‘Evolution, not revolution, at the changing of the Guard’

So, as it does, the baton passes and changes are afoot. First, we say thank you, and goodbye, to our previous editor-in-chief, Professor Humphrey Hodgson, who, over the last decade or so, has both positively influenced, and then led, this journal. Those left the mantle to continue its development have a clear task: to educate, inform and entertain the members and fellows of the RCP, and the wider readership of this journal, a task that Humphrey delivered with aplomb. *Clinical Medicine* is a cherished product, as is made clear every time we carry out a members’ survey, and Humphrey has played an important role in ensuring its prominence.

However, we must continue to evolve, ensuring a broad range of content, including original research, review, guidance and opinion, for the continuing medical and professional education of physicians. While the conditions we treat change little over time, our ever-developing understanding of disease and the myriad of pharmacological and interventional possibilities we have available to treat them continue to evolve apace and require all of us to remain committed to life-long learning and reflection, regardless of the stage of our careers.

Clinical education is writ large in this edition, with excellent CME in cerebrovascular disease and further original research on the optimal management of headaches on the acute admissions unit (AAU).[1] Following another week on the AAU, it is clear to me that, as all specialties progress, it is increasingly challenging for the general physician to keep up. To that end, the detailed and comprehensive review of interstitial lung disease,[2] the review of late medical effects of cancer treatments[3] and the reflection on the challenges of PPI failure in gastro-oesophageal reflux disease[4] are all concise and highly relevant articles for the busy physician.

In addition to CME, *Clinical Medicine* also seeks to promote balanced and responsible debate on a variety of subjects, including the latest developments in medicine, healthcare, ethics and clinical leadership. This journal is packed with important and relevant manuscripts that give insight into the future of both clinical training and world-class research in the UK, as we all face more complex clinical presentations on the front line. I recommend the articles on the new internal medicine curriculum,[5] the role of physician assistants[6] and the Francis Crick Institute[7] to you.

Finally, the journal aims to engender debate on the wider role of hospital-based medicine within the delivery of healthcare. As the editor-in-chief of the *Future Hospital Journal*, I often address this from a systems, process and quality improvement perspective, but, as made clear in the opening article by Maher *et al*,[8] while we, as clinicians, all aspire to optimise human health, including public health and, as far as possible, occupational health, this is often detached from delivery of illness-based clinical care and requires a more joined-up approach if we are to influence the wider wellness agenda.

So, it can be seen from this edition of *Clinical Medicine* that it is in good health; however, it is also clear to me we have some challenges to overcome if we are to meet our obligations going forwards. We need a larger and broader editorial board: of the 30 specialties that function under the RCP banner, the board of *Clinical Medicine* represents less than a quarter. If you are interested in being considered yourself, please contact us (clinicalmedicine@rcplondon.ac.uk) and let us know why you wish to join the board and what you would bring to the RCP's oldest and most respected journal.

I would also value your collective views on how best to build on our current offering with social media; how we invite and generate content relating to the changing medical world in which we all work, and how we balance the content of this journal with the *Future Hospital Journal* to ensure that *Clinical Medicine* retains its place as a highly valued college offering. ■

References

1 Binks S, Nagy A, Ganesalingam J, Ratnarajah A. The assessment of headaches on the acute medical unit: is it adequate and how could it be improved? *Clin Med* 2017;17:114–5.
2 Mikolasch TA, Garthwaite HS, Porter JC. Update in diagnosis and management of interstitial lung disease. *Clin Med* 2017;17:146–53.
3 Harrington J, White J. The late medical effects of cancer treatments: a growing challenge for all medical professionals. *Clin Med* 2017;17:137–9.

4 Heading RC. Proton pump inhibitor failure in gastro-oesophageal reflux disease: a perspective aided by the Gartner hype cycle. *Clin Med* 2017;17:132–6.
5 Black D. The new UK internal medicine curriculum. *Clin Med* 2017;17:103–4.
6 Halter M, Wheeler C, Drennan VM *et al.* Physician associates in England's hospitals: a survey of medical directors exploring current usage and factors affecting recruitment. *Clin Med* 2017;17:126–31.
7 Peters K, Smith J. The Francis Crick Institute. *Clin Med* 2017;17:105–7.
8 Maher D, Ford N, Gilmore I. Practical steps in promoting synergies between clinical medicine and public health. *Clin Med* 2017;17:100–2.

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Practical steps in promoting synergies between clinical medicine and public health

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Introduction

The dichotomy between clinical medicine and public health in the UK and elsewhere often starts at medical school and continues throughout postgraduate training. However, there is increasing recognition of the benefits of bridging this often deep divide,[1] most importantly for people's health. Without effective efforts to address the 'upstream' determinants of health and to improve secondary prevention, physicians will face even greater challenges in managing ever-increasing service demands.[2] Based on global health experience, areas where the practice of clinical medicine can benefit public health include disease control, advocacy and ethics, while areas where good public health practice benefits clinical medicine include routine use of data to improve care delivery and the establishment of simplified and standardised approaches in support of extending the benefits of available treatments as widely, equitably and efficiently as possible.[1]

Dr Tom Frieden, the director of the US Centers for Disease Control, has described the healthcare and public health fields as 'inevitably and increasingly interdependent'.[3] In a rapidly changing healthcare landscape in many countries, there is also an increasing impetus for clinical academic centres to collaborate more widely with the aim of moving beyond individual patient care towards population health improvement.[4] There is scope for clinicians (including academic clinicians) and public health practitioners to work together in ensuring complementarity between the two health fields and maximising the health gains from working together. In seeking the synergies between individual patient care and population health measures, the clinician's perspective on individual patient wellbeing can serve as a counterbalance to the public health concern with populations and attendant risk of subsuming individual wellbeing in the interests of 'the common good'. Conversely, the public health practitioner's perspective on population wellbeing can help to ensure that the benefits of consistently good clinical care are made widely and equitably available.

In the UK healthcare system, primary care is largely delivered through the GP system while secondary and tertiary care is delivered through the hospital system. The synergies between clinical medicine and public health are well established in primary care but much less so in secondary and tertiary care. The GP system integrates clinical care with preventive medicine and public health in delivering health services:

1 primary clinical care (patient-initiated consultations)
2 preventive medicine (eg cervical cancer screening)
3 public health (eg childhood immunisations).

While the hospital system provides some examples of synergies between clinical medicine and public health, there is plenty of scope for developing these synergies further in the interests of improved health. Building on examples in hospital care, we propose some practical steps to overcome the divide

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