reinforced the need for practice nurses to be taught by practice nurses.

We hope this work will further the development of practice nurse education in general practice.

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Books for general practitioners

Sir,
A study of general practitioners' use of postgraduate centre and practice premises libraries has been undertaken in the Vale of Trent faculty area of the Royal College of General Practitioners. A simple questionnaire was sent to all principals via the family practitioner committees in the area. The aim of the survey was to find out how many general practitioners had books on their practice premises and to determine the use made of their own practice libraries and of the postgraduate centre libraries.

Of 893 doctors, only 216 (24%) replied from 136 practices. Less than half of the practices had 50 books or more on their premises. Most of the remainder had 10–50 books. It was interesting to note the general practitioners' choices of the most useful books of reference. The five most frequently chosen books were: Fry's *Illustrated guide to dermatology;* the *British national formulary;* the *Oxford textbook of medicine;* Price's *Textbook of medicine* and Balint's *The doctor, his patient and the illness* (mentioned by 47, 45, 39, 20 and 20 doctors, respectively).

Postgraduate centre libraries appeared to be greatly under-used by general practitioners — a fact which might repay more detailed enquiry. From our survey and from general practitioners and postgraduate centre librarians in Nottinghamshire, Derbyshire and Lincolnshire a fairly comprehensive reading list has been compiled; our thanks go to them, to Margaret Hammond, RCGP librarian, and to Janet Baily, administrative assistant of the Vale of Trent faculty. The list will be kept up to date annually and it could be of value to practices whether they have a library or not. It is available from Mrs Janet Baily, Postgraduate Office, Medical School, Queen's Medical Centre, Nottingham NG7 2UH. Cost £2.50 including postage. Cheques payable to the Vale of Trent Faculty, RCGP.

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Out of hours workload

Sir,
The paper by McCarthy and Bollam on the use of telephone advice for out of hours calls (January *Journal,* p.19) is an interesting description of the situation in north London. However, two factors may limit the wider applicability of the results they report.

The first is the use of 'practices' as the primary denominator for analysis. A review of out of hours care in my own urban practice with 5800 patients revealed a large variation in the use of telephone advice among established general practitioners during 1989 — from 2.9% to 35.5% of all patient contacts made between 18.00 hours and 08.30 hours (total 802). To quote only the overall mean of 16.3% of out of hours patient contacts managed by telephone advice would lose sight of the importance of inter-doctor variation. Moreover, further analysis of this data reveals that the time of day at which the patient contact was made exerts an additional influence on the doctors' management of the contact. Figure 1 demonstrates three patterns of doctor response to out of hours patient contact seen among the five trained doctors in the practice. The time of day clearly exerts an influence on whether a doctor will visit in response to a patient contact, but this factor appears to influence different doctors in different ways.

Secondly, it would be more helpful to express the management of out of hours calls as a rate per 1000 patients at risk, rather than the number of calls per general practitioner in the practice. This would allow comparison between individual practices as list sizes vary considerably between practices in any one geographical area. Application of regression statistics to my data suggests a close relationship ($P<0.01$) between the percentage of calls managed by telephone advice and the total number of calls received.

McCarthy and Bollam observe the potential importance of daytime doctor accessibility on the use of out of hours care, a factor previously noted by Livingstone and colleagues.[1] Data from my practice suggest that when no more routine surgery appointments are available at midday, the doctor on call that evening is twice as likely to be disturbed as on days when appointments are available (Table 1). The data presented represent only 156 of 257 possible weekdays during 1989. It is likely that, given a larger data base, an even closer relationship between accessibility and out of hours workload would be demonstrated.

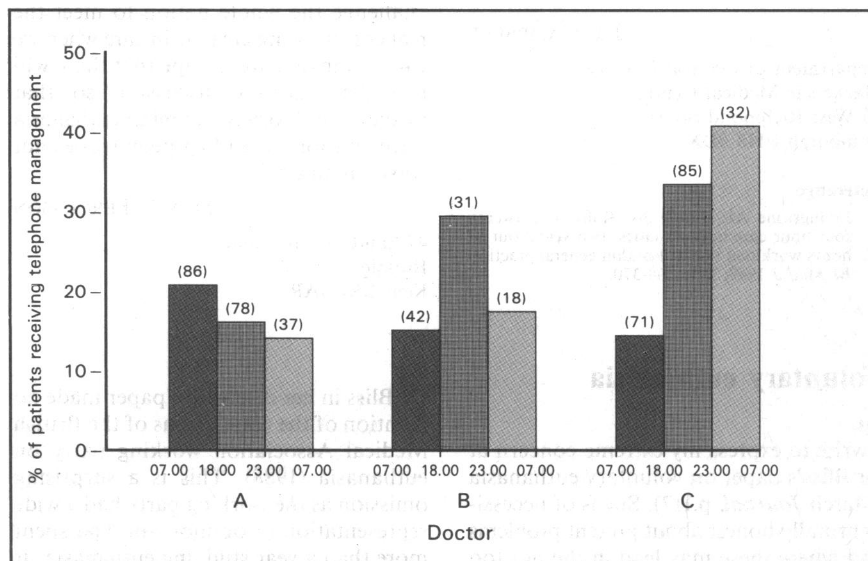

Figure 1. *Percentage of patients receiving telephone management by doctor and by time of call. The total number of patients is shown in parentheses at the top of each bar.*

Table 1. Relationship between availability of surgery appointments in the afternoon and subsequent out of hours contact for 156 weekdays.

Appointments available at midday	Out of hours contact during following night (no. of days)	
	No	Yes
No	5	44
Yes	24	83

McCarthy and Bollam's conclusion that 'deputy managed calls lead to higher night visiting rates than general practitioner managed calls' is borne out by my figures for 1989. Deputies were employed on 40 occasions in the year when they responded to 93 patient contacts between 18.00 and 08.30 hours. Visiting rates by the deputy doctor (93.5%) compared with the range for established doctors in the practice of 64.5%–97.1% (mean 79.7%, $P<0.01$, df = 1, $\chi^2 = 10.7$) during the same period. Prescribing is another important source of variation in behaviour between doctors. Deputy doctors prescribed antibiotic treatment on 54.5% of occasions where the primary diagnosis was of an upper or lower respiratory tract illness. This compared with the range for established doctors during the same time period (18.00–08.30 hours) of 23.7%–64.0% (mean 43.5%, difference not significant).

Further work needs to be undertaken to identify the factors influencing out of hours workload and, more importantly, to determine at what point the doctor's decision whether to visit becomes a measure of quality of care.

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Reference

1. Livingstone AE, Jewell JA, Robson J. Twenty four hour care in inner cities: two years' out of hours workload in east London general practice. *Br Med J* 1989; **299**: 368-370.

Voluntary euthanasia

Sir,
I write to express my extreme concern at Dr Bliss's paper on voluntary euthanasia (March *Journal*, p.117). She is of necessity brutally honest about present problems and where these may lead in the not too distant future, but is dishonest in the way she advocates euthanasia.

She is pessimistic in her presuppositions about future resources. The resources available for health and social care are determined by politicians, and decisions can be changed if the nation wills it. Her philosophy is desperately utilitarian, for example, '... how we can redeploy our limited resources to provide the maximum benefit and happiness to the whole population.' I submit that individuals matter, that 'happiness' is subjective, and that in any case there may be higher moral values.

I write as a convinced Christian believing that 'the image of God' is in every human being regardless of their physical or mental state, and that that is why all human life is valuable and not for the taking. However, one does not need religion to reject euthanasia. Could any policy be policed adequately? Would there be no abuses? Surely legalized euthanasia would fundamentally and irrevocably alter the doctor–patient relationship? Would there be any incentive to look for different solutions? It is no coincidence that in Holland where euthanasia is performed, perhaps involuntarily, there is very little in the way of a hospice movement.

It is certainly not true that all 'philosophers and theologians agree that there is no real difference between passive and active euthanasia'. Indeed many reject the terms 'passive' and 'active' — so-called 'passive' euthanasia is actually good medical practice, whereas euthanasia is active killing. The difference has been summarized as that between 'mercy-dying' and 'mercy-killing'. Doctors have traditionally respected the difference, and the general public and the law recognize it.

In a way I am grateful that Dr Bliss has painted such a stark picture so that it may challenge the whole nation to meet the real cost of being creative in care when we can no longer cure. I hope that there will now be vigorous discussion so that medicine and society can reject euthanasia once and for all. Killing people does not solve anything.

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Sir,
Dr Bliss in her discussion paper made no mention of the conclusions of the British Medical Association working party on euthanasia (1988). This is a surprising omission as the working party had a wide representation of opinion and had spent more than a year studying euthanasia. It concluded that 'The law should not be changed. The deliberate taking of a human life should remain a crime.'

Dr Bliss details demographic and economic problems. If these are used in support of euthanasia, the argument may be stated quite simply: 'there are too many old, ill or disabled people and we cannot afford to care for them, therefore we kill them.' She describes how Yakuts in Siberia do just this; surely she is not suggesting that we do likewise.

If it was realized that when human life became difficult or expensive to support it could be eliminated, euthanasia would become a common practice. A society permitting euthanasia, which is really a policy of despair, would become a sick society itself. Patients' respect for their doctors would soon be replaced by fear and suspicion; the attitudes of doctors and nurses would harden, and they might even encourage euthanasia for patients posing difficult medical or nursing problems; families would be divided by guilt and recriminations.

Just down the road from her own Hackney hospital, Dr Bliss will find St Joseph's hospice. The philosophy of hospice care as practised there and at other hospices would provide alternative solutions for many of the difficulties she mentions: relieving distressing symptoms; providing emotional support for patients and their families; enabling the patient to be occupied mentally and physically for as long as possible; allowing a peaceful death with no extraordinary efforts at resuscitation.

It is important to remember that in many cases suffering is on the part of the beholder, not the patient. Human life should be regarded as inviolable. We doctors are practising hippocratic medicine, not veterinary medicine.

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Service families

Sir,
The article by Major Vincenti (February *Journal*, p.78) is timely, given the recent dramatic changes in Eastern Europe, which will undoubtedly result in redeployment of troops, not only within Europe, but in the UK as well. Apart from British troops and their dependants, there are several thousand foreign troops and their dependants in the UK, as part of NATO.

My experience of working for some years with service personnel and their families, both as a serviceman and now as a psychotherapist, confirms that