From the Editor

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On specialisation

The schism between art and science has been forced upon us by specialization.[1]

Specialisation is driven by advances in knowledge and technology, leading to a need for specialist training and experience, which in turn limits the breadth of practice of medical practitioners. During the rise of specialisation in the nineteenth century, there was a striking proliferation of specialist hospitals, and many of our major cities saw the growth of institutions, often highly prestigious, dedicated solely to specific areas of medicine, such as diseases of women or children, ENT, diseases of the eye or neurological disorders. The twentieth century saw the proliferation of specialist societies (this College alone embraces some 29 specialties), and more recently an increasing number of Royal Colleges representing individual specialties. Is the organisation of medicine and the setting of professional standards becoming needlessly fragmented into isolated islands?

The first medical specialty to gain its own College was that of obstetrics and gynaecology. Before that, gynaecological practice had been undertaken by physicians, surgeons and apothecaries, regulated early in the twentieth century, together with operative obstetrics, under the Royal College of Surgeons, while medical obstetrics came under the aegis of the Royal College of Physicians. It was not until 1929 that the situation was rationalised when the British College of Obstetrics & Gynaecology was founded, later to become the Royal College.

As patterns of practice evolve, new specialists acquire a range of new skills. In his recent Lilly Lecture,[2] Professor Peter Cotton described the modern gastroenterologist as someone who has multiple roles – physician, surgeon and radiologist – observing that their work is scarcely different from that of a minimally invasive surgeon, and suggesting a specialty of 'therapeutic digestivist'! Radical developments in many other specialties have also created new roles that cross a range of professional boundaries. Medical practice will continue to evolve, with allegiances oscillating between different specialties. Thus, alliances made today will undoubtedly need to be changed tomorrow, generating ever more specialties. Thus, creating isolated islands of specialisation will surely in the longer term stultify growth and development.

Historically, specialists have not always been medically qualified. During the eighteenth century, midwives, bonesetters, oculists and dentists, among others, practised their crafts, often with great skill, though frequently without regulation. At present, the work of doctors, whose prime professional skill is to exercise clinical judgement especially in situations of uncertainty,[3] is increasingly complemented by non-medically qualified specialist assistants, who are trained to deliver the new crafts and procedures, often following guidelines. In the UK, medical care practitioners, whose standards and curriculum are under development by this College, will be trained to work under the supervision of consultants.[4,5] It is perhaps a matter of some concern that medical care practitioners, whose specialist brief inevitably has relatively narrow confines, will, amongst other areas of their practice, include 'clinical judgement in diagnosis and management'.[5]

'No man is an island,' wrote the poet John Donne in 1624, and continued, 'every man is a piece of the Continent, a part of the main'. Many of the nineteenth century specialist hospitals did not survive as islands of medical practice, and in the course of time merged with major general hospitals. Likewise, the many islands represented by the specialties have professional standards in common, yet are increasingly represented by separate bodies. The direction of such fragmentation needs re-examination. No specialty can remain an island.

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Unlearning

Learning something new is easy: unlearning something old is difficult . . . because you have to alter information, and in so doing you have to challenge your beliefs.[1]

Our Harveian Orator, Professor Colin Blakemore, has shown us that new sensory information from our everyday environment can empower the brain to 'break out of the information straitjacket of the genetic code',[2] a dramatic new concept which, just half a century after the discovery of DNA, compels us to unlearn something of the past. Almost 400 years ago, Harvey himself generated revolutionary concepts which eventually forced reluctant physicians to unlearn past practices. Again, in the eighteenth century, the demonstration that inoculation with cowpox prevents smallpox was greeted with disbelief, as was the recent Nobel prize-winning idea that an infection (*Helicobacter pylori*) underlies peptic ulceration, causing physicians to unlearn their previous clinical practices, with dramatic effect. And now we are learning to unlearn the concept of 'incurable' diseases with patients confined to hospitals for 'incurables', and redefine them instead as having chronic diseases for which rehabilitation in renamed hospitals for 'neurodisability' leads to improved quality of life.[3] Unlearning the past is essential to effect change and improvement for the future.

Society itself also unlearns and relearns its values. During the last seven years, Baroness Onora O'Neill has pleaded for a restoration of trust in society as the key element of all relationships;[4] the late Cardinal Basil Hume, himself the son of a physician, pleaded for all mankind to strive towards higher moral standards while understanding that we are all flawed; and now, Professor Dame Carol Black, through her instigation of a remarkable working party report on medical professionalism,[5] has universal messages for us all to relearn our professional values appropriate for the twenty-first century. The ideals for professionalism were never better expressed than by Dr GN Vyas, erstwhile Professor of Physics at Benares Hindu University, who has recently written that 'the most important personal qualities are scholarship, simplicity, sacrifice and service'.[6]

Unlearning is the essential prelude to change, finely expressed, by Ruskin who once said of Turner that his work showed a 'perpetual newness of infinity'. Ours should too.

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Editors past and future

The *Journal of the Royal College of Physicians of London* (JRCPL), which became *Clinical Medicine* in 2001, has, during its first 39 years, offered much unlearning to pave the way for new vision. It has undergone progressive changes from its inception, under the editorship of Dr Stuart Mason, over its first 21 years (1966–1987), through Dr Robert Mahler (1987–1994), and Dr David Kerr (1995–1998). So it is time now, after another seven years under its present editor, to welcome a new editor to bring new ideas for change and innovation to *Clinical Medicine*, and it gives me great pleasure to introduce Professor Robert (Bob) Allan. He qualified in Birmingham in 1964, was awarded his MD in 1973, PhD in 1978 and was elected to the Fellowship of this College in 1980. He was awarded an NIH Research Fellowship at the Mayo Clinic in the USA and developed a special interest in inflammatory bowel disease. In 1977 he was appointed consultant physician, and to a personal chair in medicine in the University of Birmingham in 2001, in recognition of his contribution to medical education. He has served the Royal College of Physicians as examiner, councillor and regional advisor and during 2002-3 he was President of the British Society of Gastroenterology. He is also Director of Medical Education and Deputy Medical Director to the Trust. Professor Allan has edited *Gut*, a major international journal for gastroenterologists. He comes with a fresh vision for *Clinical Medicine* and I wish him well.

My thanks

While welcoming our new editor, I wish to thank the many people who have helped and supported *Clinical Medicine* over the last seven years – from a range of highly talented editorial assistants, now Johanna Tootell; to Suzanne Fuzzey who redesigned the new *Clinical Medicine*, and is responsible for its fine layout month by month; to Anne Warwick who so loyally maintains my correspondence; to Andy Lamb who nurtures our book reviews; and to Joanna Reid whose meticulous copy-editing, together with that of Mary Firth, ensure the high standard of the journal. The members of the Editorial Board have given unstinting support, and our four Self Assessment Questionnaire Editors have provided their considerable expertise to maintaining the high standards needed for the award of CPD credits. Our regular contributors Professor Alan

Emery and Dr Kevin Connolly have given much pleasure to our readers with their columns on 'Treatment in Art' and 'Conversations with Charles' respectively. I am also grateful to the many physicians across the country who have selflessly contributed to the quality of *Clinical Medicine* by refereeing so many of the submitted manuscripts. And in particular, I wish to pay tribute to Diana Beaven who skilfully guides the ever-vibrant Publications Department; and to Dr Robert Mahler, Emeritus Editor, who has given so much wise advice, always spiced with a cheerful wit.

PETER WATKINS

Assisted dying: considerations in the continuing debate

John Saunders

After a long period of gestation, the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill published its report (henceforth the 'Report') on 4 April 2005.[1] It runs to three volumes and a total of 997 pages. Volume I contains the Report itself; Volume II, the evidence; and the slimmer Volume III, a selection of 32 individual written submissions selected from the 14,000 received. The Royal College of Physicians (RCP) has played a prominent role in this debate, representing the Academy of Medical Royal Colleges in its oral evidence to the Select Committee and with four of its Fellows contributing published submissions in Volume III of the Report – one supporting the Bill and three arguing the case against.

Division in the College and Select Committee

The College's own position has been one of neutrality, a position that has led to widespread comment. This includes a reference in the opening Abstract of the Report itself and in one of the more significant papers in the American literature that followed the Report's publication.[2] It is a position, however, that has led to misunderstanding – neutrality has been construed as disinterest or even passive support for the proposed legislation. Is it 'a matter of little consequence to the Royal College if the law forbidding doctors to kill, or to assist in killing a patient, were to be changed…?' wrote one distinguished public figure. In fact, the College's position has not been one of either indifference and still less a lack of concern or interest. Rather, it has represented the extent of division that is, rightly or wrongly, perceived among its Fellows on the redrafted Bill – the College opposed the Bill's earlier draft as the Patient (Assisted Dying) Bill, which was not limited to the terminally ill. It is also a reversal of the previous College position approved by Council in 2001, which stated:

> ***Our main conclusion is that, with the best clinical practice in place, situations where any arguments for euthanasia as we describe them here could possibly be justified are rare indeed. On balance there is, therefore, no current reason for abandoning the profession's established view that acts motivated by a clear intention to end a patient's life cannot be justified on ethical grounds…a doctor ought not to carry out any act that has as its primary intention the death of a patient.*** (heavy type in original)[3]

How 'rare' is, of course, yet another point at issue. So too is the number who might request euthanasia or assisted suicide with estimates under the proposed legislation varying between 700 and 13,000 per annum. Obviously this is a significant factor in the ratio of benefits to predicted drawbacks.

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