comment by the obvious impropriety of saying anything, other than heartfelt sympathy for Dr Cox, while the judge in the case was considering his verdict; and today I leave the country for a week to attend the BMA meeting in Malta.

I cannot in conscience dissent from the verdict of the jury, in the present state of the law. I now think that the law should perhaps be changed, but not so far as to legalise euthanasia, with its attendant risks of abuse. But where I feel most confident is in reiterating my contempt (expressed under oath many years ago in the Arthur trial) for those prepared to lay information in similar cases. I take a high view of medicine and nursing; but I cannot understand how members of either profession can bring themselves to cause certain misery to a colleague in pursuit of a dubious principle. Justice is important, but so is charity. Dogmatism may have its uses, for the fainthearted; but it can have dreadful consequences for those who fail to share its certainties.

DOUGLAS BLACK
Convener, Royal College of Physicians Committee on Ethical Issues in Medicine

So, what is a clinical oncologist?

Sir—The recent paper 'So, what is a clinical oncologist?' by Professor Kaye (July 1992, pages 314–5) was a ray of hope lighting the way to improving the care of patients with cancer. The principal task of clinical oncologists and medical oncologists is to give optimum care to their patients. They are all cancer doctors and there can be no place for professional rivalries. Doctors from both disciplines see and treat similar patients, and it is important that the training of the cancer doctor enables a decision on management to be made with the full knowledge of the benefits and drawbacks of all treatment options.

The answer must be in joint training in all the non-surgical treatments to a standard yet to be agreed. Specialisation and more advanced training in anti-cancer drugs and radiotherapy can take place after the core has been established.

There are too few cancer doctors and the rate of increase remains slow, especially at a time of financial constraint. The best use of available manpower must be made and duplicating work by having more than one specialist cancer doctor caring for a patient is clearly not efficient. If medical oncologists and clinical oncologists can work from the same department and feel themselves to be colleagues, genuine consultation and co-operative management of patients will take place and the joint development of protocols and treatment policies become easier.

There is already a network of radiotherapy centres throughout the country and the need to develop these into cancer centres with an increase in the number of clinical oncologists has already been emphasised in the document: A report of the Board of the Faculty of Clinical Oncology of the Royal College of Radiologists. *Medical manpower and workload in clinical oncology in the United Kingdom*. London: Royal College of Radiologists, 1991. Medical teams in cancer centres would not be complete without medical oncologists and even small centres should have ready access to their expertise. The minimum size of a cancer centre and the number of clinicians needed to staff it needs to be recognised by purchasing authorities and indeed by the Department of Health.

The needs of district general hospitals would not be well served by a proliferation of mini cancer centres complete with a single clinical oncologist with a linear accelerator and a single medical oncologist with a battery of drugs. To receive the best of modern cancer treatment, both curative and palliative, patients must have access to a modern, fully equipped cancer centre. If a cancer centre is properly staffed, the local needs of the district general hospitals it serves can be met with regular and frequent clinics by visiting oncologists, the number being determined by the workload. These regular clinics, integrated with the local palliative care team, and with the local clinical haematologist, can provide all the needs of the service.

The creation of a Joint Council by the Royal Colleges of Physicians and Radiologists with the aim of developing a common core programme for training in oncology is surely the way forward and will lead to a greater number of better trained cancer doctors, so improving the care of cancer patients throughout the country. From this basis, research and development both in National Health hospitals and university departments will be encouraged and supported to the eventual benefit of our patients.

It is to be hoped that the Joint Council will act as a catalyst to develop and cement a future good relationship between all oncologists.

J. A. BULLIMORE
Dean Elect, Faculty of Clinical Oncology, Royal College of Radiologists

Sir—Professor S. B. Kaye's Occasional Paper (July 1992, pages 314–5), which deals with the current attempts to smooth out the friction between radiotherapists and medical oncologists by creating a specialty of clinical oncology, is silent on the role of haematologists in the management of cancer and consequently fails to recognise a group which historically has been most responsible for the administration of chemotherapy to patients. In America the specialty is known as haematology/oncology and the range of practice is similar to what most clinical haematologists in Britain are doing today.

Chemotherapy largely arose from the treatment of the leukaemias, and it soon became evident that there were special skills attached to the management of these diseases. Both leukaemia and its treatment cause