# BRITISH MEDICAL JOURNAL

SATURDAY 14 JUNE 1986




## LEADING ARTICLES



## CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED



## MEDICAL PRACTICE




NO 6535 BRITISH MEDICAL JOURNAL 1986 VOLUME 292 1543-1616
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0267-0623
ASTM CODEN: BMJOAE 292 (6535) 1543-1616 (1986)

# CORRESPONDENCE



*Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.*

*Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.*

***Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.***

## Doctors and the Official Secrets Act

SIR,—Many doctors are members of DHSS or other governmental advisory committees, where our first duty is surely to promote and protect the public health. In furtherance of this duty we would expect to follow normal professional procedures, including on occasion seeking advice or further information from colleagues and not being party to concealing matters which affect the public health. Such actions, however, could bring us into conflict with the Official Secrets Act.

From a written answer by Mr Barney Hayhoe to a parliamentary question[1] it now appears that the application of the Official Secrets Act is far wider than most of us ever realised. It includes *all* the main DHSS standing expert advisory committees and seemingly all the others too: the supplementary list includes, for example, the Advisory Committee on Gene Modification Therapy, the Committee on Medical Aspects of Radiation and the Environment, the Community Medicine Inquiry, the Overseas Doctors Study Group, the Leprosy Opinion Panel, the Working Group on the Safety of Nuclear Magnetic Resonance Imaging, the Small Grants Committee—and 36 others.

The minister went on to say that "the Official Secrets Act applies to all official information whether or not a declaration has been signed. The Department does not normally call for a declaration to be made by members of advisory committees."

The decision on what constitutes "official" information is at the government's discretion. Gone are the days when it applied only to information constituting a direct and unambiguous threat to national security: the Official Secrets Act has been used to cover a widening range of politically sensitive matters, and no one can know in advance what may be classified—perhaps retrospectively—as "official."

All doctors who are members of any governmental advisory body are thus liable for prosecution and potential imprisonment if they divulge information which the government—at the time or later—decrees to be "official." If they discuss a problem with a colleague "in confidence" and that colleague makes it public they are again liable for prosecution. It would be no defence that medical duty required openness.

When a minister announces in parliament that the Official Secrets Act applies to the Leprosy Opinion Panel, something has gone wrong. The position is clearly crazy and out of control. The British Medical Association should organise pressure on government to exclude from its list all those advisory bodies whose business is not related to national security (which in the case of health means almost all of them). Meanwhile doctors who are members of governmental committees ought to inform their chairmen that discretion, not the Official Secrets Act, will be their guide; and that they will not accept secrecy if concern for the public health requires otherwise.

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1 Hayhoe B. Written answer. *House of Commons Official Report (Hansard)* 1986 May 16;97:col 587-8. (No 115.)

## Pseudo-obstruction

SIR,—The review on colonic pseudo-obstruction by Professor H A F Dudley and Dr S Paterson-Brown (3 May, p 1157) is both timely and welcome. We would agree entirely that, armed with a high index of suspicion, this is a diagnosis that should be made before ill advised surgery and that treatment should be by conservative means whenever possible.

The use of a water soluble contrast enema acutely in suspected cases of mechanical large bowel obstruction is gaining popularity. Our experience[1] is very similar to that later reported by Koruth *et al.*[2] In a series of 117 cases not only did it exclude obstruction in 35 out of 99 patients where the plain film diagnosis was that of obstruction, but in 18 cases where the clinical picture was of colonic pseudo-obstruction the diagnosis was confirmed in 16, an unsuspected mechanical obstruction being noted in the remaining two. Furthermore, we noted that the use of a water soluble enema in cases of pseudo-obstruction was frequently therapeutic in that the osmotic effect of the enema induced diarrhoea, thereby decompressing the colon. Indeed, only one patient in this series came to surgery for impending caecal rupture.

Having diagnosed pseudo-obstruction colonoscopic decompression seems appropriate whenever possible. However, there are cases when it