An important Public Health role is to protect the population from harm from potential threats to health. This role presents challenges: we may be unsure whether something is in fact a hazard (e.g. mobile phone masts); or, it may be not possible to quantify the degree or risk of harm posed by a known hazard. This can leave Public Health in a bind: wait until the degree of danger is clearly established and you can be accused of failing to act promptly to protect the population (the recent delay in closing a petting farm linked to Escherichia coli O157 is an example); act quickly, before the severity of a threat is known, and you can be accused of overreacting (an accusation made by some about the response to swine flu).

In *Terrorism, Trust and Public Health*, McKee and Coker reply to the suggestion that the risk of swine flu has been exaggerated because of vested interests and a claim in *The Guardian* that ‘Health scares are like terrorist ones. Someone somewhere has an interest in it.’ They believe this analogy is not only wrong but dangerous and jeopardizes public trust. Public trust, they note, is important for the effectiveness of Public Health policies, reminding us how public mistrust undermined the MMR vaccination programme.

Why is the analogy wrong? McKee and Coker accept that terrorism and micro-organisms share some similarities—we are unsure of the size of the threat posed and we need to respond with limited information. However, they argue that there is a clear and important difference. Many counter-terrorist activities are based on poor and inherently flawed evidence, and McKee and Coker document the vested interests, large profits, lack of transparency and inadequacy of the intelligence gathering related to the counter-terrorist response. Public mistrust and cynicism regarding this response are thus understandable.

However, McKee and Coker argue that ‘The approach to evidence in the public health community is fundamentally different.’ Firstly, public health evidence is entirely in the public domain. Moreover, evidence used to inform public health decisions is generated and constructed in ways that are designed to minimize biases and increase its trustworthiness (unlike ‘evidence’ obtained from torture). Research evidence can be critically tested and analysed, using methods like triangulation, and is open to challenge by others. This openness and transparency enables Public Health to learn from reflective practice and past failings. The weakness of the US response to the 1976 flu outbreak and the severity of previous pandemics are thus important influences on the current response to swine flu. We do not know if swine flu will be devastating but we know it could be. Thus, the authors argue, the WHO response to the reports of swine flu has been appropriate given past experience and information available and, given what is known, it is better to err on the side of caution. McKee and Coker end with a plea to Public Health to ‘...continue to place our evidence in the public domain and to accept that there is often genuine uncertainty’ because ‘Only by doing so will we retain the trust of the population we seek to protect’.

McKee and Coker are completely right that openness and honesty about the evidence is a prerequisite for it to be trusted by the public. However, it must also be seen to be clearly independent and free of political control. A recent example of inappropriate political spin occurred when Gordon Brown announced, against advice from the UK Statistics Authority, that there had been a decrease in knife crime. The head of the Authority, Sir Michael Scholar, wrote a strong letter of protest against this abuse, noting...
that such behaviour was ‘corrosive of public trust’. This courageous and robust challenge against the selective use of statistics has greatly increased my trust in the reliability and independence of the statistics produced by the UK Statistics Authority. Public Health should seek to emulate this integrity, honesty, courage and independence.

Reference