CMO Letters.

Comment by Dr Iain S. Macdonald

1. In the course of oral evidence from Professor Lowe and Professor Ludlam on 13 and 14 October 2011 there was discussion about the availability of expert guidance on the treatment of haemophilia patients to doctors in various situations . It was noted that a guidance document emanating from a meeting of haemophilia reference centre directors (UKHCDO) in December 1984 had been circulated by the secretary of that group to all directors of haemophilia centres, including those that were not reference centres. The discussion was widened to consider the position of doctors in smaller hospitals and more remote situations.
2. This wider consideration led Professor Ludlam to suggest that advice on treatment of haemophilia should perhaps come from the chief medical officer. (14 October, page 62, lines 20-21) Professor Ludlam explained later that he regarded this as a matter of public rather than medical policy and that what he had in mind was indeed that the CMO might have circulated detailed advice on the use of substances such as cryoprecipitate, Factor VIII concentrate, etc, in particular circumstances. (page 125, line 12, to page 126, line 8)
3. If this suggestion had arisen at the relevant time it would have fallen either to Sir John Reid or to me to consider it. If it had fallen to me I would have dissented from Professor Ludlam's view on what was public policy and what was medical policy.
4. It was certainly a matter of public policy that suitably qualified staff and facilities for the treatment of haemophilia should be provided. Decisions on such a provision would be taken with help from knowledgeable clinicians to determine the facilities and staffing needed. Such decisions would be conveyed to health authorities through administrative rather than medical channels.
5. Decisions about the treatment of individual patients would however be a matter for the medical staff treating them. It was generally understood to be the responsibility of the medical profession to evolve, in the various ways open to them, treatment policies. This was what the reference centre

directors (UKHCDO) were apparently doing in a difficult and evolving situation.

6. Obviously these two policies, public and medical, had to be brought together in some kind of partnership. They had to be made to mesh together, and in some important respects, to overlap. Although this was generally achieved there was always a degree of sensitivity about the boundary between public and medical policies. Decisions about issues on which a CMO should write to his medical colleagues in the NHS lay in this sensitive area.
7. There are however circumstances in which it was established and accepted practice for CMOs to write to NHS colleagues. It was usual for all CMOs to write in similar terms. Subjects normally addressed in CMO letters fell into two broad categories:-.

A. The prevention or limitation of the spread of infectious diseases.

8. Professor Ludlam cited the example of letters conveying information about infectious diseases in other countries which might be transmitted to UK. Such information may assist in early diagnosis and in taking steps to limit further transmission within UK. These letters would be based on information obtained by DHSS from sources such as WHO, health departments in other countries, or UK embassies and consulates.
9. Vaccination and immunisation have for long been important in reducing the incidence of several significant infectious diseases to a low level and it is usual for CMOs to write about new procedures or changes to existing ones. This is done on the basis of advice to all UK health departments from a standing committee of experts who keep the situation under review.
10. Another example can be found on the letter of 1 May 1975 from Dr Yellowlees, then CMO at DHSS, indicating that in spite of the relatively high risk of Hepatitis B being transmitted by the blood of prisoners, it was not necessary for the blood transfusion service to discontinue the collection of of blood at prisons providing all donations were subjected to one of the more sensitive tests then available. (SGH.003.0188) The purpose of this was to permit the continued use of blood from prisoners while eliminating the risk of further spread of Hepatitis B to recipients of blood and blood products, and the letter was transmitting advice from an expert group. (This letter was

considered twice during oral evidence – on 22 March 2011,pages 74-76 and on 24 March 2011, pages 140-145)

B. The early detection of disease by screening populations at risk.

11. This topic attracts controversy from time to time. Nevertheless, sufficient confidence was established in a number of screening procedures to justify making arrangements to introduce them. When this required the provision of space, equipment and staff, health boards would have been informed through administrative channels of the need to provide these. In parallel with this it may have been expedient for CMOs to write to some or all NHS medical staff. The decision to establish each screening programme would have been based on recommendations from an expert group assembled for the purpose. Such a group may have been appointed formally by health ministers and their report could have been published. A CMO letter could provide an opportunity to explain the reasoning underlying the decision to proceed and clarify any practical issues arising.

Conclusion.

12. Reverting to Professor Ludlam's proposition that a CMO letter outlining clinical matters would have been helpful, I have to say that if this had been put to me as CMO I believe that I would have concluded that the introduction of a government department into an essentially clinical matter being handled by UKHCDO would not have been helpful and probably not acceptable. I would therefore have felt bound to decline.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed Iain S Macdonald

Dated 8 November 2011