systems. However, his argument only adds strength to my own in that it highlights the need for the law to look at these issues impartially. Nevertheless, I would like to defend my position on two counts:

1. In reference to the moral philosophers of the past, it should not be forgotten that many based not only their ethical systems on their belief in God, but their epistemological arguments too. George Berkeley argued that we are only aware of objects of sensory perception because God put those ideas into our minds, not because they actually exist as material objects in the world. We no longer need God to explain epistemological phenomena, nor do we need Him or Her to explain morality.
2. A reasonable and coherent ethical theory can be achieved without appealing to God. Kant's categorical imperative, that we should treat other people always as ends in themselves and never as means, is a good example. The utilitarian school of thought, founded by Jeremy Bentham and currently defended by Peter Singer, is another. Neither system pontificates so much on the purpose or destiny of human life as on its value. Both are perfectly reasonable and coherent ethical theories.

Personally, I prefer secular thought to religious doctrine, but I am not the one to decide upon ethical dilemmas. We should look to the law.

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Skill mix in clinical care

Editor – Your editorial on skill mix in clinical care (*Clin Med JRCPL* July/August 2001, pp259–60) illustrates an example of the innovative delivery of health care.

It is a model that is being increasingly used in a primary care setting. Our practice was awarded 'beacon status' based on the development of skill mix in primary care. In addition to nurse practitioners who work under the guidance of protocols and the enthusiastic support of the general practitioners (they see a range of patients with minor illnesses), we also offer open referral clinics for patients to access the physiotherapist with a range of problems.

The service has proved very popular amongst our patients and there were high levels of satisfaction in a patient survey. We are currently exploring the development of a Personal Medical Services (PMS) contract, which encourages practices to consider innovative ways of delivering health care. We hope to expand our services with nurse practitioners playing a key role in the delivery of high quality chronic disease management clinics in diabetes, asthma and ischaemic heart disease.

As a practice we have recognised the need for an integrated approach to health care and continue to develop this for the benefit of the patients and the organisation of health care delivery within the practice.

Our model developed in primary care may have some useful concepts that also apply to secondary care.

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The interface between primary and secondary care

Editor – We are pleased that Professor Mike Pringle has highlighted the importance of the interface between primary and secondary care and the need to improve communication and contact around it (*Clin Med JRCPL* May/June 2001, pp172–4).

General practice has become part of primary care, the practice has evolved to become the primary health care team and responsibility for the individual patient has widened to include the registered population. The hospital physician's role has changed with increasing specialisation, a decrease in beds, greater involvement in emergency care and expanding workload.

Our experience in the North East supports the use of general practice posts to give SHOs useful, complementary educational experiences[1]. These rotations are popular and help develop important generic skills as well as give valuable insight into modern general practice.

The new Primary Care Organisations offer some exciting opportunities. General practice possesses much untapped expertise and the arrival of the Coronary Heart Disease National Service Framework (NSF) has certainly brought GPs and consultants together in our area to focus on implementation[2]. If adequately funded, collaboration between the Older Persons and Diabetes NSFs, may enable the development of clinical networks in which all services are integrated around the patient[3]. Likewise the move from a financially based model of commissioning to an evidence based activity in which clinicians sit down to discuss patient need and the effectiveness of interventions would unlock much potential to develop services.

A recent conference in Newcastle, jointly organised between the Royal College of Physicians and the Royal College of GPs, explored the bridges that are being put across the gap. It was heartening to hear about developments in the clinical, educational, research and organisational links between primary and secondary care. Speakers stressed the need for good communication, forums for discussion which bring the different agendas together, joint protocols and guidelines, using money flexibly and exploiting all opportunities for development.

Clinical governance is central to much of this work. Shared initiatives could include joint learning and significant event audit. Audit and decision support will also help to improve standards and manage demand at the interface[4].

Finally it is important to for us all to remember the multidisciplinary nature of our work and the need to include non-medical colleagues in our planning and education. Much time and effort needs to be invested for the gap to close and eventually become an overlap.

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