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EDITORIAL

Acceptability of the "bar code doctor"

In 1944 Oswald T Avery and colleagues described the agent in pneumococci of the virulent smooth sort that could transform, permanently and in an inheritable fashion, avirulent rough cultures. That transforming agent was "nucleic acid of the desoxyribose type". Molecular biology has some other origins but since the pneumococcus was then (and remains) a major pathogen, it seems reasonable to claim Avery's observation as a seminal one for molecular medicine and biology. However, unless one argues—and *The Lancet* does not—that all medicine is molecular, it is important to recognise that there is more to molecular medicine than DNA. For example, the types of article that are appearing in the new specialised literature of molecular medicine would not look out of place in other non-general journals. This new entity is multidisciplinary, combining threads that have hitherto been labelled immunology, biochemistry, genetics, molecular biology, and so on. Since no-one is suggesting that these longer established activities should now be swallowed up entirely by the newcomer, "molecular medicine" still has some way to go in defining itself.

Molecular techniques are said to be easy to learn. Maybe in a sense they are too easy. Laboratories that ten years ago might have been largely staffed by PhD's now have many MD's. Yet molecular medicine in its broadest sense risks being perceived as somehow non-clinical and therefore irrelevant. Those budding clinicians who move into this line of work do face difficulties. Their choice of subject—nucleic acid fragments on gels rather than patients—sometimes earns them the dismissive label of "bar code doctors". How can this attitude be remedied? One way is to ensure that molecular projects that the physician undertakes make good use of that person's clinical outlook and knowledge. There are other solutions.

One of the difficulties faced by young physicians who opt for a period of service and/or research in the developing world is that they find the time ignored when they return home to climb back on the competitive ladder of a clinical career. It would be a tragedy if that experience were to be repeated after a sojourn in a molecular laboratory. Clinical fellowships and programmes that recognise the value of laboratory time will be increasingly needed, and those in charge of specialist recognition and training should take note too.

An obstacle that only molecular medicine itself can remove is the temptation to promise too much too soon. The first issue (November, 1994) of *Molecular Medicine* carried an article on "Gene Therapy: Hopes, Hypes, and Hurdles". All too often papers on molecular medicine end with a poorly thought through line on "the prospect of gene therapy". This month's meeting of the panel advising the US National Institutes of Health on gene therapy has been cancelled because there is nothing to discuss.

Lastly, and here the ball lies in the court of authors and editors, is the language of communication. Launching *Molecular Medicine*, Anthony Cerami and Kenneth S Warren referred to molecular medicine as having "provided a common language and understanding among clinical groups". That the disciplines contributing to molecular medicine have much of their terminology and many of their techniques in common is not in dispute but to achieve understanding among clinicians is a very different challenge. Good review articles certainly help, as do accompanying commentaries, but the intelligibility of research conducted at the molecular level needs to stand alone. That means asking authors to communicate more simply, not by "writing down" but by "writing across", even at the risk of displeasing some of their immediate peers. The starting level will vary. Gilbert's syndrome has always interested clinicians and we hope that the presentation of its molecular biology in this week's issue is understandable.

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