management of long-term conditions, increased focus on health and preventing illness and access to urgent care. If this is so, why does the report neglect so many of the proposals of its Staying Healthy Working Group such as the redesign of services for childhood immunisation and the prevention and treatment of sexually transmitted infections, the co-location of new centres with social and leisure services and, above all, to increase the investment in prevention. It is particularly disappointing that the tackling of health inequalities, seems to have disappeared, in spite of possible available measures.

It is of interest that my editorial has not been challenged about its comments on the lack of methodological rigour in the development of models, the lack of concern with social services coordination, or mental health services, lack of concern with training or the prediction that unnecessary use will be made of technological equipment and specialist expertise and thus the costs of care will increase.

There is no doubt that secondary, hospital care in London needs to be reorganised and rationalised. The need for better general practice facilities in some parts of London is accepted by all. But the justification of radical changes in the organisation of primary, general practitioner care, made largely by hospital practitioners, has not been made. It is dispiriting that with our experience of repeated changes in health services over the past 20 years that solutions are still being made on the basis of opinions rather than actual practical, evaluated trials – and that instead of rectifying known deficiencies, unproven organisational solutions are advanced.

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Never say die?

We are encouraged to see Alex Paton, a retired physician, using his long experience in medicine to consider such an important issue as euthanasia (*Clin Med* February 2008 pp 106–7). There are aspects to Paton's article that all doctors would agree with, such as the need for even better and more widely available palliative and supportive care. We recognise too how carefully powerful tools in the care of patients such as attempted resuscitation must be used and are heartened by the British Medical Association's recent review of this.[1] However there are errors of fact and interpretation in Paton's article. To deal with them all would be wearisome but there are some which it would be wrong to leave unchallenged.

The suggestion that reluctance to kill patients is evidence of 'physicians being loath to show compassion' is at best puzzling: compassion is manifestly not exclusive to either side of this debate. The palliative care services in Oregon (we assume Paton does not mean Orlando) are fundamentally different to the UK and so much of the Oregon experience is not directly transferable.[2] The practice of so-called 'involuntary euthanasia' in Holland suggests fears of a slippery slope may not be quite as misplaced as Paton suggests.[3]

Any doctor assuming the doctrine of double effect to be hypocrisy is labouring under a misapprehension. Of the four clear criteria that must be met to invoke double effect, a cardinal one is that the intention is to relieve a symptom and not to cause the death of the patient. Recent work has shown double effect to be largely irrelevant in palliative care.[4,5]

Advance death planning is important and this is enshrined in the new lasting powers of attorney (LPA) which have replaced the enduring powers of attorney mentioned by Paton.[6] The great value of these lies in the discussions they provoke between patients, those close to them and their medical staff. The views expressed in LPA can change, as can individual views on euthanasia, and it is this continuing communication while the patient is still able which is so valuable.

The whole tenor of Paton's article implies an irresistible tide of natural justice in favour of euthanasia being obstructed by a small and unrepresentative minority of doctors. The vast majority of doctors working in palliative care – not 'the slimmest of margins' – are against euthanasia.[7] There is clear evidence of the danger of taking requests for euthanasia at face value.[8] There is also increasing recognition, even legally, of the importance of giving patients autonomy to refuse life-prolonging treatments.[6] We too believe passionately in a 'gentle and easy death' but know that assisted dying is increasingly peripheral to achieving this.

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Practice-based commissioning

Charlton's article (*Clin Med* February 2008 pp 61–4) throws up major challenges for UK secondary care physicians. New imperatives may change specialist care in a fundamental way; 'shifting care into the community' may destabilise existing secondary care services.

Specialist care reconfiguration cannot be moulded into a nationwide template. Some plans, for example the Independent Clinical Assessment and Treatment Service (ICATS) network proposed for Lancashire and Cumbria designed to make care more convenient to patients actually made things worse. We must weigh up local advantages

and disadvantages of care closer to home. What patients want may not be what they need, nor what the nation can afford. Peripatetic specialists are inefficient and re-inventing the cottage hospital network (now termed polyclinics) is unaffordable – have we forgotten that many cottage hospitals disappeared in the 1980s because they were too expensive to run? Clinicians should only support systems that are financially sound. It is illogical to argue that emergency care must be centralised on fewer sites to improve results while potentially disseminating all other care.

Services may be provided more cheaply 'in the community' but they may not be better. There is nothing wrong with hospitals as specialist bases – to maintain clinical research; high-quality training; and good clinical governance. Professional isolation is avoided and multidisciplinary teamwork facilitated. In my own area the primary care trust (PCT) has (without discussion with its local specialists) commissioned a rheumatology service within general practice run by a retired consultant. It is one-third to one-half the cost of the current Payment by Results (PbR)-based secondary care alternatives. The reduction in hospital workload if patients are diverted to such cheaper alternatives threatens the viability of existing services.

The Royal Colleges of Physicians, Paediatrics and Child Health, and GPs agree that positive incentives are required in the NHS. The barriers between primary and secondary care must be removed and we must talk of general and specialist care, between which patients can move seamlessly, unhindered by financial issues. This is the principle behind Teams without Walls and requires vertical integration of provider services.[1] All competing services will then be on a level playing field. Conflict between GPs and specialists disappears. PbR, which forces PCTs to pay prices they cannot afford to hospitals that cannot reduce their prices without going bust, collapses. There are positive models already. In Stoke-on-Trent the musculoskeletal service is now managed by primary care (with substantial cost savings) but the current pattern of delivery has been maintained.

Do we need practice-based commissioning? The integration of general and specialist care removes its raison d'être. It allows local accountability but adds a huge layer of financial management to a bankrupt system and hinders the process of specialist referral.

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Conflict of interest

At the time of writing, the author was President of the British Society for Rheumatology and a member of Council of the Royal College of Physicians, London.

In response

Many thanks for your reply to my article. I share your concerns and one of the great difficulties of practice-based commissioning (PBC) is that it is politically driven and the 'goal posts' are continually moving. The article I wrote was to summarise my current understanding of PBC, but not my opinion of the process.

In the article I cited two major concerns. Firstly, with the future possible role of private providers and so a plurality of providers, would PBC lead to improved efficiency or a path to further privatisation and de-unification of the NHS? Secondly, general practitioners (GPs) and consultants are becoming opponents in a bidding war, rather than colleagues with different areas of competence who currently cooperate in the management of patients.

It is therefore of particular concern to all of us who work as traditional NHS providers to observe this process which has no obvious evidence base and could potentially fragment and destabilise the NHS.

Bamji has made a very important observation and will perhaps be quoted for years to come on the concept of moving from the terms; primary and secondary care, to generalist and specialist care and therefore working as a 'team without walls'. It is imperative that we use these skills appropriately for the benefits of patients in the environment of the patient's choice and not those based on political visions. Competition between potential service providers should be avoided, but rather ensuring that the most appropriate practitioner is made available to treat a patient with a particular illness. A service provider based on cost rather than identified health need and the practitioner most appropriately skilled to meet that need, will compromise patient care.

There is a myth that care in the community is cheaper and equivalent and that it should be run by GPs with a specialist interest (GPwSIs). This has yet to be researched fully and like many recent changes in the NHS it should be piloted before it is implemented. Bamji is right, we should avoid 'reinventing the wheel' and concentrate in the areas of generalism and specialism where we endeavour to excel and the associated environments where that care is provided. We are currently losing the concept of shared care which is being undermined by locally enhanced PBC services which can actively discourage primary care from involving secondary specialist services, eg, in diabetes care.

Phrases often quoted that I find difficult are, 'we live in interesting times' and 'shaping the future'. In relation to the NHS it would be more true to say that as GPs and consultants we live in worrying times, particularly for our patients. I do share your concerns and thank you for writing.

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Lesson of the month (1)

Editor – I read Chirwa *et al's* lesson of the month (*Clin Med* February 2008 pp 107–8) with interest but would like to raise a few points. Modern computed tomography-based radiotherapy planning systems allow accurate calculation of the dose to specified areas of the brain making the phrase 'it was possible that radiation spread to the brain' imprecise and unnecessary. Most radiotherapy treatments for tonsillar carcinoma are carefully planned to avoid significantly irradiating the brain unless tumour location makes this necessary. No staging details are given to suggest why any volume of the central nervous system (CNS) should have