

priority setting—show that we should not waste our few pence on renal dialysis when chiropody is more value for money or when they come up with the breathtaking news that, given its head, the health service could consume the entire gross national product it is not a sober professional judgment but merely an ideological proclamation with no other relevance. Similar proclamations could be made about education to perpetuate squalid classrooms and the squeezing of universities.

Rationing is a cosy word, with overtones of fair play and wartime Britain, but, the world over, when it really bites and to the bone (which it never did in Britain) it leads to ugly corruption and black markets. Actually, Smith's editorial is inadvertently about rationing the poor, the inarticulate, and the common run of citizens. The wealthy and the establishment, the enterprising, and the organised crime mob will never be rationed, whatever the rules invented by economists and philosophers, while privilege and corruption in the supply of medical services will leak and pollute society as a whole.

Smith simply overlooks the corrosive effect on doctors and their ethics that rationing on non-clinical grounds may well have. What kind of damaged profession with market style doctors can we expect with the next generations increasingly educated in an atmosphere of spurious economic indices, where cost effectiveness is all and devil take the hindmost? And into what byways will medical research be diverted? He admires the rationing exercise in Oregon as if it did not spring from the fact that medical rationing in the United States is brutal and always has been.

Certainly, health services have to be planned amid a maze of conflicting demands, but that is no excuse for letting loose gungho solutions like rationing—denying the sick their treatment on the basis of supposedly general principles defined by managers, philosophers, and economists, of all people, and by public opinion polls. Surely, the journal should take the lead in scepticism not only about rationing but about the impossibility of decently funding the NHS, and it should not get lost in ideologically inspired pseudosolutions to its mounting debility. Much less should the editor, over impressed by Oregon, eagerly promote the dissolution of its soul.

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1 Smith R. Rationing: the search for sunlight. *BMJ* 1991;303:1561-2. (21-28 December.)

2 Donaldson C, Mooney G. Needs assessment, priority setting, and contracts for health care: an economic view. *BMJ* 1991;303:1529-30. (14 December.)

Advice on foreign travel is not health promotion

SIR,—For some years our nurses have been telling patients travelling abroad how to avoid getting ill while they are away. There is a lot to cover: sensible precautions against food poisoning, avoiding excessive exposure to the sun, malaria, and so on. Most importantly now, the nurses specifically discuss the risk of HIV infection.

Under the new contract we were able to count this 15 minute consultation as part of a health promotion clinic. Our family health services authority has now told us that advice on foreign travel no longer counts as health promotion. Sadly, we will therefore not have time to discuss these issues properly with our patients. All we can do is give them the Department of Health's leaflet "Health Advice for Travellers" and hope that they read it.

We are paid £4.50 per patient for health promotion. We would probably need to prevent only one

case of AIDS per 10 000 patients seen to be cost effective. Perhaps the Department of Health could explain why it would rather spend this money treating AIDS instead of preventing it.

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Euthanasia around the world

SIR,—Did the news items on euthanasia around the world imply a change in the position of the *BMJ* in line with other professional opinion worldwide,¹ as indicated for instance by the reports of the Institute of Medical Ethics² and the Rummelink Commission?³

A corresponding shift in public attitudes has been measured objectively by market research organisations in polls repeating the same question over time. In Britain National Opinion Poll found that agreement with the statement "Some people say that the law should allow adults to receive medical help to an immediate peaceful death if they suffer from an incurable physical illness that is intolerable to them, provided that they have previously requested such help in writing" rose from 69% (95% confidence interval 67% to 71%) in 1976, through 72% (70% to 74%) in 1985, to 75% (73% to 77%) in 1989. Similarly, in the United States the Roper Organisation's question "When a person has painful and distressing terminal disease, do you think doctors should or should not be allowed by law to end the patient's life if there is no hope of recovery and the patient requests it?" elicited support from 62% (60% to 64%) in 1986, increasing to 68% (66% to 70%) in 1991.

Evidence from Canada and Australia is available over a longer timescale and is therefore more compelling (tables I and II). It shows a trend that it would be imprudent to ignore. Though medicine should take a note of the views of three quarters of the population, however, it also needs a clear legal framework. Active euthanasia is an act of pre-

TABLE I—Response of people aged 18 and over in Canada to question "When a person has an incurable disease that causes great suffering do you, or do you not, think that competent doctors should be allowed by law to end the patient's life through mercy killing if the patient has made a formal request in writing?"

Year	No sampled	% Replying (95% confidence interval)		
		Yes	No	Undecided
1968	705	45 (41 to 49)	43 (39 to 47)	12 (10 to 14)
1974	1047	55 (52 to 58)	35 (32 to 38)	10 (8 to 12)
1979	1031	68 (65 to 71)	23 (20 to 26)	9 (7 to 11)
1984	1050	66 (63 to 69)	24 (21 to 27)	10 (8 to 12)
1989	1029	77 (74 to 80)	17 (15 to 19)	6 (5 to 8)
1990	1051	78 (76 to 81)	14 (12 to 16)	8 (6 to 10)

Poll commissioned by a group of Canadian newspapers and conducted by Gallup Canada, of Toronto.

TABLE II—Response of people aged 14 and over in Australia to question "If a hopelessly ill patient in great pain with absolutely no chance of recovering asks for a lethal dose, so as not to wake again, should the doctor be allowed to give the lethal dose or not?"

Year	No sampled	% Replying (95% confidence interval)		
		Give lethal dose	No lethal dose	Undecided
1962	2000	47 (45 to 49)	39 (37 to 41)	14 (13 to 16)
1978	1800	67 (65 to 69)	22 (20 to 24)	11 (10 to 12)
1983	1057	67 (64 to 70)	21 (19 to 24)	12 (10 to 14)
1986	1117	66 (63 to 69)	21 (19 to 23)	13 (11 to 15)
1987	1100	75 (72 to 78)	18 (16 to 20)	7 (6 to 9)
1989	1191	71 (68 to 74)	20 (18 to 22)	9 (7 to 11)
1990	1160	77 (75 to 79)	17 (15 to 19)	6 (5 to 7)
1991	1257	73 (71 to 76)	20 (18 to 22)	7 (6 to 8)

Poll commissioned and conducted by Morgan Gallup Poll, of Melbourne.

meditated homicide, which is no more acceptable under common law for doctors than for lay people, even if autonomously requested. If parliament decided that "to change the law would appear to be in keeping with the logic of respect for autonomy" a "special defence" would be needed which could then be pleaded in justification.

The Mental Health Act 1983 illustrates the advantages of statutory law in allowing doctors exceptional privileges while providing additional safeguards. It formally separates the responsibilities for an application for a section, the medical recommendations, and receipt by the hospital managers. A similar mechanism could be designed for euthanasia.

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- 1 Euthanasia around the world. *BMJ* 1992;304:7-10. (4 January.)
- 2 Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death. Assisted death. *Lancet* 1990;336:610-3.
- 3 Van der Maas PJ, van Delden JJM, Pijnenborg L, Looman CWN. Euthanasia and other medical decisions concerning the end of life. *Lancet* 1991;338:669-74.
- 4 Age Concern, Institute of Gerontology, and Centre of Medical Law and Ethics, King's College, London. *The living will*. London: Edward Arnold, 1988.

Women in the NHS

SIR,—It is worth remembering that 75 years ago, on 13 February 1917, a small group of women doctors, finding that their applications for membership of the British Medical Association had been rejected because of their sex, founded the Medical Women's Federation. The active list of the General Medical Council now includes over 40 000 women doctors. One quarter of general practice principals and over half of last year's entrants to medical school are women. Relations with the BMA have changed since 1917—two former presidents of the Medical Women's Federation have gone on to be presidents of the BMA, and there are close working relationships at officer level.

Caroline Langridge, head of the NHS women's unit, has indicated ways in which women capable of filling senior management posts can be brought forward.¹ Positive discrimination is rightly unlawful, but positive action to identify and encourage talent is good sense. Applicable in management and nursing, it is equally applicable in medicine. In 1989 the Advisory Committee on Medical Manpower gave a figure of £130 000 as the undergraduate training cost for one doctor. That figure must now be around £160 000. A programme of positive action to ensure that the talent and training of young doctors—both men and women—is not wasted is overdue.

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1 Dillner L. Where are the women in the NHS? *BMJ* 1992;304:399. (15 February.)

Hospices and the NHS

SIR,—Colin Douglas snipes again at the hospice movement in his brief article.¹ In his novels his sourness of spirit can be amusing, but in this context I do not find it so.

I serve the Marie Curie Memorial Foundation in an honorary capacity, partly as a clinician and partly as an administrator. This charitable organisation functions in the field of cancer and is older than the NHS. In addition to education and research, we maintain a unique, nationwide home nursing service for patients with cancer as well as

facilities for respite care, convalescence, and rehabilitation in 11 centres throughout the United Kingdom. These centres also provide terminal care, so we are clearly a part of the greater hospice movement, which in practice is mostly, though not entirely, concerned with patients suffering from cancer.

I do not believe that Douglas would quarrel with the statement that the particularly distressing and prolonged symptoms caused by cancer call for special skills and experience in nursing and medical care—indeed, he has conceded faint praise to the hospice movement in this respect—but when he writes that “The NHS should now take charge” he is being less than realistic. These special skills work best in small units where morale and esprit de corps are high; let them not be lost in a huge machine.

Douglas’s faith in the potential comprehensiveness of the NHS is touchingly naive and outmoded. Does he not realise that no health service that a British government could, on its own, support could meet all the needs and demands of the public with complete satisfaction? Sustained by charity, the hospice movement carries its share of the burden with an economy and efficiency that are exemplary. The government recognises this in making the contributions to which Douglas takes such offensive exception.

Finally, one of the finer facets of human nature is the willingness of many to help fellow creatures, especially those in pain and trouble. This is not the perquisite of dowagers and duchesses, as Douglas implies, but is far more widespread than he seems to realise. Surely charity should be encouraged and not despised and derided.

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1 Douglas C. For all the saints. *BMJ* 1992;304:579. (29 February.)

SIR,—Colin Douglas has written a brave, if rather brusque, article suggesting that palliative medicine and the hospice movement should be incorporated into the NHS.¹ This is a view that many of us share but is usually expressed only quietly for fear of upsetting the founders of palliative medicine, to whom we owe so much. The arguments are stronger, however, than the mere economic issues outlined in the article. This district’s deliberations on the subject have been published,² but the arguments in favour of a community service with its base in the local district general hospital should be more widely appreciated.

Siting inpatient palliative medicine beds on the site of a district general hospital gives easy access to the investigative facilities needed for diagnosis and relief of symptoms. It makes it easier to provide medical cover, physiotherapy, occupational therapists, and social workers, and there are obvious economies of scale for hotel support services. One of the strongest arguments, however, is educational. It will never be the case that all patients die in hospices or that all die at home supported by their family doctors and Macmillan nurses. Most will probably continue to die in district general hospitals, and messages about good pain relief, listening, and support are more likely to spread to these patients if the palliative medicine service is based on the same site. This service can incorporate a day centre and a base for community nurses, and patients with newly diagnosed disease who are being discharged from the ward can visit the day centre and meet their community nurse before they return home. A palliative medicine service based with a district general hospital will always attract donations and additional funds, and these can be used as a catalyst to improve services generally but also to the advantage of a wider number of patients dying in either the hospital or their own homes.

Palliative medicine should now stand alongside

other specialties, be funded in the same way, and provide care to all those who need it.

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- 1 Douglas C. For all the saints. *BMJ* 1992;304:579. (29 February.)
- 2 Partridge MR. NHS provision for terminal care: one district’s deliberations. *Journal of Management in Medicine* 1989;3: 362-71.

SIR,—Colin Douglas’s charges against the hospice movement deserve reply.¹ Hospice home care teams work with general practitioners and district nurses to ensure continuity of care for patients and their families. This teamwork has evolved to prevent “care at the end of illness being so separate from all that has gone before.”

Deaths from cancer account for 20-25% of all deaths in our society; this “minority” is the particular concern of hospices. Most of these patients choose to die at home but may be denied this choice because of a lack of resources.²

I am surprised that Douglas decries a high standard of care for dying patients: surely we should be striving to provide de luxe care for every patient. I agree, however, that such an important part of care should not have to rely so heavily on charitable donations. Indeed, if general managers are looking for value for money they should be placing contracts with hospice services, which are so generously supported by the public. The lessons learnt from the larger teaching hospices have become incorporated into mainstream medicine and have transformed standards of care for patients dying not only of cancer but of other diseases. The hospice movement makes no apology for respecting the autonomy of individual patients and their families. At a time when market forces threaten personalised care and we face the challenge of AIDS we need the skills and resources of the hospices.

If Douglas was to listen to the patient’s voice he would learn that hospices are people, not buildings, and that the joy of living is as important to hospices as the quality of dying.

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- 1 Douglas C. For all the saints. *BMJ* 1992;304:579. (29 February.)
- 2 Cartwright A. Balance of care for the dying between hospitals and the community: perceptions of general practitioners, hospital consultants, community nurses and relatives. *Br J Gen Pract* 1991;41:271-4.

SIR,—I can appreciate some of the points made by Colin Douglas in his article on the hospice movement, particularly that it offers a very high quality service to a small elite group of patients and that its workings should not be excluded from the service demands placed on other parts of the NHS.¹ However, I think that he has been too hasty in relegating the hospice movement to the past tense, as it is clear that it still has at least an educational role.

After a month’s attachment to a local hospice as part of my senior registrar training, I recently surveyed 99 career Scottish geriatricians (of which Douglas is one) to ascertain knowledge of commonly used techniques in palliative medicine. Among other points, only about one third had ever used hyoscine or similar for hypersecretion or “death rattle.” Some two thirds had never heard of nebulising lignocaine for intractable cough.

That the hospice movement has highlighted the need for good terminal care I have no doubt; that it has served as a base for service developments I will not argue; that palliative medicine is a specialty I will not deny: what I do not accept is that it has served its purpose and that we are all now accomplished in palliative care. Whether the (undeniable) educational needs are met by palliative care support teams or by attachment to hospices is another

matter. It is interesting that Douglas has used the model of “high quality-low volume” to criticise the hospice services—he should know this model well, as it has been quoted many times against geriatric medicine services. We both know how false this argument is in our own specialty—perhaps he should not throw stones at others.

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1 Douglas C. For all the saints. *BMJ* 1992;304:579. (29 February.)

SIR,—We have heard from time to time of the “politics of envy.” Colin Douglas’s brief article epitomises the “medicine of envy.” In lecturing us on the hospice movement he asks, “Why should only the minority who die of malignancies—and precious few even of them—be singled out for de luxe dying?” That any doctor should use such language in writing about the care of the dying in hospices or at home under the supervision of hospices is astonishing. The fact is that the pioneers of the hospice movement, notably Dr (now Dame) Cicely Saunders, saw the needs of the dying neglected and taught many people to fulfil those needs with excellent and appropriate care.

Douglas writes of the hospice movement’s “committee loads of duchesses.” All honour to any who help. But in fact the movement draws its strength from many thousands of men and women of all ranks—doctors, nurses, housewives, farmers, clerks, shopkeepers, and those who, like me, are retired. Douglas has “doctor and novelist” appended to his name. He should keep fiction out of his *BMJ* column.

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1 Douglas C. For all the saints. *BMJ* 1992;304:579. (29 February.)

SIR,—I was dismayed and saddened to read Colin Douglas’s gloating article about the alleged impending crisis facing the hospice movement.¹

For many years the hospice movement has provided a shining example of how to allow people to die with dignity and with reduced suffering. Its efforts may indeed by scanty and choosy, but I suggest that this is not of its own volition.

Furthermore, de luxe dying may be an appropriate term but it does highlight the stark contrast with the disgraceful state of affairs in mainstream hospitals. Standards of terminal care are still broadly lamentable, and patients are often not allowed to die with dignity (even when their disease is imminently terminal), and when they are permitted to do so they are left to pass their remaining hours without adequate support or pain relief.

Part of the problem lies in the inability and insensitivity of certain members of our profession to recognise that death is imminent. For example, I recall an elderly man with acute myeloid leukaemia who was dying in a ward, but a senior registrar insisted that he should have at least six weeks of chemotherapy. This unfortunate man died within 48 hours of this statement. Sadly, this was not an isolated incident.

If the hospice movement is to be made redundant the appropriate time will be when standards of terminal care have been raised to those of the movement. I suggest that “a few beds for the difficult cases” is precisely why the hospice movement exists.

Douglas’s misguided attack on the hospice movement is spiteful and unworthy.

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1 Douglas C. For all the saints. *BMJ* 1992;304:579. (29 February.)