the need for research to develop more effective abstinence promotion programs; it objects to the dissemination of these programs without empirical justification.

It is important to distinguish funding research studies designed to develop more effective abstinence programs, which is clearly needed, from allocating substantial fiscal resources to widely disseminate unproven programs. Thus, in the absence of evidence demonstrating the efficacy of abstinence programs, a prudent course of action would be to develop a research agenda to stimulate basic social and behavioral science research designed to develop and rigorously evaluate a new generation of innovative abstinence programs.

As Dr Berman and colleagues note, early detection and treatment of STIs can also be an effective prevention strategy. Such a strategy is greatly enhanced by the advent of new, noninvasive diagnostic tests that can be reliably used in nonclinical settings. To maximize the effectiveness of different strategies for preventing STIs, a coordinated, multifaceted, national program that tailors prevention efforts toward the individual, the family, the community, and the health care system is urgently needed.

Effective abstinence programs would be a valuable weapon in the public health armamentarium to confront the growing threat posed by the epidemic of STIs, including HIV. The public health and clinical significance of postponing adolescents' sexual onset cannot be overstated. However, priorities need to be directed away from programs that are based on persuasive philosophy or anecdotal evidence and toward those that are based on solid empirical research and demonstrated efficacy.

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1. Jemmott JB III, Jemmott LS, Fong GT. Abstinence and safer sex HIV risk-reduction interventions for African American adolescents. *JAMA*. 1998;279:1529-1536.

Euthanasia and End-of-Life Care

To the Editor: We were surprised that in their article assessing patients' perspectives of what constitutes quality end-of-life care, Dr Singer and colleagues[1] did not address the issue of euthanasia. Certainly before the availability of highly active antiretroviral treatment, many patients with human immunodeficiency virus (HIV) infection asked us whether active euthanasia would be possible if their suffering became unbearable and they had no further treatment options. During an anonymous questionnaire survey among 315 persons with HIV infection in Belgium, 82% of the respondents felt that physicians should be able to help terminate life at the explicit request of a patient in severe physical pain.[2]

In practice, many persons with HIV infection, even if they become severely ill, do not request euthanasia. However, the knowledge that euthanasia could be available for them on request is important in enabling them to cope better with their insecure future. Therefore, to improve the quality of life for patients with chronic and incurable disease, offering patients the option of euthanasia should be legally possible.

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1. Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspectives. *JAMA*. 1999;281:163-168.
2. Fleerackers Y, Colebunders R, Fonck K, Depraetere K, Pelgrom J. Euthanasia and physician-assisted suicide. *Lancet*. 1996;347:1046.

In Reply: When end-of-life care surfaces on television, in the newspapers, or on the radio, 9 times out of 10 the issue arises as "euthanasia" or "assisted suicide." At the bedside, however, the primary concerns of dying patients are the ones in our study—receiving adequate pain and symptom management, avoiding inappropriate prolongation of dying, achieving a sense of control, relieving burden, and strengthening relationships with loved ones. In our study, which involved patients receiving dialysis (n = 48), people with HIV (n = 40), and residents of a long-term care facility (n = 38), euthanasia was mentioned by less than 5% of participants in each group. Is it possible that the dramatic issue of euthanasia and assisted suicide has obscured the more "mundane" personal issues that are of primary concern to dying patients?

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Self-prescribing by Physicians

To the Editor: I agree with Dr Christie and colleagues[1] that self-prescribing antibiotics may be a problem and actually have potential negative health effects for the physician/patient, given that antibiotics are overprescribed for patients even when the physician is not the patient.

However, I am concerned with the overall tone of the article, which almost conveys a sense of immorality on the part of the responsible physician with health problems. For example, if an experienced internist cannot look at a simple lipid profile and make a determination, based on what he or she knows of the patient's lifestyle and diet, whether medical therapy would be appropriate, then what business does he or she have seeing patients with this problem? If the physician has hyperlipidemia, what objectivity is lost in looking at a simple laboratory report?

The authors specifically address physicians' "inappropriate . . . [use of] self-initiated bronchodilators to treat asthma." What would the authors propose for a physician in the middle of a busy day, on call? I imagine the physician trying to commute to an appointment that is likely some distance away (to