public health doctor) for talking to the press. They have all failed: either the doctor has been reinstated or an expensive settlement has had to be paid by the health authority.

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- 1 Craft N, Sheard S, Smith R. The rise of Stalinism in the NHS. *BMJ* 1994;309:1640-5. (17 December.)
- 2 European Court of Human Rights. *Case of Damell v the United Kingdom*. Strasbourg: ECHR, 1993. (34/1992/379/453.)
- 3 Van Dyke B, van Hoof GJH. *The theory and practice of the European Convention on Human Rights*. 2nd ed. Deventer, Netherlands: Kluwer Law and Taxation, 1990.

Creeping censorship occurs

EDITOR,—I was appalled to hear the response of Alan Langlands, the chief executive of the NHS Executive, on BBC Radio 4's *Today* programme (16 December 1994) to Naomi Craft and colleagues' articles.¹ He accused the *BMJ* of sensationalism and said that there was no place for secrecy (I believe that he qualified this to commercial secrecy) within the NHS. I believe that consultants are now the only people who are still able to speak out; indeed, we must do so, otherwise we are in danger of losing our ability to do so through the fear of violence rather than violence itself. We still have freedom of speech within our contracts, and it is vital that we do not relinquish that either positively by a change of contracts or negatively by refusing to exercise that option.

My trust has a reasonably enlightened approach. It admits that consultants may speak to the press about whatever they like without prior consultation with the managers. There is, however, a sting in the tail: if the press, especially the visual media, wishes to come on to trust property for interviews then the managers decide whether they wish to talk to the press and also whether consultants can talk to the press on trust property. In a recent incident I was to be filmed in the trust's buildings (I had received a guarantee that the trust would be anonymised as I was speaking not on behalf of the trust but on national matters). My request to the managers for permission to be filmed in the hospital buildings was refused. There is, therefore, creeping censorship as consultants can be gagged on trust property. It is vital, however, that consultants retain their right to freedom of speech and, if necessary, stand outside the gates of the trust to give their interview.

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Cordial relationships restored

EDITOR,—I do not wish to detract from the main message of Naomi Craft's article on secrecy in the NHS but wish to prevent possible false inferences being drawn from the two items she discusses about which I am familiar (items 24 and 25).¹

In item 24 she says that "senior consultants . . . attempted to persuade the managers not to follow through this threat" (of disciplinary proceedings); in fact, the managers were advised not to follow through this threat and, to their credit, readily took the advice. The phrase "attempted to persuade" implies recalcitrance or resistance on the part of the managers; this was not the case.

In item 25 the phrase "were called to a meeting with the medical director" implies a directive or instruction; in fact, we were invited to meet the medical director to discuss with him the contents of the letter. The final sentence again implies that

we felt threatened. It is certainly true that when the letter was read out to Mr Kyle at the meeting of the hospital staff association (to which he had asked to be invited), and when the letter was subsequently leaked, the general atmosphere was fraught, but at no time were any of the five signatories subjected to any unpleasantness or threats from the trust managers. Since then, cordial relationships have been completely re-established and the running of the hospital by the trust has improved.

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Doctors were previously the leading practitioners of secrecy

EDITOR,—Naomi Craft asks for further examples of secrecy surrounding health and the NHS in Britain.¹ May I nominate the Access to Medical Reports Act 1988 (exemptions, section 7, paragraph 1)² and the Access to Health Records Act 1990 (section 5, paragraphs 1 (a) (i) and (b))³? But these statutory restrictions on patients' already statutorily limited rights of access to their own medical records are not the result of any nefarious new trend within health service management. Secrecy in the NHS has long been the rule rather than the exception. Historically, doctors have been its leading practitioners. All that has changed in the new era is who now has the power to keep secrets from whom.

It is not clear whether what doctors are objecting to is secrecy itself or merely that fact that they now find themselves on the receiving end of it. Perhaps the nature of their complaint will be clarified by the future actions they undertake to alleviate their distress. Meanwhile, it should be recalled that, when the legislation was introduced, the then junior health minister, Stephen Dorrell, said that patients were not to be granted unrestricted rights of access to their entire medical records because it "wouldn't be fair to doctors" for people to know what doctors had written about them in the belief that it wouldn't be seen.

The metaphor of Stalinism rising may be misleading. The differential diagnosis of the current malaise surely includes the "biter bit" syndrome and "chickens returning to the roost," not to mention "monkey see, monkey do."

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- 1 Craft N, Sheard S, Smith R. The rise of Stalinism in the NHS. *BMJ* 1994;309:1640-5. (17 December.)
- 2 Access to Medical Reports Act 1988. London: HMSO, 1988.
- 3 Access to Health Records Act 1990. London: HMSO, 1990.

Clinicians should not restrict access to basic information

EDITOR,—The articles on the rise of Stalinism in the NHS, which espouse liberty to facilitate transparency and accountability so that clinicians and others can blow the whistle on poor management practices, are laudable.¹ However, consistency in advocacy and behaviour is essential.

Openness for whistle blowers should facilitate public analysis and debate about all aspects of clinical practice. Thus clinicians must also be accountable and not inhibit the liberty of others who want to know how doctors use society's scarce resources. Consequently, interpretable information based on the data on surgical and anaesthetic mortality collected by the national confidential enquiry into perioperative deaths in England should be openly available for non-clinical managers and patients to blow the whistle on inadequate consultant practice. The results of

the investment of over £200m in clinical audit might also be opened up to public scrutiny to promote accountability in clinical practice and assessment of whether audit processes have been conducted with sufficient rigour and have led to appropriate change in clinical practice. The decisions about who gets distinction awards should be made in public so that the inefficient and unethical tendency to allocate over £100m to "chums" and those about to retire can be seen for what it is.

Surely it is time for free speech and more open debate about these and many other clinical topics. It is unacceptable for clinicians to restrict access to basic information. We look forward to an open and accountable 1995 in all aspects of NHS decision making.

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Title is sensationalist and inaccurate

EDITOR,—For a journal with the influence of the *BMJ* to give any series of articles on freedom of speech within the NHS the title "The rise of Stalinism in the NHS" is a major editorial error.¹ The British establishment consistently failed to grasp the nature of socialism in Soviet Russia. But during the purges Stalin was directly responsible for the deaths of, at the very least, 15 million people. A further 20 million Soviet citizens died during the second world war, the first two years of which Stalin spent as the ally of Nazi Germany.

By all means argue with passion and attack injustice. But it seems particularly wrong for the scientific and medical establishment to abandon accuracy and devalue its argument in the fashion of the uninformed tabloid press by using allusions that could not possibly ever be valid for the sake of sensational and inaccurate publicity.

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- 1 Craft N, Sheard S, Smith R. The rise of Stalinism in the NHS. *BMJ* 1994;309:1640-5. (17 December.)

Royal Devon and Exeter Hospital has policy of openness

EDITOR,—Naomi Craft gives 30 examples of secrecy in the NHS, which range widely; if these are all substantially correct there is indeed cause for concern.¹ She specifically lists 10 hospital trusts—among them the Royal Devon and Exeter Healthcare NHS Trust—which, she claims, "have inserted a confidentiality or conflict of interest clause, or both, into contracts." She implies that these have replaced paragraph 330 of the Whitley Council conditions of service for medical and dental staff and that consequently they are "gagging clauses."

In fact, at the Royal Devon and Exeter Hospital paragraph 330—as quoted in the article—is retained and our consultants have the right to speak freely. Far from restricting information, we have a clear policy of openness among all our staff and board members; we ask them to declare potential conflicts of interest in business matters. This is a proper standard of accountability in the public arena. Furthermore, we believe that public interest is best served by a clear policy requiring confidentiality about matters concerning patients. In addition, we require internal consultation about

business matters only to ensure that doctors are fully informed of all the facts about particular issues before they consider speaking publicly about them.

These specific policies have not replaced, and are not in any conflict with, paragraph 330 and have been agreed with all our consultants and staff through their negotiating committee in consultation with the BMA. The health of any organisation depends in large measure on its ability to be honest with itself, and we commend our policy of frankness and accountability to others.

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Public health advocacy will remain

EDITOR,—Sally Sheard is right to draw attention to the widely held fears that regional directors of public health will be less able to speak as advocates of the population once they have become civil servants employed by the regional offices of the NHS Executive.¹ To say, however, that “the last vestiges of public health advocacy in Britain will be abolished when the eight regional health authorities are replaced by eight analogous NHS Executive regional offices” is grossly to overstate the case.

Regional directors of public health are only one small part of the specialty of public health medicine, and in turn the specialty is only one of the many bodies whose opinions and practice have an influence on public health policies and the health of the population. The specialty and its practitioners have many opportunities to influence determinants of health, including the delivery of health care. Opportunities include directly influencing the use of NHS resources while holding appointments as executive directors of health authorities and actively encouraging the development of better links with local populations so that health issues—including determinants of health such as unemployment, housing, and smoking—can be discussed.

The removal of the regional tier of the NHS and its incorporation into the civil service may mean that regional directors of public health find it difficult to take as public a stand on important issues as they might like. This will doubtless make these new posts less attractive to many, but they may appeal to those who consider that they offer access to ministers and participation in policy development. There remain different areas of work of equal importance, which allows people with different skills and personalities to work where they are most likely to be effective. Public health advocacy should be judged by the sum of total public health activity and not by consideration of individual contributions in isolation.

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1 Craft N, Sheard S, Smith R. The rise of Stalinism in the NHS.
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Advocacy for public health will continue

EDITOR,—By saying that “the last vestiges of public health advocacy in Britain will be abolished when the eight regional health authorities are replaced” Sally Sheard overstates the case.¹ Impartial advocacy for the public health will depend entirely on district public health practitioners. They will rise to the challenge but will lose regionally published support.

Leadership—called for in the job descriptions of the new regional directors of public health—is usually exercised openly. In the regional offices of the NHS Executive it seems to be restricted to advising in private. Members of the health professions might understand, though be disappointed. The public is likely to be unaware and fail to recognise that leadership is being exercised.

To mitigate the loss of regional annual reports, the new directors will contribute to the annual report of the chief medical officer. Unfortunately, the chief medical officer's report can be overcautious in its handling of certain topics.

Sheard refers to the holding of office in professional bodies. In a letter sent to regional directors of public health last November the chief executive of the NHS Executive, Alan Langlands, cited “the customary ban on doctors' membership of their College Councils.” It is not clear how long the custom has existed, although there are examples of office holders in the Faculty of Public Health Medicine and in royal colleges who have simultaneously held positions in health departments during the past 20 years. A ban on membership of councils denies people the opportunity to serve their peers in the management of professional affairs. It also denies professional bodies the services of some of their most experienced members.

There is potential for conflict. Office holders might be called on to represent organisations publicly on matters that conflict with government policy inimical to the public health. Before 1974 public health advice was given in public meetings held in the presence of the press. When such advice was not accepted no one could doubt that the authority and its officer held different views, but there was sufficient professional and political maturity to recognise and live with this public knowledge. The only relevant difference between then and now is that of scale between local authorities and national government.

The last words should come from the chief medical officer. Summarising the position of medicine, he gave both hope and direction: “the purpose of medicine . . . is precisely to do with serving . . . the public. Perhaps we should be more willing to say this explicitly rather than implicitly.”² The Faculty of Public Health Medicine and its members will follow that clear lead. They will continue explicitly to advocate the public health.

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1 Craft N, Sheard S, Smith R. The rise of Stalinism in the NHS.
BMJ 1994;309:1640-5. (17 December.)

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

Defend the principles of our calling together

EDITOR,—As Naomi Craft and colleagues' articles illustrate, many of the forebodings about the damaging consequences of the legislation imposed in 1990 are being realised.¹ It is a little noted irony of history that the first (Guy's/Lewisham) trust, formed in the usual effusion of glossy covered, management inspired, Madison Avenue hyperbole promising the institution a great and prosperous future and the local population ever improving care, should be the first to be dismembered. It

gives no pleasure when colleagues at Guy's Hospital recall the “flagship's” struggles of five years ago over the white paper and agree how wrong they were then to have been beguiled by misinformation. The staff's voices now are muted, comments circumspect, noses kept publicly clean as the flagship slips beneath the waves.

Some consultant colleagues have derived a certain anguished pleasure from the spectacle of London medicine in distress—getting, they believe, something of a long deserved come uppance. Other colleagues in general practice may be inclined to rejoice in seeing the mighty fallen, the “cap in hand consultants” consuming humble pie, scuffling even among themselves for survival. Other public services—teachers and the police, for instance—have learnt the value of standing together on great issues of principle. We, who have one of the greatest issues of principle of all, have failed to stand together to protect it and be protected by it.

The one great principle that binds us as a profession is our commitment to the health and welfare of our patients and the public. Our squabbles and sectional rivalries notwithstanding, patients and the public still believe, sometimes falteringly perhaps, that care, cure, and prevention of disease are our prime concern as a profession. Clarifying the relevance and importance of our arguments to the public interest represents the true accountability of the professional in our society. Some of us are trying to do this by sharing our concern for the future of the NHS through organisations like the NHS Support Federation, which, uniquely, brings the public and professions together in a common cause.

The practice of medicine today is almost unrecognisably different from that when I qualified in 1948, as the NHS was born. Change is inherent in medicine and to be welcomed and exploited when it is for the public good. Unchanging is the duty that we owe to ourselves, to each other, and to the public, with whose confidence we are entrusted, to uphold the principles and purposes of our calling. It is these purposes and principles that are now being challenged and that we must defend together.

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1 Craft N, Sheard S, Smith R. The rise of Stalinism in the NHS.
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PHLS reports on food poisoning should be published routinely

EDITOR,—The refusal of the Public Health Laboratory Service to supply information on outbreaks of food poisoning associated with eggs—except for a fee of £2000-3000¹—has important implications for public health. According to Bryan *et al*, information from investigations of outbreaks of food poisoning is needed to enable all those involved in the production of food, whether directly or indirectly, “to better formulate and implement food safety precautions and strategies.”² It also helps officials who enforce food safety to identify hazards and could aid the direction and prioritisation of control activities. It is not good enough—as has been done to date—merely to offer conclusions regarding sources of infection. Workers need detailed information about causal factors, of a type which can be obtained only from the study of detailed investigation reports.

Furthermore, the Public Health Laboratory Service is a public service funded by the taxpayers. As such, taxpayers—that is, the British public—have the right to the information that will enable them to assess the quality of service provided. In the white paper on open government it was stated, “information enables citizens to demand the quality of service they are entitled to expect and