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, χ^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

'married families', as the Ministry of Defence delightfully calls them, are different in many ways from non-military families.

First, the military politics governing the career and responsibilities of the serviceman come first, with health coming second. Referral for psychotherapy (and perhaps for psychiatry also) may be detrimental to the promotion prospects of the patient. It may result in transfer of job within the unit or, where intensive work with the family is required, in posting back to the serviceman's home area.

Secondly, military families have no extended family system locally to support them in times of psychological or social distress. Apart from cases of child abuse, where there are usually clear referral procedures to the local authority, routine support of such families is often left to the military themselves, as it is difficult for a local authority to become involved. There are relatively few people like myself around, who know the military system and respect it, and as Major Vincenti points out, it is left to organizations like Soldiers, Sailors and Airmen Families Association to offer their professional help.

Finally, military security prevents personnel talking about their work at home and this can be a psychological strain, as they may also be unable to express their feelings in a tight command system. The fact that I have signed the official secrets act, makes it easier for some personnel to share their feelings with me. However, repression of feelings is the more common coping strategy, with resultant somatization. Further pressure, for example from family problems, could cause the patient to be insubordinate or take leave without permission, which may result in charges and courts martial. Military families often remark that they prefer the civilian medical referral system because personal, intimate matters can be discussed privately, without the line of command system getting too much information.

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MRCGP and palliative medicine

Sir,

In recent months there has been correspondence in the *Journal* about the future of the MRCGP examination and about the close relationship between the specialties of general practice and palliative medicine. There is a link between these issues.

Dr MacLeod (November *Journal*, p.477) writes of the physician in palliative medicine as having training in both that specialty and in family medicine. This is not true of all palliative medicine specialists but it is a possible combination. The Joint Committee on Higher Medical Training in its criteria for entry to training in the specialty includes possession of the MRCGP as a permitted alternative to holding the MRCP.

However, the eligibility of such alternative higher qualifications is due to be reviewed in 1992. Dr Ford (September *Journal*, p.392) hopes 'the College will act to preserve the value of its qualification to its members', a view we share. Whatever its defects, the examination is unique in testing both factual clinical information and doctors' attitudes. These attitudes are relevant not only to primary care but also to other areas of medical practice, not least palliative medicine.

In the case of palliative medicine the MRCGP functions not so much as a seal of training but as a qualification for entry to it, with up to four years of selected experience to follow prior to accreditation. Alterations to the MRCGP may mean the effective disbarring of doctors from entry to palliative medicine who have received what is arguably the most appropriate early preparation for the specialty. Such an event is unlikely to promote the collaboration on which Dr MacLeod and Dr Charlton (August *Journal*, p.347) rightly place such emphasis.

The MRCGP can have importance beyond the boundaries of general practice itself. We hope that nothing will be done to jeopardize the role it can play and hence the greater influence general practice can exert.

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Academic general practice

Sir,

I am constantly astonished at the implication that academic general practice is remote from the daily activities and problems of the rest of the profession (letters, March *Journal*, p.126). Almost without exception departments of general practice are staffed by active general practitioners, often of considerable experience who alas have not only general practice problems but university or medical college ones as well.

Dr Holden suggests the *Journal* should carry an unreviewed short reports section. As I understand it papers are frequently rejected because of methodological flaws rather than 'academic flaws'. This is right and proper; conclusions which are drawn as a consequence of research which is poorly designed or executed are not only misleading but may prove dangerous not only to patients but to readers who may be bored into extinction.

The Royal College of General Practitioners has a reputation to uphold and does this relatively well — although there is always scope for improvement. Are the keenest doctors discouraged from research by the *Journal?* I doubt it; they increasingly turn to departments of general practice for help with their projects and as a consequence the standard of papers in methodological terms is improving. I wish I could say the same for the 'interest' element — the boredom index remains remarkably uniform.

If doctors feel the need to have their flawed articles published there are always the 'freebees'. I confess I find some of the articles riveting and with these, who cares about methodological flaws?

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Iron deficiency and sources of iron

Sir,

Dr Grant's study (March *Journal*, p.112) showed a high prevalence of iron deficiency in rural pre-school children in Northern Ireland. The author concluded that the main cause of this was an inadequate dietary intake of iron, and suggested that education should cover the fact that iron absorption from foods of animal origin generally surpasses iron absorption from foods of vegetable origin. This may be misleading. Meats, and particularly liver, are rich in iron which is well absorbed, but the iron in eggs is poorly absorbed and dairy products are not rich in iron.[1] Beans and dark green leafy vegetables are good vegetable sources of iron, and fresh fruits and vegetables are good sources of vitamin C which has a very important