deaths recorded by death certificate were examined. (Incidentally, 45% (n = 107) of deaths recorded by the coroner were sudden deaths due to cardio- and cerebrovascular disease. A further 23% (n = 54) were unnatural deaths.) The boundaries of the Greater Belfast area had not changed in the intervening 15 years, although the population of Belfast had fallen by 11%.

In 1979, Reilly found that 56% (n = 663) of deaths occurred in hospital with 36% (n = 413) occurring at home and 8% (n = 99) occurring in various institutions. In 1994, 51% (n = 423) of deaths occurred in hospital with 24% (n = 199) dying at home, 15% (n = 129) occurring in residential or nursing homes, and 9% (n = 73) dying in hospices (Table 1).

Various institutions in 1994 constituted nursing homes, hospice in-patient units and residential accommodation. In 1979 there were no hospice beds in Northern Ireland. Over the 15 years, the number of registered nursing homes increased from five to 87 (data supplied by the Registration and Inspection Unit of the Eastern Health and Social Services Board).

As yet we can only speculate as to why these changes exist. It is unlikely that the spectrum of pathology has changed much over the 15 years. It is interesting to note that the population of the Greater Belfast area fell by 11% between 1981 and 1991 (with a subsequent rise in the populations of surrounding dormitory towns). No significant difference is noted in any age group between the Belfast populations of 1981[3] and 1991.[2] It would seem probable that economic factors and changes in health and social security policies have influenced the place of death. We propose to undertake further study to account for our findings.

There is evidence to suggest that the majority of patients who know they are dying wish to die at home.[4] There is also evidence that care of dying patients in hospital is sub-optimal.[5] It would therefore seem appropriate to direct resources so as to enable people to die in their own homes. Reilly *et al*[1] end their paper with the question, 'Why are so few people dying at home?'. Fifteen years later we ask, 'Why are so many people still dying in hospital, and even smaller numbers than before dying at home?'

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Primary healthcare information needs

Sir,

Your readers may be interested in the research outlined in this letter which has been reported only in publications unlikely to be seen by them. Further information is available in the publications listed or from the writers. The research looked at information aspects of 13 general practices in the Trent region[1,2,4] and eight general practices in the Anglia and Oxford Region.[2,3,4] In total, those interviewed consisted of 62 GPs, some practice nurses and the purchasing staff from the Anglia and Oxford study, and representatives of other practice staff in the Trent study. The data were analysed using a variety of qualitative methods.

The research topics covered included:

- why the GPs needed information and how they obtained it
- how communication worked within the practices and with external organizations
- how the NHS reforms had affected information-handling in the practice, and what GPs and staff thought could be done to improve the situation
- information for purchasing, and
- future information services for general practitioners and practice staff.

The Trent study resulted in the development of guidelines for managing information effectively in general practices. The Anglia and Oxford study ended with a workshop at which participants were encouraged to consider ways in which library and information services might be tailored to the needs of general practices, both fundholding and non-fundholding. A follow-on study — the Primary Care Sharing the Evidence Project — is now underway in Anglia and Oxford.

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Sexual harassment of doctors

Sir,

I wonder if either Dr Jarvis or the authors of the paper she quotes from (international digest section, August *Journal*) have considered the larger and more threatening problem of sexual harassment of male doctors by female patients? One suspects that if the researchers had bothered to carry out a similar survey of their male peers, they might have found that for many male doctors sexual harassment is an almost daily occurrence. Not only are the majority of consultations held with female patients; male doctors are traditionally seen (whether they welcome it or not) as objects of sexual desire. Acting within a society which generally absolves women of responsibility for their own actions and searches for male scapegoats instead, the General Medical Council happily persecutes male victims of even the most absurd, malicious sexual allegations, and yet has been known to decline to take action against female doctors who embark on sexual relations with male patients.

Sexual harassment of male doctors by female patients is not merely more common than the converse, but is done with impunity as if it were a right, bringing with it a threat which women have no need to fear from men.

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