fractures and cancers. For other diseases few agreed case definitions exist[8] and when they exist they are rarely used. Tackling this comprehensively would be a massive task and, given the rate with which knowledge is advancing, one that would be doomed to permanent obsolescence.

There is, however, a strong case for clinicians to come together, locally or nationally, to develop and disseminate agreed definitions of the most important diagnoses, procedures, and complications so that, when information is produced, everyone speaks the same language. This requires more than the substitution of one set of words, such as those associated with Read codes, for existing classifications. It will sometimes require research to develop validated tools that can be used to determine whether a patient has a particular disorder and, equally importantly, how much of it he or she has.

These studies, and others, also support the view that ownership of data contributes to accuracy.[9] Yet this may not mean that information systems based on separate specialties are always a good thing. In too many hospitals they do not interface with the routine data system and therefore can duplicate work. Also, systematic training for specialty based coders should be available, as it is for routine clinical coders. At present some hospitals manage to obtain much better results than others. It is unclear why, and this merits further study.

Clearly, many routine administrative data are still inadequate to support audit, not to mention contracting. Some purchasers are beginning to impose financial penalties for inadequate data, although this may encourage providers to focus on completeness rather than accuracy.[10] Increased use of clinical data in contracting may improve some aspects of accuracy, although experience from the United States indicates the potential pitfalls.[11]

If comparative audit, based on either routine or ad hoc collection of data, is to succeed, it will require support. The royal colleges and professional associations have done much, but, with the fragmentation of the NHS resulting from increasing competition between providers and the demise of regions, it is far from clear how such activities might be supported in the future.

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Medicine's core values

Summit meeting agrees on several, but others need further debate

British doctors failed to notice that the world around them had changed utterly and so were unprepared for the "blitzkrieg from the right" that overwhelmed them at the end of the 1980s. This was the diagnosis from Sir Maurice Shock, former rector of Lincoln College, Oxford, when he opened last week's meeting of doctors' leaders to discuss the core values of medicine. This was the first "summit" meeting of the profession since 1961 and was prompted by falling morale and influence and a request from the chief medical officer for the profession to look beyond present circumstances to consider its future.[1] It occurred the day after the General Medical Council discussed proposals to change its guidance to doctors from a list of what must not be done to a description of what is required of a good doctor (p 1251).

Doctors seemed to imagine, said Sir Maurice, that they were living in Gladstone's world of minimal government, benign self regulation, and a self effacing state. In fact, "instead of the rights of man we have the rights of the consumer, the social contract has given way to the sales contract, and, above all, the electorate has been fed with political promises . . . about rising standards of living and levels of public service." The appearance of the consumer society together with medical advances on an unprecedented scale and "the rise and rise of the geriatrics" has meant that "the doctor is different, the patient is different, and the medicine is different." In short, warned Sir Maurice, "everything is different except the way you organise yourselves."

The clergy may have escaped to what Sir Maurice called "a niche market," but there can be no escape for doctors: "medicine is right at the centre of our affairs." Doctors cannot swim against the tide and must recognise that "this is an age of regulated capitalism in which the consumer is courted and protected, encouraged to be autocratic, and persuaded of his or her power." Doctors must, he advised, form alliances with others, use the media, and deal with politicians at all levels. They must participate in the management of the health service, and he said: "You have also got to put your backs into ensuring that managers—whether doctors or not—are properly trained." Doctors must be willing to "get their hands dirty" with making decisions on allocation of resources, must speak authoritatively and sensibly to the consumer, and must get the message across on the importance of research and development in the quality of medicine. If they organised themselves in these ways, the government, said Sir Maurice, would have to work with doctors because "you can conquer with a blitzkrieg but you cannot occupy."

Sir Maurice, who has had wide experience in political life, advised that "doctors will have to surrender some independence to a new representative body which in its turn has an executive served by a small administration of the highest calibre. The remit of such a body would need to be loosely defined within a federal structure, and it should largely concern itself with matters of high politics and strategy." But he also supported strongly the re-

evaluation, redefinition, and restatement of core values, which he called "ancient virtues distilled over time." They remain, he said, the profession's greatest asset, but "they are not enough in modern times unless they are related to the problems we face now and backed by an organisation fit for the purpose." Sir Maurice galvanised his audience. Some disagreed with his message, but most seemed to accept both his diagnosis and his prescription.

Agreeing on core values

David Morrell, president of the BMA and a former professor of general practice, presented the meeting with six core values to discuss: confidence, confidentiality, competence, contract, community responsibility, and commitment. These core values are derived, he believes, from the centrality of the doctor-patient relationship. James Spence wrote in 1960 that "the essential unit of medical practice is the occasion when in the intimacy of the consulting room or the sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in medicine derives from it."[2]

Confidence of the patient in the doctor is at the heart of the doctor-patient relationship, which must be "a real human relationship based on love, caring, and sharing." The confidence depends on the integrity of the doctor. Confidentiality must be a core value for medicine, but teamwork, accountability to management, and computers all threaten it. Doctors must maintain their competence through continuing study and development, and the profession must be able to guarantee the competence of its members through audit, peer review, and possibly reaccreditation. Doctors have an unwritten contract with their patients to provide optimal care within available resources, but they also have contracts with their employers. If a conflict arises between these two then priority must be given to the contract with patients. Responsibility to the community includes pursuing the equitable distribution of resources. The last core value, commitment, meant that those entering the profession should commit their working lives to the service of patients. Medicine "is not a job which can be constrained by strict working hours or subject to demarcation disputes . . . [and] has an inevitable impact on family life, friends, and social activities."

Four of the five working groups at the conference that discussed these proposals essentially agreed with them, although they added the values of encouraging a spirit of inquiry, promoting good communication and cooperation, working together and respecting each other within the profession, and speaking out on matters of importance to the public health. One group, however, thought that the Spence concept was too restrictive in that it excluded the many doctors who do not consult with individual patients and failed to recognise the importance of promoting health and how much of modern health care and prevention is practised in teams. This group was more attracted to the core values proposed by Kenneth Calman, the chief medical officer, in the *BMJ* of two weeks ago: a high standard of ethics; continuing professional development; the ability to work in a team; concern with health as well as illness; patient and public focus; concern with clinical stan-dards, outcomes, effectiveness, and audit; ability to define outcomes; interest in change and improvement, research, and development; and ability to communicate.[3] The group thought that these values were robust, worked for all parts of the profession, were in touch with the modern world, and gave something to aspire to.

There was more agreement than disagreement over core values, and the steering group responsible for organising the conference summarised the areas of agreement as caring, integrity, competence, confidentiality, responsibility, and advocacy. These were presented to the press earlier this week. There will need to be further debate on how much the profession at large accepts these values (because those at the meeting were predominantly male and middle aged and unfortunately included no doctors from ethnic minorities), to define what the values mean in term of action, and to explore further the areas of disagreement.

One issue that the meeting found difficult was how much a doctor's responsibility stopped with the patient in the consultation and how much it extended to other patients, potential patients, the local community, and the world beyond. Should all doctors adopt a broad view or was it enough if some members of the profession did? How far did the doctor's responsibility for allocation of resources extend? Could it ever influence the treatment of an individual patient? The conference also had difficulty with the balance between being responsible for promoting health and treating disease. If health care has only a limited impact on the health of the population should doctors encourage a shift of resources from health care to education, housing, and employment, which might have a greater impact? There were questions too about how much doctors should promote social justice: did they have an obligation to speak out on the subject in public or was it enough to ameliorate its effects among their patients? How too could doctors balance respecting each other with having to act to stop a colleague who might be harming patients? There was also spirited debate over how closely doctors could work with managers; despite Sir Maurice's advice, some thought the value systems of doctors and managers were in fundamental conflict.

Commitment gave rise to discussion in most of the groups. While some wholeheartedly supported Professor Morrell's message, others thought that his view was outdated: it failed to recognise that many doctors of both sexes choose to work part time and that putting commitment to patients ahead of commitment to family may injure both. General practitioners have already tackled this issue in their debate over 24 hour cover,[4] but the profession will have to work hard to decide exactly what it thinks.

Although the topic was often mentioned, the conference did not tackle in depth the issue of whether doctors need a further organisation to allow them to speak with one voice. This idea, which was discussed in the *BMJ* of two weeks ago,[5] has long been on the agenda,[6,7] but there seems now to be a growing conviction that action is needed. Existing organisations would need to cede some of their power, but the overall power of doctors to understand and influence the world changing around them would surely increase. It must happen.

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