

from area to area. Unless vigilance is maintained many schoolgirls may not be immunized and this danger may only become apparent in about 10 years when people are feeling confident about the new programme, or have other priorities.

It is the general practitioner's task to ensure that all young women reaching child-bearing age are protected against rubella infection, preferably by personal rubella immunity or because the immunity rate in the community is high enough to prevent a rubella epidemic. In order to carry out this task each practice will need to achieve three objectives: first, a high primary immunization rate for mumps, measles and rubella; secondly, an efficient mechanism for identifying those children who are not

immunized so that they can be targeted when they present for booster diphtheria, tetanus and polio immunization; and thirdly, the continuation of the schoolgirl rubella immunization programme until the first primary immunization cohort reaches early adolescence.

A new era of primary prevention is about to begin, presenting a unique challenge to primary care. All the skills of practice management, primary care screening techniques and clinical objective setting will be tested. We have got to get it right.

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## The role of general practitioners in supporting carers of the elderly in the community

**E**LDERLY people in the community are largely cared for by lay carers — well over a million of them.<sup>1</sup> A door-to-door survey carried out in the North Tyneside metropolitan borough found more carers of frail and disabled relatives than mothers of children under 16 years old.<sup>2</sup> Many of the dependent relatives were elderly and in some households there were two dependants. When carers were asked to describe the illnesses which their elderly dependant suffered from, many were imprecise and referred to 'old age'. So the majority of them were caring for people whom they see as suffering from nothing out of the ordinary in terms of their age. The carers therefore saw themselves as nothing out of the ordinary, unlike the parents of handicapped children, who perceive themselves as unusual and as having special needs and rights.<sup>2</sup>

Although the average carer is a married woman in her fifties, some carers are in their sixties and seventies.<sup>3</sup> Thus, in some cases it is difficult to say who is caring for whom.<sup>2</sup> Extended family support has all but disappeared.<sup>3</sup> Further research has shown that elderly people who live alone are more likely to receive statutory services than those living with others.<sup>4</sup> So carers are faced with a stark choice of looking after their dependants with minimal support from the community and great cost to themselves, or of putting them into residential accommodation permanently.<sup>4</sup>

The results of a survey carried out in Wales of elderly dependants living in the community<sup>5</sup> revealed the following effects on the carers: one-quarter felt their health was adversely affected; one-quarter reported that their social life was impaired; one-sixth felt that their family life had definitely suffered; one-quarter had not had a holiday in five years; one-tenth had had to give up their job; and almost one-fifth, particularly those who were daughters, reported a lot or an unbearable amount of stress.

So even if willingly borne, the work of caring can impose severe strain, affect health, family life, work, finances and leisure. As one woman carer summed up the situation 'There is no yesterday or tomorrow, only today.'<sup>6</sup> The physical, emotional and economic cost of informal caring is now becoming a matter of public concern.

The Welsh survey<sup>5</sup> showed that the general practitioner is the most likely professional to be in contact with elderly people and their carers because many people are unaware of how to make contact with other professionals. Some services of course can only be reached via the general practitioner, who is in the best position to initiate an assessment of needs and refer carers to appropriate agencies and services. General practitioners therefore have a key role in ensuring that medical and social assessments of carers are initiated, for it is to them that families turn.<sup>7</sup>

Many carers, however, reported that the general practitioner did not talk to them at all when he or she visited the elderly patient at home.<sup>5</sup> Certainly, doctors, nurses and social workers often only get involved with the carers when they are at breaking point.<sup>6</sup>

In discussions between the MSD Foundation and the Informal Caring Support Unit of the Kings Fund Centre, it was agreed that it was important to raise the awareness of health professionals to the needs of informal carers. This led to a series of multiprofessional workshops piloted by the MSD Foundation, which aimed to identify the needs of informal carers of elderly dependants, to consider ways in which doctors can provide support for such carers in a multiprofessional setting and to propose a training strategy for staff working in the community health services.

Six workshops were set up in various parts of Britain. Each workshop was convened by a local general practitioner and included geriatricians, general practitioners, district nurses, social workers and a facilitator (the project leader). In addition, each was attended by four informal carers, whose presence was crucial to the success of the workshops, since they were able to demonstrate in the group discussion something of the physical, social and emotional cost of caring.

It emerged from the workshops that one of the most important barriers to support for carers are the attitudes and beliefs of both the professionals and the carers themselves. Carers are keen not to upset the professional and are hesitant to call on 'busy doctors' — a reluctance compounded by the belief that their dependants are not ill, but simply old and therefore not entitled to medical treatment. Even when carers clearly need help, they feel guilty about asking for it.

Professionals too have beliefs which limit the support which they give to carers. For example, many do not imagine that caring may be taken on not by choice but by force of circumstance and it is assumed that women take on the role of carer because they are women. Many doctors and nurses in our workshops expressed the view that families should 'look after their own', and that care by relatives is always preferable to any of the alternatives. Few have considered, say, the emotional effect on the carer who has to provide intimate physical tending for a parent. In addition, many general practitioners say they feel inadequate because they have 'so little to offer'. Carers, on the other hand, make it clear that when the doctor visits the home and values their commitment and work, the effect on their morale is considerable.

The other key issues which the workshops highlighted are the need for more information for carers and for improved com-

munication with carers and between health professionals. Carers want information from their general practitioner about the prognosis of their elderly dependant and its implications for care in the future. They want this information at an early stage, even if it is bad news. Some doctors express a reluctance to give such bad news, particularly when they are not able to make a confident prognosis, but they must recognize that although it may be uncomfortable for the doctor and painful for the carer, it is important to be honest about their uncertainty. Carers also need detailed information about the practical aspects of providing care, such as coping with incontinence, lifting, bathing and dressing, and need to be trained to carry out these functions without injury to themselves and their dependant. This training could be provided by nurses or health visitors.

Carers need information about available resources — how to get financial help from the DHSS, how to make contact with support groups or obtain respite care. Since many carers who are themselves elderly turn to their general practitioner for help he or she needs to know what help is available. Printed information about sources of help should be made available in the practices.

More workshops such as those described here should be set up so that general practitioners and other members of the primary care team can discuss the needs of carers and how they can be supported. College faculties should be taking the initiative in stimulating practices and young principal groups to set up

multiprofessional workshops. One such initiative, following on from the work of the MSD Foundation, was described recently in this *Journal*.<sup>8</sup> It is essential that carers are included in the groups since they can describe powerfully the emotional as well as the physical responsibilities of caring for a relative at home.

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# Continuing education for general practitioners

CONTINUING medical education for established general practitioners is emerging as one of the central educational challenges for general practice. Progress in undergraduate education and vocational training both continue but at a slow and relatively unspectacular rate. The major issue now is how to support and encourage 30 000 doctors throughout a lifetime in professional practice.

It is generally accepted that continuing education for general practitioners is unsatisfactory both in content and in presentation, and that all too little is known about it. There is an urgent need for research and *Occasional paper 38* by Branthwaite and colleagues, from the Departments of Psychology and Postgraduate Medicine at the University of Keele, is therefore particularly welcome as it throws light on the many issues involved.

Branthwaite and colleagues report a study which involved in-depth interviews of general practitioners by trained psychologists followed by a questionnaire incorporating points arising from the interviews. The interviews, which lasted between one and three hours, did not just seek factual information but probed the attitudes of general practitioners to themselves and their work.

One of the most important findings was the clear cut evidence that a substantial minority of general practitioners have major problems in their self-image and satisfaction with their work, saying that they feel lonely and isolated, and uncertain about their role. Older doctors tend to find that the work of the general practitioner is becoming more restricted, a good many worry about their responsibilities, and over a third consider that 'general practitioners are looked down upon by hospital doctors'. Over a third also believe that there is 'insufficient separation of work, leisure and personal/family life', while over two-thirds believe that 'medical training does not lay enough emphasis on the social and personal problems of patients'.

Evidence is also given about the relative satisfaction found in different aspects of a general practitioner's work including a ranking order running from making a correct diagnosis at the top to prescribing at the bottom.

The authors devote considerable time to identifying differences in attitudes and behaviour between those who attend courses frequently and those who do not. They found that 'frequent course attenders exhibited more progressive attitudes to their work, in their approach to preventive medicine and changing people's health behaviour. They were more concerned about developing special skills and about the time and scope to practise medicine effectively, and more conscientious about developing and improving their work'. If this finding can be reproduced, it raises the question whether or not education is effective in achieving these attitudes or whether it is those who already have them who seek education. This is by no means certain as 'two-fifths of general practitioners were unsure that attending lectures made any difference to their competence'.

There are some useful tables about attitudes to lunchtime lectures and the reasons given by general practitioners for not attending — lack of time, 65%; inconvenient meeting time, 44%; unattractive programme, 29%; venue too far, 27%. It appears that non-UK qualified doctors are significantly more likely to attend lunchtime lectures. It is interesting that younger general practitioners seem to have more time away from the practice in that they work significantly fewer Saturdays than their older partners and have significantly more half-days.

On the question whether or not there should be more lecturing by general practitioners, the finding reported by Reedy and colleagues<sup>1</sup> in an earlier occasional paper was supported in that different populations of general practitioners were seen to have different wishes, and indeed it will almost certainly be necessary to continue to offer different kinds of programme to meet differing needs. Nevertheless many general practitioners now