changed. The principle objective now is to support and encourage the 31 primary care trusts (PCTs) in London to commission high-quality services – services which the population of London deserve and expect.

Since it is London's 31 PCTs that have the legal duty to consult on any proposals for significant change in services, they are now engaged in that process. It is those PCTs which will reflect upon the outcomes of the consultation and according to what they hear will then plan the next steps. Those next steps will require further consultation.

The PCTs have the duty to improve the health and healthcare of their population and they have the power of commissioning to carry out that duty. It is the utilisation of this authority that will have the most influence upon change and improvement in NHS services in the future.

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Spheres of medical influence: Academic Vice President, Royal College of Physicians

Editor – I greatly enjoyed Jane Dacre's thoughtful and thought-provoking piece (*Clin Med* February 2008 pp 13–5). There were two main themes. Firstly, that medical voices were not always effective in influencing policy even when bodies such as the British Medical Association, specialty societies and royal colleges had been consulted (a theme loudly echoed in the Tooke Report[1]). Secondly, that the demography of medical 'leadership' positions does not truly reflect the range or gender of practising doctors. I would like to add the following observations.

I have seen at first hand the extent and usefulness of often unpaid and unrecognised but vital work put in by clinicians who go the extra mile to contribute to local service leadership, postgraduate education, health policy and guidelines. However, I have also witnessed colleagues participating in external activities largely motivated by the desire for recognition, advancement, financial reward or the glamour of being close to the levers of power. Within trusts, medical managers often have little formal leadership training and are at best 'tolerated' by general managers so long as they are not too challenging of what should be their primary patient advocacy rather than 'corporate' role. Independence of thought and vision is not always rewarded; implementing government directives and targets is what counts. Likewise, in royal colleges or deaneries the way to advancement is to subscribe to the tribal norms and not be too troublesome. If we look at the behaviour which is rewarded/penalised, and the amateur 'Buggin's-turn' ethos, there is a clue to the leadership vacuum identified by Tooke and others.[2] In my experience, this is one of the reasons why so many able and committed female or overseas colleagues prefer to stick to local service leadership where they can see tangible gains for their effort and are put off many external roles. It's not all about work–life balance or discrimination.

Moving onto representativeness, an issue not really alluded to by Dacre is the inherent and overwhelming bias in the values of British medicine towards academia. Most physicians, for instance, work in busy district general hospitals dealing largely with patients who are ageing, or frail or with multiple long-term comorbidities. The service is largely about successfully managing common conditions with standard treatments. Not only is there a covert prestige hierarchy of diagnoses/specialties but there appears to be an assumption that the true leaders of the profession are academics based in tertiary referral centres and preferably those dealing with cutting-edge technologies.[3] A trawl through the names at the 'top' of most royal colleges and specialist societies will confirm this impression. This situation has been compounded by research performance frameworks which reify basic lab-based science and lucrative pharmaceutical research over research concerning service delivery, making academic clinicians even less representative. At its most extreme, this leads to chairs in disciplines appointed on the basis of their research expertise but with little training, competence or day-to-day activity in that craft. An academic contract signals a highly trained mind and more readily lends itself to external activities, but is no guarantee of having the right expertise or leadership skills to influence front-end service delivery or health policy. Meanwhile 'coalface' clinicians who have developed or led busy local services are under represented. This is an imbalance that has to shift. At the moment, I believe that such doctors, along with many female or overseas colleagues, survey the landscape and vote with their feet.

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Never say die?

Editor – Alex Paton accuses those who oppose assisted dying of doing so on the basis of 'confusing definitions, inappropriate ethics and more than a whiff of hypocrisy', and yet his own article is suffused with examples of the same (*Clin Med* February 2008 pp 106–7). Paton implies that the only way to achieve a 'gentle and easy death' is through euthanasia, and that opposition to the latter includes an unwillingness to 'help at the end of life'. He dismisses worries about the 'slippery slope', yet at the same time espouses and hints, quite rightly, at the inevitability of such extensions of practice beyond that allowed in initially limited legislation. Sadly, he also reinforces some of the misunderstanding that may fuel public support for assisted dying[1]: he seeks to blur the distinction between withdrawing treatments that are becoming increasingly futile, and actively killing[2]; and the doctrine of double effect is increasingly being seen as a 'red herring' in end-of-life care, as opioids and sedatives need not hasten death when used appropriately.

Paton is right that there will always be some people who would like the option of assisted dying. Many of us would no doubt