

## *The care of the dying patient in general practice*

*From a Journal Correspondent*

A study day organised by the King's Fund Centre, King Edward's Hospital Fund for London, was held at the Royal College of General Practitioners, 14 Princes Gate, London, on 8 October 1975. A large group of general practitioners, hospital doctors, and other professional staff met under the chairmanship of Professor E. Wilkes *O.B.E.* to discuss the attitudes and responsibility of professional staff, especially doctors, towards the dying patient.

Topics covered in discussion were how and what to talk about to dying patients and their relatives, the ways in which doctors and other staff could learn to do this, the needs of dying patients and their relatives, and the ways in which services could be made to respond to these needs. There was general recognition that very high standards in the hospices of the dying made other professionals aware of their own inadequacies, but a feeling that more attention and training in these subjects could help them all to cope better with their own feelings on this very difficult topic and so to help their patients.

### **Views of four professionals**

*Dr N. Howard* (Consultant Physician)

Dr N. Howard spoke as a consultant physician. He felt that the care of the dying was generally done rather badly, partly because most people were afraid of dying and some of death itself. Doctors often resented the dying patient because he represented failure and even went out of their way to avoid a patient when nothing more could be done.

The high standard of care set by such doctors as Cicely Saunders only made the average doctor feel guilty at being unable to do so well. There was always something to be done for the dying patient, not least by being prepared to provide powerful narcotics.

*Mrs Anne Dawar* (Divisional Nursing Officer)

Mrs Anne Dawar, a divisional nursing officer, said that young nurses had very little personal understanding or experience of death or dying. Both doctors and nurses of all degrees of seniority were fearful of emotional closeness with their patients because it might be painful; confidences came more easily in moments of closeness and touching, and the nurse must be ready at these times to talk about death or the fear of death.

*Dr O. Samuel* (General Practitioner)

Dr O. Samuel, a general practitioner, also said that doctors tend to feel guilty because the death of a patient seems like failure. He had examined the records of his own and his partners' patients who had died and found that in the past five years about one third had had cancer, one third heart disease, and one fifth pneumonia; two thirds were over 70 and about half died at home. Few patients seemed to ask for absolutely honest information about their condition, and Dr Samuel wondered if his own optimistic and cheerful attitude to illness might sometimes lead him to miss significant indications from the patient. He found it hard to identify the best moment to talk, a moment when the patient was alone and able to be receptive.

*Dr S. Greer* (Consultant Psychiatrist)

Finally Dr S Greer, a psychiatrist, described the five stages which E. K. Ross (1970) spoke of most dying patients as experiencing: denial, anger, bargaining (the attempt to buy more time), depression, and acceptance. Not all patients go through all stages; some preferred not to accept death, but to say with Dylan Thomas

“ Do not go gentle into that good night,  
Rage rage against the dying of the light.”

### Discussion

In the discussion on these papers, a doctor wondered if it was not divisive for the family, but not the patient, to be told the true prognosis. Dr Samuel said that some of his patients had clearly said they did not wish to know and Professor Wilkes referred to a Manchester study where a large number of terminally ill patients had been told their diagnosis and followed up by a social worker. Two thirds approved of having been told, ten per cent wished they had not, and 19 per cent denied that they had ever been told at all. This suggested a saving ability to deny a fact too painful to accept.

The afternoon session began with a videotaped conversation made at St. Christopher's Hospice, with the Sister in outpatients discussing their illness with two terminally ill men—the diagnosis, prognosis and what it felt like.

The Conference divided into groups to answer various questions under three main headings.

#### (1) *At home or in hospital?*

Participants wanted more resources for home care rather than more special general-practitioner hospices, but were keen on a general-practitioner hospital as a good compromise, particularly since it was recognised that the socially isolated would always need institutional care. One of the most important tasks for the special hospice was in educating doctors, nurses, and relatives in the care of the dying.

#### (2) *Education*

Asked whether their own training in terminal care had been helpful, nearly a third of the doctors felt that it had been positively unhelpful; most thought it had done little either way. For the future undergraduates, one group suggested that death needed more status, that the facts about it (such as those described by Ross) should be taught, and more emphasis given to techniques of pain relief.

Several doctors suggested a bereavement register noting the names of all close relatives and indicating when these people had been visited; a note of the bereavement was also sent to the general practitioner of all close relatives on other practice lists.

Dr Greer said that students seldom learned how to talk with the dying by observing their teachers, since this was either not done at all, not done well or not done when the students were around. He thought that videotapes and role playing would be more helpful.

#### (3) *Communication and care*

Communication difficulties exist at many levels, both because of the team concept of care and in spite of it difficulties may be language, religious, or cultural differences, letters from hospital to general practice may fail to convey what is said to the patient and within the team itself members may not see each other often enough or be led by a good enough co-ordinator.

### Conclusion

A panel discussion ended the study day. A general practitioner commented that after more than 20 years in practice he had very rarely been asked directly "Am I dying?" The chairman cited a study of terminally ill patients in general practice: only 16 per cent had been told the diagnosis but in another 50 per cent the doctor thought they knew, but did not discuss it. What was clear was that more patients wanted information now than had ten years ago, and that this was still fewer than were likely to want information in ten years' time. Patients wanted to know more and had to be told, but this did not mean that they were better equipped to deal with the truth once they knew it.

### REFERENCE

Ross, E. K. (1970). *Death and Dying*. London: Tavistock Publications.

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