

Freedom of speech in the new NHS

SIR,—The recent changes to the NHS and the circumstances in which consultants may be made redundant have made us fear for the right of professionals to speak out independently in the new NHS. This issue was discussed in BBC2's *Public Eye*.¹ We believe that this uncomfortable subject should be discussed widely among the profession. We wish to raise several issues, which are neither of malpractice nor of persistently inadequate work.

Firstly, what are the grounds for dismissing a consultant from the NHS? The NHS is, after all, virtually a monopoly employer of doctors.

Work patterns are changing as a result of restructuring of the hospital service, and consultant services may therefore have to be redistributed. Potentially these changes could be considerable. When a hospital is closed, clearly the staff has to be either redeployed or dismissed. Are there guidelines for the proper protection of NHS consultants? What part would the BMA play in such negotiations, or is there a need for some independent arbitrating body? Does the BMA regard one of its principal functions to be to represent its members against dismissal without valid cause?

What security of tenure do consultants have? Who decides who is made redundant? And on what terms? Will these decisions be taken in the open, and with the BMA acting in the interests of its members, or can the decisions be made in secret? Can redundancy be used, or threatened, as a substitute for disciplinary hearings? Can we be sure that a consultant will not be made redundant on the grounds that "he does not fit in with our new corporate image"; "she keeps complaining that the nursing establishment on her wards is inadequate to maintain proper standards of care"; or "look what our hospital might save if we got rid of this difficult old codger"—are there any guarantees that these arguments are not going to determine who is made to go?

When a consultant is to be made redundant on the grounds of the workload being insufficient who determines what constitutes an inadequate workload? Is it the provider, who sets costs; the purchaser at the health authority; or the professional bodies, the royal colleges? Do the rules change under trust status?

Secondly, precisely what position is the BMA taking in its role of protecting a member's right to voice concern in an appropriate way about the care of patients for whom he or she is responsible, even if this may cause embarrassment to his or her employers? Can changing work patterns be used as a pretext for engineering the dismissal of a consultant who may have made it known that he or she does not agree with managerial policies, even though the consultant is delivering excellent medical care?

Thirdly, in these kinds of cases presumably neither of the medical defence organisations is the appropriate body. Is the BMA the organisation responsible for defending its members at tribunals and for covering their legal costs? What of the royal colleges?

When issues concerning the responsibility of consultants and continuity of care for patients arise it is important that we, as professionals, can speak out unfettered by those who pay our salaries and that we are supported by our professional body.

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1 Godlee F. Secret service. *BMJ* 1991;302:1214. (18 May.)

*The secretary of the BMA replies: The right of consultants to speak and write freely on any matter without the prior consent of the employing authority is a fundamental protection of their professional independence. This right is set out in paragraph 190 of the terms and conditions of service of consultants, and the BMA has strongly advised consultants in trusts to ensure that this provision is retained in their contracts.

Detailed guidance on disciplinary, complaints, and redundancy procedures has been set out in the BMA's consultant handbook, which was recently distributed to all consultant members. Again, doctors working in trusts should seek to ensure that they retain the same degree of security and the same rights as their colleagues in directly managed units. Members may seek advice and support on any contractual problems as necessary from their local BMA office.

Deaths certified as due to coronary artery disease

SIR,—I take issue with Dr K R Sumner's comments concerning the accuracy of pathologists' diagnoses after a coroner's necropsy.¹ Dr Sumner believes that many unexpected deaths are wrongly attributed by the pathologist as being due to ischaemic heart disease, whereas the actual cause of death in a considerable proportion of these cases may be intracerebral disease but the pathologist has not examined the brain. It is implied that such inaccuracies may explain the relatively high mortality from ischaemic heart disease in Britain compared with countries such as the United States, where deaths may be certified more accurately.

During the past five years over 6000 coroner's necropsies have been performed at Bristol City Mortuary, where it has been the policy to open the cranium and examine the brain in every case. This practice has shown an unexpected intracranial cause of death (that is, there was no clinical history suggestive of intracranial disease) in just six cases. In no way do these figures exempt examination of the cranial vault and its contents from routine necropsy procedure; a necropsy at which this has not been performed cannot be considered to be complete. (Is not examination of the brain the rule in British practice rather than the exception?)

A common obstacle faced by British pathologists is the rigid format of death certification. This leads to "pigeon holing," whereby death is neatly attributed to one underlying disease process whereas in practice it is often the result of multiple diseases. For example, if an elderly patient with known ischaemic heart disease dies at home from acute renal failure secondary to dehydration then in the absence of full clinical details the pathologist might conclude that the most likely cause of death was ischaemic heart disease. Unfortunately, the absence of an adequate clinical history at the time of necropsy is not uncommon, even when the person who has died was recently attended by his or her practitioner. Surely the case cited by Dr Sumner (in which a patient exsanguinated and the diagnosis after postmortem examination was given as myocardial ischaemia secondary to coronary artery disease) is an example of this.

The accuracy of death certification in this country is worrying, as it is well known that clinical and postmortem diagnoses disagree in a considerable proportion of cases and rates of necropsy are falling in nearly all centres. But as is the case with other histopathological tests, the accuracy of the result of a necropsy will vary with the adequacy of the clinical details available.

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1 Sumner KR. Deaths certified as due to coronary artery disease. *BMJ* 1991;302:1402. (8 June.)

SIR,—Dr K R Sumner raises the possibility that failure to examine the brain at necropsies performed for a coroner will result in incorrect reporting of the incidence of ischaemic heart disease.¹ We have examined our records on adults who were dead on arrival at Derbyshire Royal Infirmary and had a coroner's necropsy during 1986-90. Excluding deaths from suicide, trauma, industrial disease, and industrial injury, the total number for the five years was 2645. Examination of the brain was recorded in 2642 cases and a brain lesion was the main cause of death in 108 (4%).

These figures support Dr Sumner's view that failure to examine the brain at necropsy will produce errors in diagnosis. We doubt, however, that this occurs to any appreciable degree: we believe that for most departments of histopathology the proportion of brains examined in cases of sudden unexpected death in adults are similar to, or better than, ours.

We do regret the three that got away.

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1 Sumner KR. Deaths certified as due to coronary artery disease. *BMJ* 1991;302:1402. (8 June.)

SIR,—Dr K R Sumner is right to question the accuracy of mortality statistics for ischaemic heart disease in the United Kingdom.¹ Although inaccurate postmortem reports such as he describes may well occur, I suggest that a more important source of error is the large number of deaths for which no postmortem information is available.

In England and Wales in 1988, 153 084 deaths were certified as due to ischaemic heart disease. Only 18% of these deaths occurred in people aged under 65 and 53% occurred in those aged over 75. The figures for deaths due to ischaemic heart disease among women are even more striking, being 9% and 69% respectively.²

Although no British statistics on rates of postmortem examination at different ages are published, data from the United States show a progressive fall with age, with a rate of postmortem examination of 5% in those aged 85 or more,³ and there is no reason to suspect that this trend is not repeated in Britain. This is important as the accuracy of the clinical diagnosis of cause of death declines with increasing age of the patient, with only 47% of all clinical diagnoses in those aged over 75 being confirmed at postmortem examination.⁴ Reasons for this are multiple but may include the relative, and sometimes appropriate, under-investigation of elderly patients in their terminal illness.

Most deaths certified as due to ischaemic heart disease in the United Kingdom are therefore those of people who in life were less likely to be thoroughly investigated and in death were less likely to have a confirmatory postmortem examination. Any death certification system that, like our own, demands a precise pathological diagnosis but does not require confirmation by postmortem examination can lead only to inaccuracy, particularly among elderly people.

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1 Sumner KR. Deaths certified as due to coronary artery disease. *BMJ* 1991;302:1402. (8 June.)

2 Office of Population Censuses and Surveys. *Mortality statistics: cause. England and Wales*. London: HMSO, 1988:35-7. (Series DH2, No 15.)

3 Kohn RR. Cause of death in very old people. *JAMA* 1982;247:2793-6.

4 Cameron HM, McGoogan E. A prospective study of 1152 hospital autopsies. I. Inaccuracies in death certification. *J Pathol* 1981;133:273-83.