his future support. But now a revised contract specifies that the publication "is subject to the prior consent of the Secretary of State, which consent shall not be unreasonably withheld." The change has been questioned, and the answers have been (a) that nothing has changed, the effect of copyright being "vested in the Crown" is merely being spelt out; and (b) that weight must be given to the clause "consent shall not be unreasonably withheld." As is the sad way with explanations, these leave room for doubt—why make a change which alters nothing, and who judges what is "unreasonable."

DOUGLAS BLACK

Whitchurch on Thames
Nr Reading RH8 7EN

- 1 Popper KR. *The open society and its enemies*. Vol 1. 5th ed. London: Routledge, 1966:86.
- 2 Blumenthal D, Gluck M, Louis KS, Stoto MA, Wise D. University-Industry research relationships in bio-technology: implications for the University. *Science* 1986;232:1361-6.

Clinical freedom

Twenty years ago, in 1967, a younger Sir Raymond Hoffenberg was in charge of the iron lung respirator at Groote Schuur Hospital in Cape Town. Journalists from all over the world had come to the hospital to write about the first heart transplant operation on Louis Washkansky, who had died after a few days. For his second operation Dr Christian Barnard wanted the heart of a patient being ventilated after a subarachnoid haemorrhage. This was Hoffenberg's patient, and he had to make the decision: Was the patient brain dead? "After a sleepless night and three visits to the bedside," he now tells us, "I acceded to the request."¹ The heart was transplanted into Philip Blaiberg, who lived for about 18 months—and whose survival led to a euphoric, uncontrolled epidemic of heart transplantation around the world.

The decision to switch off the ventilator and the surgeons' rush to join the transplant bandwagon were examples of old style clinical freedom, defined by Sir Theodore Fox: the doctor "can see whatever patients consult him when it suits him; he can give what advice he pleases, however unorthodox, and provide whatever treatment he pleases, however expensive or lethal; he can behave towards his patients however he pleases and extract from them whatever they will pay."²

Such freedoms no longer exist in Western countries, and the process by which they have become restricted is the subject of Sir Raymond Hoffenberg's 1987 Rock Carling Fellowship lecture and monograph—nowadays as familiar a feature of the English Christmas as the lectures for children at the Royal Institution or the tree in Trafalgar Square.¹

This year in Britain the most obvious restraint on the clinician's freedom comes from the lack of resources—nurses, theatre time, equipment, or simply money. Yet, paradoxically, Sir Raymond argues that economic restraints have had more impact on clinical freedom in the commercialised, competitive environment of the United States than in Britain. Payments in the Medicare-Medicaid programmes are linked to the concept of diagnosis related groups, which effectively limit the amount that can be spent on each patient admitted. Health maintenance organisations exert similar controls. In every country (outside private practice at the most affluent level) every doctor nowadays has to consider the costs of his proposed management of a patient—and

increasingly often he may decide against an expensive intervention.

But will he—and should he—tell the patient what he is thinking? Paralleling the financial restraints on clinicians has come far greater awareness by patients of their claim to participate in medical decisions. And in clinical research a third constraint has emerged—the need for an independent ethical committee to approve the design of studies and to ensure that patients' consent is freely given after they have been given all the relevant information.

Yet after 20 years of effort to introduce controls the clinician who has the old style insensitive arrogance may sweep many of them aside. Sir Raymond quotes the example given by Professor Michael Baum—the surgeon who treats breast cancer by mastectomy until suddenly he undergoes a conversion and switches to lumpectomy and radiotherapy. If he wants to compare the two treatments he needs a research protocol based on informed consent; but if he simply changes his daily practice he has no need to tell his patients that he has changed his mind or why. Indeed, it is the variation in clinical practice that remains the uncontrolled, unregulated territory of clinical freedom. Despite a measure of uniformity resulting from cost constraints, ethical reviews, fears of litigation, and more articulate patients there are still some clinicians who are less than competent or whose decisions would not be approved by their colleagues.

The medical profession has been talking about medical audit throughout the 20 years that have seen the emergence of the other controls. Sir Raymond describes the scheme at the medical unit at the Queen Elizabeth Hospital in Birmingham. A one hour lunchtime meeting is attended by the consultant physicians on the unit, their junior staff, and the senior medical students attached to the consultants at the time. The inpatient notes of randomly selected patients discharged within the previous month are reviewed by a consultant or a member of the junior staff on the basis of a detailed form. Questions relate to the quality of the notes, the use of investigations, the appropriateness of treatment, and the (recorded) information given to the patient, relatives, and (on discharge) the general practitioner.³

Such meetings are educational and seem certain to improve the quality of care—by those consultants who attend. But all too often the one consultant whose activities have been worrying colleagues is the one who will not go to audit meetings. The maverick goes on his or her way until a catastrophe forces the medical disciplinary procedures into their cumbersome action.

Clinical freedom may, indeed, have something in common with freedom of the press—it is the glib excuse occasionally put forward to explain why the profession does nothing about behaviour that is, in reality, inexcusable. "More than ever," Sir Raymond concludes, "it is now necessary for us to introduce a system for assessing professional competence. If we do not we shall fail to satisfy the public and invite regulation from outside the profession." And some initiative is needed urgently—for with the NHS in turmoil a radical restructuring of medicine may be close at hand, in which doctors may have all too little a part.

TONY SMITH
Deputy editor, *BMJ*.

1 Hoffenberg R. *The Rock Carling Fellowship 1986. Clinical freedom*. London: Nuffield Provincial Hospitals Trust, 1987.

2 Fox TF. Professional freedom. *Lancet* 1951;iii:115-9.

3 Heath DA, Hoffenberg R, Bishop JM, Kendall MJ, Wade OL. Medical audits. *J R Coll Physicians Lond* 1980;14:200-1.