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

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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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 over-cautious 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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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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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

puts pressure on those running services to deliver high standards.” In this context Galbraith, a former director of the Public Health Laboratory Service, observed of investigation reports that “there is no better record of performance of the investigation team.”⁴ Wider, unselective publication of reports, therefore, would provide powerful evidence of the performance of the Public Health Laboratory Service and increase pressure for a more efficient service. By effectively denying access to reports on outbreaks the service is not only inhibiting the formulation of effective control policies but also prohibiting independent review of its performance.

It is not for the Public Health Laboratory Service to decide to whom it should give information. The essence of quality is “the totality of features and characteristics of a product or service that bear upon their ability to satisfy implied or stated needs.”⁵ The ultimate arbiters of quality are those who pay for the service, the public. In any case, it ill behoves the Public Health Laboratory Service to raise charges for that information. This organisation defines part of its functions as surveillance.⁶ That function is defined as the collection of data, their processing into information, and the dissemination of this information to all those who need it.⁴

As the Public Health Laboratory Service is already paid a substantial amount for its surveillance function the idea that it should charge for that for which it is already paid defies reason. Publication of all reports investigating outbreaks of food poisoning should therefore be a matter of routine.

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Measles campaign

Involve general practitioners in future

EDITOR,—I await with interest the outcome of the measles and rubella immunisation campaign being conducted throughout Britain.¹ Correspondents have discussed some of the controversies surrounding the campaign.² The predicted herd acceptance has not occurred, and since the campaign started parents have made many thousands of telephone calls to general practitioners. Schools have run out of soft mats to cater for the children who faint or are distressed by the immunisation. Developmental checks and routine vaccinations have been delayed by a minimum of six weeks while staff have been diverted to give immune children further immunity.

A meeting of general practitioners, public health doctors, and virologists took place during the first weekend of November as part of the national symposium for the Primary Care Virology Group. A workshop discussed the difficulties in immunisation campaigns and came to several conclusions. The following points, which the group termed the “Salisbury rules,” were identified.

- (1) General practitioners and primary care

teams are the most appropriate people in Britain to undertake any immunisation campaign in the future.

- (2) A district based service is necessary to identify and plan for individual pockets of susceptible subjects who would not be reached by primary care teams.

- (3) Any immunisation must be shown to be safe, acceptable, and appropriate.

- (4) The need for the immunisation must be shown by appropriate research in general practice populations.

- (5) There should be absolute honesty about the purpose of the campaign.

- (6) Payment for planning campaigns and giving vaccines should be based on a combination of item of service and performance related pay.

- (7) The primary care team must be fully and appropriately involved from the outset.

- (8) There must be a cost benefit in terms of the patient, the relatives, employment or education costs, and health care costs.

Mass campaigns may work in the Third World, where uptake of routine vaccination is low. In Britain uptake is extremely high as a result of the activities in primary care over the past three decades. To change a system that has worked is not appropriate to the NHS in the 1990s. To use over £20m of scarce resources in drug and administrative costs alone requires more justification than has been presented to us.

Damage done by the inappropriate and inaccurate literature issued in the course of the measles and rubella immunisation campaign could have serious consequences for the acceptance of vaccines in the future. I hope that possible rejection of a highly effective and safe vaccine by certain religious groups will not increase the number of fetuses damaged by rubella virus in the future.

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Little importance placed on infants aged under 15 months

EDITOR,—The national measles immunisation campaign last November aimed at immunising 95% of all primary and secondary school children and preventing an outbreak of measles. The government's emphasis was that the campaign would prevent measles occurring among the school age population.¹ Little importance, however, was placed on how this campaign would prevent outbreaks of measles in infants under 15 months.

An outbreak of measles occurred in the Southern Health and Social Services Board area last winter. In 1992 only 55 cases of measles were notified in the board's area, the lowest number recorded in the past 20 years. The number of notifications increased in November 1993. Initial notifications were of secondary school children, and subsequent notifications were of all age groups during the outbreak between November 1993 and March 1994. A total of 235 cases were notified during this period (table). The largest number of cases notified were in people aged over 12. This may be explained

Age specific attack rates during outbreak of measles

Age	No of cases	Age specific attack rate/1000 population
< 15 Months	55	9.02
16 Months-5 years	47	2.57
6-11 Years	57	1.87
12-18 Years	76	2.23
Total	235	

by the poor uptake of measles vaccine during 1980-4.² A large number of cases occurred in children under the age of 15 months—another group who had not been immunised.

Although initially the outbreak started among older schoolchildren, the highest attack rate occurred among the children aged under 15 months. These findings are consistent with experience of outbreaks of measles in the United States.³ For optimum immunity to measles, mumps, and rubella it is recommended that the vaccine should be given at 15 months of age. Normally, if no outbreak of measles occurs among older children those aged under 15 months are protected. It is hoped that the current immunisation campaign will not only prevent the transmission of measles among older children but also protect vulnerable infants who have not been immunised (under 15 months of age), who have the highest attack rate in any outbreak.

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Rubella component of vaccine was ignored

EDITOR,—The recent measles-rubella campaign in schools around Britain has had a mixed reception.¹ Despite some adverse publicity the uptake of the vaccine has been quite high (89% of parents signed for the vaccine in Gateshead; final uptake figures are awaited). The campaign aimed at avoiding a predicted outbreak of measles at the same time as speeding up the elimination of the congenital rubella syndrome.² Did the children, however, really know what they were getting? While being given the vaccine in schools in Gateshead children were asked if they knew what the vaccine was for. Most mentioned measles, but few mentioned rubella (or German measles). A small survey was carried out in one school during a vaccination session. Of the 90 children aged between 6 and 11, 64 were aged ≥8. Seventy nine children knew that they were being immunised against measles. Only 10 knew they were also being immunised against rubella. Many suggested that they were being immunised against “brain damage.” One thought that the vaccine was to prevent “wheezles.”

Most children are aware that they have been given an injection to protect them from measles, and many equate this with protection against brain damage (which was emphasised strongly in the government's promotional campaign). Sadly, few of the children were aware of the rubella component of the vaccine. The advertising campaign emphasised measles but ignored rubella.

Before this campaign rubella vaccine was given to all girls aged about 11 years. In many schools a school nurse would visit and explain about rubella before the vaccine was given. The measles-rubella campaign, however, was carried out rapidly with little time for health education. It is still not too late to provide further information to these children so that they can understand the potential benefits of this campaign.

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