charities, and organisations continue to build inpatient units and recruit staff, including home care nurses, as if nothing has changed in the past 14 years. Is the goal that every dying patient is seen by a home care nurse? If so, this will guarantee that deskilling occurs and produce resistance against existing resources for palliative care. Contracting, combined with effective health planning, is probably the most effective deterrent to such excesses.

To their credit, some palliative care groups are beginning to recognise the issue of resourcing, although their recruitment drives continue. It is time for palliative care groups to collaborate or enter into partnerships with existing services. This implies shared planning based on identified needs, joint ownership of strengths and weaknesses, and the willingness of palliative care teams to make resourcing their primary role. Specialist palliative care teams will continue to have a service role owing to the sheer numbers of patients with advanced disease (not just cancer) and the disappointingly slow rise in general skill in palliative care. The demands on specialist care are not just to provide education and specialist support but to lead in clinical development and research, to work alongside colleagues when needed, and, just as importantly, to withdraw when not needed.

Certainly we must be proud of the achievements suggested by Smith and Eve. These new estimates, however, should now trigger the second wave of development described by Clark,⁵ in which specialist palliative care is a vital resource in health care partnerships.

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Purchasers come between complementary specialties

EDITOR,—Anthony M Smith and Ann Eve¹ are correct in suggesting that many more people with advanced cancer receive specialist palliative care than Geoffrey Hanks suggested.² Roughly half of the patients with advanced cancer in Britain are managed throughout their illness by oncologists (either medical and clinical), most of whom also have specialist skills in palliative care. Patients may be referred to a palliative medicine specialist—if they are referred at all—only during the last few days or weeks of an illness that has lasted months or even years since attempts at curative treatment were abandoned.

The division between palliative oncology and the relatively new specialty of palliative medicine has become increasingly blurred. Oncology centres now offer outreach teams, counselling, and specialist pain relief services. Palliative care physicians now become involved with patients with cancer at a much earlier stage in their disease, during the transition from curative treatment to relief of symptoms. This can only benefit the patients.

Unfortunately, current purchasing practice seeks to divide palliative care from medical and clinical oncology. Cancer treatment is purchased in terms of the chemotherapy or radiotherapy given, and the many hours of specialist time that are devoted to supportive care and control of symptoms are often inadequately recognised. This

may eventually deny patients the possibility of being cared for in their terminal illness by the specialist who has been with them since their cancer was diagnosed. It also puts the complementary specialties of oncology and palliative care into direct competition when we are all trying to work more closely to provide seamless specialist care for our patients.

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Arbitration and the NHS

EDITOR,—Malcolm Forsythe's editorial on arbitration and the internal market is thought provoking.¹ He suggests that guidance on the use of arbitration to resolve disputes between the public and NHS purchasers once other attempts at resolution have been exhausted would benefit everyone. A recent editorial in the *Times* said: "With [the British government's] current ethos of competition and comparison... politicians have encouraged citizens to scrutinize the institutions that serve them. The effect is paradoxical. Standards rise, but so too do knowledge, expectations, dissatisfaction and disappointment."² In this climate one can see the expectations and militancy of the public increasing, against the backdrop of the publicly stated statistic that over half of the population has no access to justice, the reason being cost.

To ease this situation in medicine the Chartered Institute of Arbitrators has proposed to the Department of Health that one or two pilot schemes should be run for disputes between patients and doctors; these would be based on the institute's mediation and arbitration scheme. So far there has been no response. Surely the following factors demand that this proposal should be taken up: the finite resources of the NHS; the increasing cost of treatment; the increasing expectations of the public, encouraged by the citizen's charter; and the lack of access to justice for many citizens.

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Sunburn and melanoma

EDITOR,—Robin Marks and David Whiteman raise two interesting points in their editorial on the link between sunburn and melanoma—namely, that recall as a measure of assessing the prevalence and severity of sunburn is unreliable and that there is a possibility that the risk associated with sunburn is not constant throughout life but is more important in childhood.¹ In considering these two issues the North Western Regional Health Authority has set as an interim local target a reduction in the prevalence of skin burning in children. The first stage is to measure the prevalence of sunburn in the younger age groups.

We recently undertook a pilot study aimed at validating a questionnaire for use as an instrument for the self reporting of episodes of sunburn by children aged 7 to 11. In addition to giving a

baseline prevalence it includes a measure of severity. Initial analysis of the pilot study has shown that 250 of the 540 children surveyed reported an episode of sunburn this summer; many of the children reported more than one episode. Altogether 334 of the 584 episodes occurred in the British Isles. Twenty one of the children reporting episodes of sunburn had non-white skin types.

This level of sunburning in childhood supports the argument for a programme aimed at altering behaviour to reduce the prevalence. Such a programme would need to take into account the pattern of exposure—that is, that 57% of episodes occurred in Britain—and should not be complacent about people with non-white skin types as they too seem to be at risk. Further work needs to be done, including measurement of the baseline prevalence of sunburn in all age groups as well as the development and evaluation of effective interventions.

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Doctors and execution in Turkey

EDITOR,—As Tessa Richards points out, the considerable problems besetting the World Medical Association should not mislead us into underestimating the importance of its ethical declarations.¹ One of its more important resolutions was that passed in 1981 prohibiting the active participation of physicians in capital punishment other than to certify death. This resolution was in effect adopted in 1992 as one of the recommendations of the BMA's working party on the participation of doctors in abuses of human rights.²

Unfortunately, many countries demand in law that a doctor be present at an execution not only to certify death but also to confirm that the prisoner is fit for execution and possibly to indicate if the execution needs to be repeated. One such country is Turkey, and the Turkish Medical Association has several times expressed its opposition to this legal requirement, calling for changes in the law to bring it into line with the World Medical Association's resolutions.

The last execution in Turkey occurred in 1984. Since then no death sentences have been approved by the parliamentary judicial commission, although the courts continue to hand them down. Last November, however, for the first time in over nine years, the commission approved a sentence of death in the case of a (non-political) murderer. All that is now needed for the execution to take place is a simple majority in the Turkish parliament when the case is sent to it for approval; this may happen in the next few months. In December the Turkish Medical Association issued its most recent statement on the issue, reiterating its ethical position and calling for urgent changes to the law.³

Amnesty International is gravely concerned about the situation in Turkey; these events have taken place against a background of a violent uprising in the mainly Kurdish south east of the country, in which both government forces and armed opposition groups have been responsible for brutal abuses of human rights. The death sentence is mandatory after conviction for "acts of separatism" (which include the expression of certain non-violent opinions), and if executions resume in Turkey many political prisoners, some of them prisoners of conscience, will probably be executed. Amnesty International fully supports the Turkish Medical Association in its attempts to prohibit the participation of doctors in the execution process