Editorial, advertising and subscription enquiries to:
Publications Department,
Royal College of Physicians,
11 St Andrews Place,
London NW1 4LE

Tel: 0171 935 1174
Fax: 0171 486 5425

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General vs specialist medicine

The issue of general vs specialist medicine is back again with the publication, this month, of an RCP discussion paper (pp359–364). The pendulum swings to and fro, from 'partialist'[1] (sorry, specialist) to generalist. This time it is firmly in the court of the specialist, but what is different is a lively paper with several innovative ideas. These include the appointment of general physicians with a special interest in acute medicine (not universally accepted), and the value of a 'physician of the week' to handle all emergencies over a given period. It examines a redistribution of work to even the load between different specialties (ie there is probably too much for cardiologists and chest physicians and not quite enough for diabetologists/endocrinologists). While triage and direct referral to specialists are clearly important, does every respiratory case (eg pneumonia) need referral to a specialist chest physician, thus burdening him needlessly? Perhaps the general medical expertise of every specialist needs to be more carefully defined, and more appropriate training of specialist registrars might be achieved by ensuring continuing rotations through all acute specialties. Many of these suggestions, however, result in attrition of the principle of continuity of care, which quite apart from its importance for patients, also maintains the commitment of physicians. There are many interesting, often controversial views here. Experiments are needed, and so are your views in our correspondence column.

NICE

NICE was born on 31 March 1999, and in this issue of *JRCPL* (pp303–304), Dr Gina Radford and Sir Michael Rawlins describe some of the principles on which it might work, together with a *modus operandi*. The need to appraise research evidence and to reduce the confusion arising from work done by different bodies to give a single national focus, are laudable aims. It should link the 'large but fragmented community of academic, professional and user intiatives' under its umbrella as a special health authority. Thereafter, its remit is indeed vast: production of guidelines for 'certain conditions'; guidelines on clinical and cost effectiveness (does that really address the rationing issues as ministers have claimed?); development of audit methodologies; and comparison of the benefits of new interventions with better use of established ones.

The involvement of RCP as a stakeholder and the inclusion of the President and other officers on the Partner's Council, Board and Appraisal Committee respectively, provides mechanisms for both input and implementation which are crucial if NICE is to be effective. We wish it well, and will report on its effectiveness early in the millennium.

Continuing medical education (CME) – clinical practice and its basis

The key to 'revalidation' must be CME and for physicians this must be relevant to their practice of medicine. We try to achieve this in compiling reviews for CME, and the series published in *JRCPL* has shifted its emphasis to 'clinical practice and its basis'. Observant readers will notice this new heading for our series. Self assessment questionnaires (SAQs) will be specifically targeted at general medical requirements, and are not written for specialists whose needs are dealt with elsewhere, notably in specialist journals

and societies. The contents of 'clinical practice' articles are not set in stone. Unanimity of views rarely exists and errors occasionally creep into review articles. We ask for continuing correspondence and a lively debate to ensure the appropriateness of publications aimed at CME. And in future, sets of CME/clinical practice sections of the *Journal* will be available for sale as reprints. Please contact Sarah Webb in the Journal Office.

A physician's son

Death and dying are increasingly subjects for discussion in the public domain and recently several articles in *JRCPL* have addressed these issues. The recent death of Cardinal Basil Hume marks the loss of one of the great leaders of this century. His openness and dignity in dying have given inspiration to many, and emphasis to living (rather than dying) with cancer. He was the son of a distinguished Newcastle physician, Sir William Errington Hume (1879–1960), a tolerant Scottish Protestant who was described as 'inspiring the intense devotion of all who worked with him'[2]. Cardinal Hume's leadership qualities of humility and imagination combined with firmness and gentleness based on his deeply spiritual commitment, were recognised beyond his own communion and have given us an example to follow in life. In death as in life, Cardinal Hume has brought fresh inspiration to the people of this country. The son of the physician has left us a great legacy and we should listen.

References

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2. Trail RR (ed). *Lives of the Fellows of the Royal College of Physicians of London continued to 1965 (Munk's Roll).* London: RCP, 1968:206–7

PETER WATKINS
Editor