normal? Pink and well perfused? Glasgow Coma Scale 15?' In a word, we practise triage, constantly.

That is why we practise CPR. Forget the QOF.

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Salaried doctors

As a former senior partner of 20 years and a salaried doctor of 4 years, the conclusions of this rather interesting piece of research are no surprise. We are left with the overall impression of smug partners and embittered salaried GPs. My sympathies tend to be with the latter.

I know that my following plea is likely to fall on deaf ears, but I think it is worth making nevertheless. That is for those partners who are perhaps half a decade, or even a decade, away from retirement to make the brave step of changing directions. Perhaps it is time to voluntarily step down to a salaried position? Why not act as a grandparent to our younger colleagues? You know what I mean. To be happy to hold the baby while your sons/daughters are out shopping, but to be even happier handing him/her back at the end of the day for them to go through those sleepless nights. We are still there for advice, and are still going to be paid more than the vast majority of people in this country. We still have our savings, our paid-for house, our comfortable living. And now perhaps a chance to expand to do what we always wanted to do — hobbies or another field of medicine. What are you waiting for?

I know this because I did it. I have never regretted for a second that I left my well-established and increasingly successful practice. I enjoy watching it expand and I am pretty sure that I would have held it back if I had remained. We are still on friendly terms, and perhaps I retain a bit of a feeling that I had some part in its creation ... but it now needs to grow-up. Meanwhile, I am learning and working in other areas of medicine that I never really knew existed, and meeting others in related professions whom I continue to learn from. This would never have happened had I stayed.

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STIs in general practice

Sacks and Goodburn discuss increasing HIV-testing in general practice.[1] Improved uptake of HIV-testing is important since the Health Protection Agency estimate that 21 000 people are living with undiagnosed HIV in the UK.[2] Women attending antenatal clinics are already tested for HIV routinely, but little is known about the feasibility of testing male partners. Following ethical review (Wandsworth Research Ethics Committee Reference: 00167.09) we conducted a questionnaire survey to investigate the attitudes of pregnant women to having their partners tested for HIV.

In December 2009, a confidential questionnaire was handed out by a medical student (TS) to consecutive pregnant women attending the antenatal clinic at St. George's Hospital, London.

The response rate was 93% (100/108). The mean age of responders was 30 years (range 20–45 years). Fifty-eight per cent of women described their ethnic group as white, 18% as black, 18% as South Asian, and 6% as other ethnic group. Most women (83%) thought it was a good idea for their partner to have a salivary test to check for HIV, while 82% thought it was a good idea to have a blood test. They identified the main benefits of testing their partners: to ensure the safety of the mother and baby, and for peace of mind. They saw less benefit if their partner had recently been tested or the mother had already tested negative. The myth that one partner testing negative means that the other does not need to be tested was identified in our earlier study of male partners who cited the same reason for not testing.[3]

However, many women wanted to know how HIV-testing could help their baby, and appeared to be unaware of effective treatments to prevent transmission of infection. Increased knowledge about HIV has been shown to be associated with increased test uptake by pregnant women.[4] Sacks and Goodburn suggest little pre-test counselling is needed unless a patient is high-risk,[1] and most pregnant women in our study were happy for their partner to be tested for HIV. However, GPs and other health professionals could have a crucial role in encouraging uptake of HIV-testing by educating patients about the benefits of early diagnosis and treatment of HIV.

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Assisted suicide

The debate on assisted suicide will surely run for many months, if not years to come. Opinion may be divided but, as the *BJGP*'s recent letters, editorial,[1] and original article[2] demonstrate, the closer doctors are to the work of caring for the dying, the less they tend to support a change in the law. If we owe our dying patients any kind of debt, it is to afford them the same value and standard of care as those that live on.

Opinion polls may show a majority in favour of euthanasia or assisted suicide, but they also favour the death sentence, and our representative democracy allows us to reach a consensus in other ways than a simple head count.

As a GP for 13 years and a consultant in palliative medicine for the following 13, I am perfectly aware that the technology of controlling symptoms and alleviating distress still fails a few patients with severe terminal illness, as well as a few more whose illness will not be likely to kill them anytime soon. However, this should be a spur to a greater effort in researching, organising, and practising better terminal care.

Our duty to society is to do our best and clearly state the threat that legalised assisted suicide would bring to vulnerable and compliant patients, already so devalued by our society that many no longer benefit from the standards of care mandated in the state sector. Care of the old and chronically sick is likely to be further eroded and outsourced to commercial enterprise as economic and political conditions change. This is no time to introduce suicide as any kind of therapeutic choice. The Association for Palliative Medicine continues to oppose a change in the law.

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Persistent vegetative state

Mick Leach, commenting on David Jewell's editorial on assisted dying,[1] writes that 'we are part of a wider global society that is in many ways becoming more uniform ... that does not mean that we should necessarily always take the same route as other countries'.[2]

I would like to underline two key cases that happened in the UK and Italy that have been described in their different aspects by Paquita De Zulueta and myself.[3] I'd invite you to read them.

In April 1989 in England, Tony Bland, aged 17, was trampled and crushed by a stampede at the Hillsborough football stadium — a disaster in which 95 people were killed. Nearly 3 years later, in January 1992 in Italy, Eluana Englaro, aged 21, lost control of her father's car while driving at night on an icy road and crashed into a lamp post fracturing her skull and neck. When these young people were admitted to hospital, both of them were found to have suffered devastating anoxic brain damage and both were later diagnosed as being in a permanent vegetative state. This situation lasted for many years.[4,5]

We had two young people disastrously brain damaged and incapacitated provoking a painful and public debate regarding their future. In both cases the families wished treatment to end and were supported by the law, and in the UK case also the medical profession (but not the nursing profession). In Italy, the medical profession was divided and Italy appeared to be in danger of sliding into a constitutional mayhem and theocracy. The religious stance, however, is relatively new (since 20 March 2004, when Pope John Paul delivered a papal allocution on the subject) and with the Catholic tradition in fact offering two competing viewpoints on the ethics of withholding or administering hydration.

Debates about permanent vegetative state vary greatly between countries, revealing the different visions of what constitutes the 'Good Life' and what it is to be human. In both cases mentioned some kind of legal compromise was reached: in Italy there was an acceptance that the individual's prior wishes are determinative, even though arguably, that person no longer exists, and in England a subjective quality-of-life assessment was made that permitted treatment to be discontinued in the full knowledge that death would follow. Both decisions aimed to reflect a compassionate and holistic view of what it means to be fully human.[6]

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Circumcision

In answer to the article's question — a religious obligation or the 'cruellest of cuts'? — neither.[1] No-one is obliged to be religious, and if they choose to be, there are plenty of religions where non-