never meant to be sporadic care: it requires care to be focused on a person over time. The health benefits of delivering primary care through a long term relationship with a single practitioner or small team at a local "single point of access" are clear.[6]

The second important feature of a strong primary healthcare system is a comprehensive financing mechanism. A recent report written jointly by the World Health Organization, the World Organisation of Family Doctors, and the Royal College of General Practitioners warns that no single form of payment system can easily remunerate the complexity of the tasks carried out by general practitioners.[7] It suggests that additional forms of payment, such as session payments, fees for service, and target payments, will be needed to motivate general practitioners. Target payments in particular can be used to strive for improved quality to implement specific government health policies, such as delivering successful immunisation and screening programmes. The report also states that a mechanism for basic funding that is derived from a weighted capitation system is the best way of allowing countries to identify and treat their own health priorities.

The current "red book" payment system for general practitioners (the system that sets out payments, reimbursements, and targets and is used to pay British general practitioners) has proved to be a flexible mechanism for the central control and direction of activity in primary care. Abandoning this system in favour of salaried service or other payment systems would be to disregard the available evidence, and abandonment could result in less health improvement occurring at the same cost.

The current registered list and payment systems for general practitioners have served the health of Britain well, and over decades they have delivered more health than international comparisons would have predicted. Rather than interfering with these aspects of primary care, the government's review of the NHS should consider the evidence from studies of the effects of organisational context and the mode of payment on the services provided by general practitioners. If incentives for quality and dedicated service have proved successful in primary care, is it now time to experiment and evaluate secondary care in the same way?

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1 Hjortdahl P, Laerum E. Continuity of care in general practice: effect on patient satisfaction. *BMJ* 1992;304:1287-90.
2 Freeman G, Hjortdahl P. What future for continuity of care in general practice? *BMJ* 1997;314:1870-3.
3 Hjortdahl P, Borchgrevink CF. Continuity of care: influence of general practitioners' knowledge about their patients on use of resources in consultations. *BMJ* 1991;303:1181-4.
4 Flint S. The impact of continuity of care on the utilization and cost of pediatric care in a Medicaid population [dissertation]. Chicago: University of Chicago, 1987.
5 Gill J, Mainous A. The role of provider continuity in preventing hospitalizations. *Arch Fam Med* 1998;7:352-7.
6 Starfield B. *Primary care: balancing health needs, services and technology*. Oxford: Oxford University Press, 1998.
7 Brown S, ed. *Physician funding and health care systems—an international perspective*. London: Royal College of General Practitioners, 1999.

Suicidal behaviour in gay, lesbian, and bisexual youth

It's an international problem that is associated with homophobic legislation

There is now a bitter debate in the United Kingdom over the repeal of Section 28 of the Local Government Act 1988, which forbids the promotion of homosexuality. This debate should be enlightened by accumulating research on the development of sexual orientation in adolescence and the mental health consequences of growing up in a climate of homophobic intolerance.[1] British research documenting the impact of homophobia has been corroborated by extensive research in the United States, Canada, and New Zealand.[2–4]

Sexual orientation emerges strongly during early adolescence. Youths with emerging identities that are gay, lesbian, or bisexual, living in generally hostile climates, face particular dilemmas. They are well aware that in many secondary schools the words "fag" and "dyke" are terms of denigration and that anyone who is openly gay, lesbian, or bisexual is open to social exclusion and psychological and physical persecution.[4] Some of their families too will express negative feelings about people who are gay, lesbian, or bisexual; youths in such families may be victimised if they disclose that they are not heterosexual.[5 6]

Youths who feel that they are gay must either hide their feelings from others for many years or face the risk of "coming out" to family and peers. Either course is perilous, and for some, one consequence of the confusion over their identity in a climate of intense intolerance and victimisation may be suicidal behaviour.[7] Epidemiological studies from North America and New Zealand show that gay and bisexual males are at least four times as likely to report a serious suicide attempt.[3 4 8–11]

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Many schools allow a climate of homophobia

In the United States, more youths are disclosing their gay, lesbian, or bisexual orientation during high school, especially as more support services are being made available. However, many schools provide no assistance and allow a climate of homophobia to persist. For

example, legislation in the state of Utah (now repealed) was enacted to eliminate after school clubs that supported gay, lesbian, and bisexual youths. Additionally, many families remain unable to respond positively to their gay, lesbian, and bisexual children and have little access to information and support; this in turn may contribute to the stresses in adolescents' lives—stresses that can lead to despair.[12]

Thus, Section 28 must be seen as homophobic legislation that may contribute to the mental health problems—such as depression, substance misuse, and suicide—of gay, lesbian, and bisexual youths. The limbo into which these youths are assigned by Section 28 regulations must be ended.

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1 D'Augelli AR. Developmental implications of victimization of lesbian, gay, and bisexual youths. In: Herek GM, ed. *Stigma and sexual orientation: understanding prejudice against lesbians, gay men, and bisexuals*. Thousand Oaks, CA: Sage Publications 1998:187-210.
2 Rivers I. School exclusion, absenteeism, and sexual minority youth. *Support for Learning: British Journal of Learning Support* 2000;15:13-8.
3 Tremblay P. Suicide attempt research data: thirty G(L)B samples. www.virtualcity.com/youthsuicide/news/studies.htm (accessed 5 June 2000).
4 Bagley C, Tremblay P. Suicidal behaviors in homosexual and bisexual males. *Crisis* 1997;18:24-34.
5 Remafedi G. *Death by denial: studies of suicide in gay and lesbian teenagers*. Boston: Alyson Books, 1994.
6 D'Augelli AR, Hershberger SL, Pilkington NW. Lesbian, gay, and bisexual youths and their families: disclosure of sexual orientation and its consequences. *Am J Orthopsychiatry* 1998;68:361-71.
7 Savin-Williams R. Verbal and physical abuse as stressors in health and risk behaviors among bisexual and homosexual adolescents: association with school problems, running away, substance abuse, prostitution, and suicide. *J Consult Clin Psychol* 1994;62:261-9.
8 D'Augelli A, Hershberger S. Lesbian, gay and bisexual youth in community settings: personal challenges and mental health problems. *Am J Community Psychol* 1993;21:421-48.
9 Remafedi G, French S, Story M, Resnick M, Blum R. The relationship between suicide risk and sexual orientation: results of a population-based study. *Am J Public Health* 1998;88:57-60.
10 Garofalo R, Wolf R, Lawrence M, Wissow S. Sexual orientation and risk of suicide attempts among a representative sample of youth. *Arch Pediatr Adolesc Med* 1999;152:487-93.
11 Remafedi G. Suicide and sexual orientation: nearing the end of the controversy? *Arch Gen Psychiatry* 1999;56:876-85.
12 Hershberger S, D'Augelli A. The impact of victimization on the mental health and suicidality of lesbian, gay and bisexual youth. *Dev Psychol* 1995;31:65-74.

How living wills can help doctors and patients talk about dying

They can open the door to a positive, caring approach to death

Papers p 1640

Many people are unaware of living wills but are highly interested once they hear about them. In this week's *BMJ* Schiff et al (p 1640) find that elderly inpatients are confused by the term living will, but most would welcome the chance to discuss issues about facing the end of life, and many would want to limit their health care if they were terminally ill.[1] An assessment of the understanding of living wills in the United States some time ago found a similar state of affairs.[2] This juxtaposition of ignorance and interest raises an important question: what is this apparent appetite to discuss and prepare for dying?

When lawyer Louis Kutner proposed the notion of a living will in 1969, he was responding to the fear that technology was driving doctors to impose life sustaining treatment on patients who might not want it. The living will was seen as a simple device to allow patients to say no, even if they were too ill to communicate. The first living wills used phrases such as avoiding "heroic treatment" in the face of "hopeless prognosis," and states passed legislation to give legal sanction to physicians honouring such directives throughout the United States. But physicians found difficulty translating these dispositions into specific treatment choices. A new wave of work began: the development of validated worksheets.[3]

It is difficult to turn subjective phenomena such as a person's values and goals for care in hypothetical scenarios into objective criteria. But psychometricians have set out a series of standards for the valid framing of topics and the elicitation and recording of opinions, wishes, and reasoning.[4] So the living will movement, which aimed to elicit preferences on how decisions should be made and by whom, tried to apply these standard procedures.[5–9] In the process of developing validated forms it became clear that they needed to be used as worksheets to facilitate discussions and the making of decisions.[10]

Moving away from the notion of a legal defence against aggressive doctors, the living will movement realised that it is the process that is the central issue. The main outcome was to honour the best available portrait of the patient's desires. A good process had to deal with several more things: the patients having a chance to consider and have some control over their last chapter of life; the proxy decision makers being ready for their roles; and the families having a chance to talk about issues relating to end of life and to resolve personal matters. Dying, it emerged, was a taboo topic that patients and families wanted to repossess.

Advance care planning is a component of care

But studies showed that living wills did not achieve their goal.[11] Some commentators advocated dropping the whole idea. Meanwhile the hospice movement and palliative care services were gaining prominence, and pioneer clinicians were trying to integrate both concepts into medical practice.[12 13] Both movements accepted advance care planning as central to their philosophy of total care.

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