members' comments which have moulded the discussion paper into the definitive evidence.

The evidence working party was given firm guidance from the membership on many matters. For example, there was a general feeling that the discussion document was not sufficiently incisive, did not indicate clearly enough our appreciation of the strengths and weaknesses of general practice today, and did not really reveal the College's general philosophy on the future of primary health care based on general practice. We were also asked by most respondents to be unequivocal about the need to retain the independent contractor status of the general practitioner, to preserve clinical freedom, to enlarge on the problem of poor general practice in some of our conurbations, and to have adequate manpower, premises, and equipment to do our job well. Many people mentioned the need to develop continuing education and with it medical audit controlled by the whole profession rather than by Government.

Council would like to thank the faculties and individual writers for the care, time, and trouble they have taken in giving their views on the content and presentation of the evidence. On a subject with so many important aspects total unanimity would have been impossible to achieve. Nevertheless, Council believes that the consultations on the draft evidence have given it a surer feel of the general lines along which the majority of members would like to see the College's policy evolve in future.

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COPING WITH DEATH

Sir,

There has certainly been a spate of articles recently in the medical press about death and how to cope with it. Obviously this is to be welcomed, since we are doctors and deal with it all the time and must therefore be concerned. We cannot, or should not, hide our heads in the sand, for eventually we ourselves will be personally involved.

It is true to say that our own attitude to death and our belief about it largely determines how we shall deal with our patients.

The article by Drs Tombleson and Garsed (January *Journal,* p. 33) is humane and helpful, and comes out strongly against evasion and untruth. This is good, but their philosophy basically is the mournful necessity of getting the patient to accept the inevitable with as much grace and calmness as possible—it is amazing that so many do, and with great courage.

I do not believe that death is the end of life. I regard it, and have no doubt about this, as the door to real life, and this transforms the whole process of dying and makes dreaded death a welcomed friend. It is merely a door into a splendid, inconceivably grand life.

This is no strange or fanciful imagination. It is orthodox Christian belief, endorsed unequivocally for us by Christ himself, and conclusively demonstrated to us by his resurrection. I have seen many people die in this faith and it has transformed the experience for them into peaceful triumph.

Why then have Drs Tombleson and Garsed not mentioned this aspect? I can scarcely believe that they are totally unaware of the Christian teaching on death. I am prepared to believe that they have rejected it for themselves, but that is no reason for excluding such a living, hopeful option from their patients.

This is a plea to our humane profession. If doctors cannot personally offer hope to patients as death approaches—and to leave without hope is to leave to despair and unalleviated gloom—then please lay aside personal prejudice and put them in touch with those who can offer spiritual help.

Not every chaplain—unlike the one in the poem quoted—will shirk the issue of death, and most patients will welcome the opportunity.

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Sir,

I would like to thank and congratulate Drs Tombleson and Garsed on their lucid and sensitive article in the January *Journal.* In this short article they covered all the important points which arise in the management of terminal patients.

A group of general practitioners working with the late Michael Balint were involved in studying the doctor-patient relationship in connection with dying patients. We confirmed everything that Drs Tombleson and Garsed found in their work but perhaps there is one small point that they have not mentioned. In looking at a relatively large number of dying patients managed by their general practitioners we came to the conclusion that patients manage their dying in the same way as they managed their lives. In fact, "patients die as they have lived". We found that the secure mature adult was able to face his own death with fortitude and make all the necessary arrangements to put his affairs in order. Despite the general practitioners' willingness to discuss with these patients the fact of their dying, there were several who resolutely declined to enter into any discussion about their future.

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Sir,

The article on this subject (p. 33) in your January issue reveals the anomalous state in which we as doctors find ourselves when confronted with the dying. How long will it be before we can take dying out of the limbo of irrationality within which it has taken refuge for so long?

We could begin by accepting three propositions:

a) The inevitability of death for all. This being so, the quality of days lived is very much more important than their quantity.

b) The desirability of death for the dying.

c) The preferability of meeting death voluntarily rather than being forced to die *faute de mieux.*

The acceptance of (a) would clear the air of subterfuge in the sick room. We should be able to talk of dying as we talk of taking a holiday. In this respect our society is less fortunate than those in the past, when death was an almost daily occurrence. We have made death so rare that many delude themselves that it need never be considered at all.

With regard to (b) we should respect the wishes of those who want a 'quick exit' once the event is only a matter of time. Legislation for voluntary dying (not suicide) is overdue. Society is so pro-vitalist today that freedom to live is guaranteed but not the freedom to die. The result is a great deal of avoidable misery both for the patient and the relatives.

Doctors should be in the forefront of those who are seeking a new approach to dying. This new approach is already being forced on us by burgeoning world population and diminishing resources. Mere postponement of dying had some validity when religious belief sustained the idea of death-bed repentance. With the general absence of belief an intelligent person should be allowed openly to welcome death without any imputation of depression or connotation of suicide. Society has generally accepted contraception and legal abortion in the limitation of unborn life. The acceptance of voluntary dying is merely the corollary of the same argument at the other end of life. What an immense cloud would be lifted from man's horizon if the idea