When patients often ask innocently, "What would you do if it were you, doctor?" the answer should come with a health warning
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All countries need a strong advocate for public health

The role of chief medical officer is an essential part of good health governance, says **Gabriel Scally**

As the global economic crisis continues to have detrimental effects on health and health services around the world, the need for powerful advocates for public health at the heart of government has never been greater. The importance of an articulate and authoritative voice that can tell elected politicians the potential health consequences of their actions and inactions has been recognised in many democracies since the 19th century.

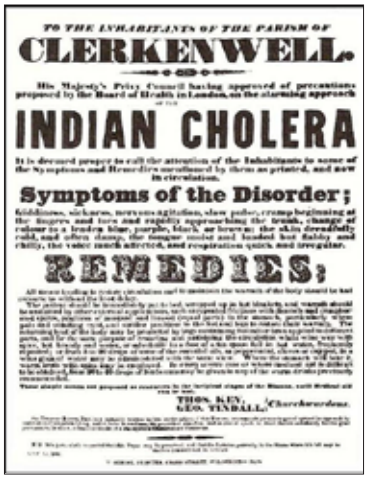
Many countries have such a post designated in their governmental structures to provide expert advice on current and potential hazards to public health. How this national role is positioned varies hugely, however. In European Union countries it ranges from a top level office occupied by a public health physician to a post at a lower level of government, or even separate from it, and occupied by an administrator rather than a physician.[1]

Perhaps the two most prominent posts globally are the US surgeon general and the chief medical officer (CMO) of England, which incorporates the role of chief medical adviser to the UK government. These two posts show the advantages and hazards of having a medical voice so close to the heart of government.

The US has had a surgeon general since 1871. He or she is an officer in the US Public Health Service, and the holder is appointed by, and serves at, the pleasure of the president. Although lacking substantial power, the post has traditionally had a high profile and carries a public expectation of championing public health goals and aspirations.

The close connection with the political process can lead to conflict if the surgeon general's views meet with the disapproval of the president. Bill Clinton sacked Joycelyn Elders, the 15th surgeon general, after a series of controversial statements on sexual health.[2] Even more tellingly, at a hearing of a House of Representatives committee in 2007 three former surgeons general gave testimony of a culture of political interference in their role.[3] Richard Carmona, who served George W Bush, experienced the most extreme professional repression, he told the House Committee on Oversight and Government Reform in 2007. He was regularly told what he should or should not say and had his reports censored and suppressed. He was even instructed not to prepare reports on mental health, emergency preparedness, and global health.

The history of the CMO in England stretches back to 1855, when John Simon was appointed medical officer to the Board of Health in response to the threat of cholera.[4] Simon used his considerable political skills to establish his freedom of speech and his access to ministers and the machinery of government. Despite being the driving force behind many pieces of public health legislation that laid the foundations of the improvement in population mortality, even Simon was eventually marginalised and resigned.[5] The post, however, has remained: it is a high level civil service post, and now has its 16th holder. Liam Donaldson, the 15th, broke new ground as a senior civil servant by making public his disagreement with the government on the subject of control of environmental tobacco smoke and by surviving in office with even greater influence. His robust approach to protecting the public's health won the day. He combined this independence of view with helping the government develop important policies on health and healthcare.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Public health has a long history

Historically, the best CMOs have been willing to speak publicly without fear or favour but often also did so behind closed doors

Historically, the best CMOs have been willing to speak publicly without fear or favour but often also did so behind closed doors, where tough arguments with recalcitrant or ideologically dogged ministers needed to be won. This strength often garnered respect—sometimes, ironically, from politicians who received praise for taking the firm public health action on which they were reluctant to embark (smoke-free legislation in England is a good example of this).[6] Perhaps, though, strength and fearlessness are not to the taste of all political administrations. Donaldson's successor was appointed on a short term contract to a post diluted by being combined with the role of director general of research and development (a demanding portfolio in its own right with extensive international commitments) and is one of the few English CMOs to have no public health background.

Even more curious is the UK government's decision to appoint a medical scientist to the post of chief scientific adviser. This seems a recipe for conflict, misunderstanding, and confusion, particularly in giving advice to the public on aspects of health risk and also in the handling of emergencies, where both CMO and chief scientific adviser sit around the COBRA table to guide ministers' decisions. It remains to be seen whether the nation can have two doctors, especially if they disagree in public, say, on vaccination policy.

The challenges set by landmark reports on social determinants of health in the UK and globally should presage a broadening in health thinking that is, in its way, equivalent to the sanitarian movement that shifted the focus from care to prevention in the 19th century.[7 8] For this reorientation to succeed even partially requires outspoken public advocacy at local, national, and international level. The role of CMO at national level as an empowered advocate of population health should be promoted by the World Health Organization as an essential component of good health governance for the 21st century.

Towards the end of Brecht's play *Life of Galileo*, Galileo says, "Unhappy is the land that needs a hero."[9] The state of global health is such as to indicate clearly that we desperately need passionate public health heroes at the heart of national governments.

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Competing interests: GS was a candidate for chief medical officer of England in 2011.
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FROM THE FRONTLINE **Des Spence**

The cause of clinical variance

Why does the United States spend so much on healthcare yet have such poor health outcomes? Why do many patients from the developing world believe that "injections" are a cure-all? The answer is simple: financial incentives are grossly disfiguring world healthcare. Pay doctors to intervene, and they duly will, irrespective of the harms caused. A nation's health seeking behaviour is solely defined by the payment structure of its healthcare system. Thus, private systems have a vested interest in making us all patients, for this is just good business. More medicine should never be confused with better medicine. If we paid all doctors salaries, it would save money and lives and hence should be the number one health priority for the World Health Organization.

There is another unacknowledged, uninvestigated, yet irrefutable fact—that the personality of the doctor directly affects his or her clinical care and the advice he or she gives patients. And remember that clinical medicine is just a casino, playing the odds, counting cards, and working out the probability of disease. The good news is that the odds are wildly stacked in our favour, for disease is rare. Yet most doctors aren't the gaming types, naturally uncomfortable with risk, unwilling to chance something going wrong, however long the odds. So, just as disease is declining, we are investigating ever more. The more tests, the more spurious abnormal results. We get a pyramid scheme, more referrals, more unnecessary investigation, an unstoppable chain reaction of false positive results. This is all compounded by superspecialism and the loss of generalism. We have forgotten the most important intervention of all—non-intervention. Little wonder that overdiagnosis, overtreatment, and iatrogenic harm are the defining characteristics of today's financially unsustainable medicine.

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And it's not merely our personality that influences patient care but our own health beliefs as individual doctors. It is not science but emotion—beliefs in, for example, antibiotics for sore throats, physiotherapy, homeopathy, statins, acupuncture, pain, gluten, antidepressants, and the rest. This combination of personality and our disparate health beliefs explains the wide variance in referral rates (which vary 10-fold between GPs[1]), hospital admissions, prescribing rates, investigations, and, ultimately, the costs between doctors. None of this variance is explainable by epidemiology or the demographics of the populations served. This might even be worthy of research, but no one seems interested in the bigger picture when they have the microscopic to measure. So when patients often ask innocently, "What would you do if it were you, doctor?" the answer should come with a health warning.

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BMJ BLOG **David Payne**

Horsemeat and the FSA

The horsemeat scandal has triggered calls for the UK's food safety watchdog to have stronger regulatory powers. The Food Standards Agency was stripped of its nutrition and labelling roles in a cull of quangoes shortly after the coalition government entered office in 2010. Isn't it time they were returned, to restore public confidence in the food chain?

The FSA never was a quango. It's a Treasury funded UK government department which, in the six years I worked there (from 2001 to 2008), negotiated in Brussels on a raft of food safety and dietary legislation, provided hands-on enforcement and surveillance at UK abattoirs, and worked with local authority food law enforcement and trading standards teams.

Stripping the FSA of its powers has left its founding "farm to fork" principles in tatters. Nutrition now sits with the Department of Health in England and Wales, but not in Scotland and Northern Ireland. Labelling sits with Defra in England, but still with the FSA in Scotland, Wales, and Northern Ireland. This hotch-potch situation is ridiculous in a country the size of the UK, where food businesses operate in all four countries.

Food is an emotive topic, so the agency is always upsetting people and is vulnerable to attack. It was perceived as anti-organic because it could not find conclusive evidence that organic food had nutritional benefits. It was accused of being pro-GM, despite holding a citizens' jury in 2003 in its drive to put consumer interests first.

The FSA took on the supermarkets by championing traffic light labelling over guideline daily amounts. Its risk based approach means cattle older than 30 months were allowed back into the food chain, and its food safety star rating system allows us to see instantly how food outlets fared in their last hygiene inspection. The agency also persuaded bakeries and other food producers to reformulate products so they contain less salt. This was underpinned by an awareness campaign to persuade consumers that 6 g a day (a teaspoon) is too much.

The agency wasn't perfect, of course. Sometimes it misjudged the public mood, most notably when it appeared to defend the practice of bulking out chicken portions with water, on the grounds that it wasn't illegal as long as the water content was displayed on the label.

Last week the cross party Environment, Food and Rural Affairs Committee said the agency should have the power to force producers to undertake testing and that testing results should be reported.

But how can it do this unless some of its former powers and budget are restored?

The coalition government should bring back the FSA outlined in the 2000 Food Standards Act, an independent government department that puts consumers first and takes decisions in public based on robust scientific evidence.

Bring back the FSA as a government department that puts consumers first and takes decisions based on robust scientific evidence

David Payne is editor, bmj.com. He was the FSA's web editor from 2001 until 2008.
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