Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

Palliative medicine as a specialty

We agree with your correspondents that general practice has no monopoly on holistic care, and that there is some way to go before all general practitioners can be said to exemplify it. The holistic approach does though have a long history in general practice, which has large numbers of practitioners for whom multiple problems in the same patient and constantly changing needs are the norm.

Our article on palliative medicine (November 1998 *JRSM*, pp. 568–572) acknowledges, at an early stage—contrary to the comments of Dr Backhouse (January 1999 *JRSM*, p. 53)—that the hospice movement and the specialty of palliative medicine arose in response to exposed deficiencies in care of the dying. However, the factors described by Beeson remain conspicuously relevant. There can be no escaping the fact that the current disease-specific model for palliative medicine immediately excludes three-quarters of patients it might otherwise seek to help. A basic tension remains too between the objective of integrating palliative care into all clinical fields and the development of specialist services and training that perforce depend on regarding it as a separate function[1].

We did not refer to the Calman–Hine report, as Professor Finlay notes (February 1999, *JRSM* pp. 100–101), in part because it is concerned only with cancer services and thus of little direct relevance to the main thrust of our argument against the current disease-specific model of specialist practice. A palliative approach early in the history of many conditions was independently advocated in our article and this need provides a potent argument against specialization. We agree that alienation may not be a problem in most hospices. However, 'palliative care' has sometimes been used as a euphemism for 'death imminent' and it can arouse such fears in some patients.

Dr Rich (January 1999 *JRSM*, p. 54) points out the role of all specialists in assuming responsibility for cases that are beyond the expertise of the generalist. Regrettably, this is not always the case. As well as having cancer, hospice patients are less likely to be over 65, unmarried or from the ethnic minorities[3]. The uneven geographical distribution of palliative care units is in favour of the prosperous regions[4]. Many specialists in palliative medicine thus concentrate their energies on patients who have predictable symptoms that are of short duration and amenable to control; who have little comorbidity, few social problems and intact informal care mechanisms. More complex cases may tend to remain under general practitioner or hospital care.

Surely all medical fields should follow Dr Buckley (February 1999, *JRSM* p. 100) as champions of the patient's right to know? We need to extend this beyond cancer care now. Do we tell our patients—even when they ask—they are dying of heart failure or chronic obstructive pulmonary disease[5]?

We remain concerned that advocacy of additional resources, out of an inescapably finite whole, to some of those with cancer does militate against the interests of most dying patients. Certainly effective care for all dying patients—presumably Dr Sloan's 'Utopia' (February 1999 *JRSM*, p. 100)—will no more be found in an under-resourced primary care team than in deluxe services for a selected minority.

If Professor Finlay's advocacy of general practice training as a valid entry qualification for specialist palliative medicine[6] has been lastingly successful, this could be more effectively publicized as a triumph for objective observation of the skills used in palliative medicine.

Former general practitioners who have changed to specialist careers have little immediate need to fear for their jobs, but the social and political reasons for this are as important as their achievements in improving symptom control.

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Recreational pharmacology

I read Dr Charlton's article (November 1998 *JRSM*, pp. 599–601) and Dr Field's response (February 1999 *JRSM*, pp. 101–102) with sympathy for both their views. As an expert witness in 'a cocaine case', in the hope of being non-judgmental I introduced the term 'what the American literature refers to as recreational use', with even the judge taking up the term 'recreational use'.

The Medicines Act 1968 (s. 130) controls the supply not only of therapeutic and prophylactic products, but also of substances used for 'contraception . . . [and] otherwise

preventing or interfering with the normal operation of a physiological function, whether permanently or temporarily, and whether by way of terminating, reducing or postponing, or increasing or accelerating, the operation of that function or in any other way.' Chemical contraceptives seem now to be accepted as a matter of course as 'medicines', yet they neither treat nor prevent disease. Abortion is a medical procedure. There has been much debate as to whether the mental health and physical health grounds now mean 'abortion on demand'. Yet chemical abortifactants do not treat or prevent disease. They legally are medicines under the Act.

Dr Field highlights what can only be an increasing problem. If there are potent chemicals that society wishes to control (but not ban), and they neither treat nor prevent disease, who should be society's gatekeeper? As the group that knows most about the contraindications and side-effects the medical profession is obviously best fitted. Whether antidepressants should be used to make the non-depressed happier is perhaps too emotive (and subjective). But should a safe but potent treatment for obesity, if it arrives, be used for the non-obese individual. Chemicals that modify alcohol metabolism, sexual prowess, and skin pigmentation each offer challenges which need to be exposed and explored now. Otherwise we may have a series of creeping compromises ('being overweight whilst not obese is still bad for physical health', 'thinking you are overweight, even when not, is bad for mental health', and so on).

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Extinction of the general physician

By arguing for the appointment of consultant physicians with a special interest in neurology Dr Freeman (February 1998, *JRSM*, p. 103) is surely attempting to put the clock back. Since he retired from active practice there has been a considerable expansion in knowledge in the neurosciences with important therapeutic implications. In the next decade it is likely that there will be increasing specialization *within* clinical neurology and already most neurologists have a special interest. It may be that we will see the extinction of the general neurologist. In the post-Calman era there is concern among neurologists about the adequacy of the present training programme and I doubt very much whether it is possible now to have a physician 'well versed' in both general medicine and neurology. To produce such an individual would require a very lengthy training programme. I suspect it is difficult to find a truly general physician in major teaching hospitals and the best approximation is probably a physician in elderly medicine.

Dr Freeman states that neurologists decided to opt out of acute general medical rotas for emergency admissions but the real problem in my opinion was that general physicians and professors of medicine of Dr Freeman's era were not willing to make facilities available to neurologists to look after acute neurological disorders including stroke. Surely it was not in the interests of patients with myocardial infarction and respiratory failure, for example, to be managed by neurologists, but neurologists would have been willing to manage acute neurological problems.

It is my experience that doctors with a neurological problem wish to see a neurologist not a general physician with an interest. Why should we expect our patients to behave differently?

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Music as male competition

Anthony Storr's fascinating and enjoyable article on the enigma of music (January 1999 *JRSM*, pp. 28–34) begins by declaring that music is 'an evolutionary puzzle'. I agree it is difficult to guess the specific adaptive purpose of music, but there are a couple of facts that seem to support the notion that in some way or other music may enhance reproductive performance. There are more male than female composers. Without doubt there are cultural factors that have disadvantaged many women but, as with patterns of violence, where men are also over-represented, it seems plausible to suggest an underlying biological basis for this asymmetry. Secondly, Geoffrey Miller of University College London has noted that the age when rock stars write hit records coincides almost exactly with the age distribution of homicide[1]. It is not suggested that rock stars are murderers but that both homicide and music may be expressions of sexual competition between men and therefore follow the same age profile.

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Death in custody

The article by Dr Karch and Dr Stephens (March 1999 *JRSM*, pp. 110–113) is an important summary of the science applicable to the investigation of cases of death, during custody. As a retired Chief Medical Examiner I believe it should be required reading for all jurors and judges considering such cases.

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