, which over the years have been remarkably effective. Secondly, the committee, elected I know not how, would have a high proportion of academics, who are not renowned for their political wisdom, and if truly representative would be vast. Almost by definition the members would be "yesterday's men" and disproportionately old. The committee could be answerable only to its constituent parts, which on many issues would be at variance with each other, and the mind boggles at the thought of drawing up a timetable when all the members would be free to meet.

I accept that politically the profession has not done well over the past few years, but we have only ourselves to blame. The BMA represents more than three quarters of the medical profession in Britain; if its members are agreed on a policy, and if it has wise and resolute leadership, its forces are irresistible and there is no need for yet another committee to be interposed between it and the government.

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1 Grabham T. Divided we fall (yet again). *BMJ* 1994;309:1100-1. (29 October.)

The future of public health

Further economic growth may not improve health

EDITOR,—I dispute Raj Bhopal's contention that further rises in economic strength are necessary to improve the nation's health.¹ This rests on two assumptions: firstly, that further increases in gross national product will lead to further increases in health and, secondly, that when a country becomes more prosperous all its citizens benefit equally. I believe that the first will not hold true in the future, while the second is clearly not true even now, socioeconomic differences in health being well recognised.²

It is indisputable that higher living standards have made us healthier over the past century, but is it possible to say that this relation will hold for the future? Most of us already enjoy a more than adequate standard of living, and I cannot understand how further increases in the national wealth will make us healthier still. On the contrary, I suggest that these would be positively damaging to our health, for the creation of wealth depends on industrial processes that increase environmental pollution, and the extra spending power that results tends to be used not on items that enhance health but on new cars and consumer goods that contribute to our society's ever increasing energy consumption. Furthermore, as the resources on which even our current lifestyle depends are finite, that lifestyle, with its health benefits and material benefits, is ultimately unsustainable. Further increases in consumption, which the politicians' talk of exponential economic growth implies, would merely bring closer the point at which our

raw materials are exhausted while worsening both our health and our quality of life.³

The relation between the environment, income, and health is now being reflected in the scope and activities of public health as a discipline,⁴ but all clinicians see the effects on health of our sick environment. Surely we should be working towards industrial, employment, transport, and building policies that develop sustainable ways of living without depleting the earth's resources. Doctors proved themselves surprisingly political in the fight against smoking. Will they take arms against similar big business interests and government inertia to clean up our environment and encourage them to promote ways to make us healthier, though not necessarily wealthier, in the years to come?

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1 Bhopal R. Past and future influences on public health. *BMJ* 1994;309:1156. (29 October.)

2 Davey Smith G, Egger M. Socioeconomic differentials in public health. *BMJ* 1993;307:1085-6.

3 Douthwaite R. *The growth illusion*. London: Resurgence Books, 1992.

4 Ashton J. Sanitarian becomes ecologist: the new environmental health. *BMJ* 1991;302:189-90.

5 Thompson E. The woman on the kerb. *BMJ* 1994;309:141-2. (16 July.)

Evidence based public health

EDITOR,—I am surprised that Stephen Watkins thinks that those who seek "objective measures of health gain, efficiency, and effectiveness" are a threat to public health.¹ In his opinion this model is a poor substitute for professional judgment because "not all human experience is measurable in numbers, and that which is not may be more important than that which is." Surely, many of the most important aspects of human experience relevant to public health—namely, death, disease, and disability—can be measured. As for the rest, I concur with Lord Kelvin's observation: "until you have measured it, you don't know what you are talking about."

In their editorial on the future of medicine Ian Morrison and Richard Smith argue that evidence based medicine will transform the practice of medicine.² I would argue that professional judgment in the absence of data is a poor basis for the future of public health. Evidence based public health would be a more secure foundation.

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1 Watkins SJ. For debate: public health 2020. *BMJ* 1994;309:1147-9. (29 October.)

2 Morrison I, Smith R. The future of medicine. *BMJ* 1994;309:1099-100. (29 October.)

Forget the old days of medical officers of health

EDITOR,—Stephen J Watkins advocates a return to public health paternalism, from which, thankfully, the specialty has begun to move in recent years.¹ Despite his assertion that public health doctors cannot work with "arbitrarily defined populations" in the same way as they can with "communities," the community that holds centre stage in the article is one based on the boundaries of local government—a clear example of boundaries that are not defined by the population within them.

More careful analysis of the text shows that this reflects the fact that the community that has centre place in Watkins's allegiance is a community not of ordinary residents but of bureaucrats. After all,