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 officer[1] 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. (12 November.)

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

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