members' comments which have moulded the discussion paper into the definitive evidence.

The evidence working party was given firm guidance from the membership on many matters. For example, there was a general feeling that the discussion document was not sufficiently incisive, did not indicate clearly enough our appreciation of the strengths and weaknesses of general practice today, and did not really reveal the College's general philosophy on the future of primary health care based on general practice. We were also asked by most respondents to be unequivocal about the need to retain the independent contractor status of the general practitioner, to preserve clinical freedom, to enlarge on the problem of poor general practice in some of our conurbations, and to have adequate manpower, premises, and equipment to do our job well. Many people mentioned the need to develop continuing education and with it medical audit controlled by the whole profession rather than by Government.

Council would like to thank the faculties and individual writers for the care, time, and trouble they have taken in giving their views on the content and presentation of the evidence. On a subject with so many important aspects total unanimity would have been impossible to achieve. Nevertheless, Council believes that the consultations on the draft evidence have given it a surer feel of the general lines along which the majority of members would like to see the College's policy evolve in future.

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COPING WITH DEATH

Sir,

There has certainly been a spate of articles recently in the medical press about death and how to cope with it. Obviously this is to be welcomed, since we are doctors and deal with it all the time and must therefore be concerned. We cannot, or should not, hide our heads in the sand, for eventually we ourselves will be personally involved.

It is true to say that our own attitude to death and our belief about it largely determines how we shall deal with our patients.

The article by Drs Tombleson and Garsed (January *Journal,* p. 33) is humane and helpful, and comes out strongly against evasion and untruth. This is good, but their philosophy basically is the mournful necessity of getting the patient to accept the inevitable with as much grace and calmness as possible—it is amazing that so many do, and with great courage.

I do not believe that death is the end of life. I regard it, and have no doubt about this, as the door to real life, and this transforms the whole process of dying and makes dreaded death a welcomed friend. It is merely a door into a splendid, inconceivably grand life.

This is no strange or fanciful imagination. It is orthodox Christian belief, endorsed unequivocally for us by Christ himself, and conclusively demonstrated to us by his resurrection. I have seen many people die in this faith and it has transformed the experience for them into peaceful triumph.

Why then have Drs Tombleson and Garsed not mentioned this aspect? I can scarcely believe that they are totally unaware of the Christian teaching on death. I am prepared to believe that they have rejected it for themselves, but that is no reason for excluding such a living, hopeful option from their patients.

This is a plea to our humane profession. If doctors cannot personally offer hope to patients as death approaches—and to leave without hope is to leave to despair and unalleviated gloom—then please lay aside personal prejudice and put them in touch with those who can offer spiritual help.

Not every chaplain—unlike the one in the poem quoted—will shirk the issue of death, and most patients will welcome the opportunity.

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Sir,

I would like to thank and congratulate Drs Tombleson and Garsed on their lucid and sensitive article in the January *Journal.* In this short article they covered all the important points which arise in the management of terminal patients.

A group of general practitioners working with the late Michael Balint were involved in studying the doctor-patient relationship in connection with dying patients. We confirmed everything that Drs Tombleson and Garsed found in their work but perhaps there is one small point that they have not mentioned. In looking at a relatively large number of dying patients managed by their general practitioners we came to the conclusion that patients manage their dying in the same way as they managed their lives. In fact, "patients die as they have lived". We found that the secure mature adult was able to face his own death with fortitude and make all the necessary arrangements to put his affairs in order. Despite the general practitioners' willingness to discuss with these patients the fact of their dying, there were several who resolutely declined to enter into any discussion about their future.

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Sir,

The article on this subject (p. 33) in your January issue reveals the anomalous state in which we as doctors find ourselves when confronted with the dying. How long will it be before we can take dying out of the limbo of irrationality within which it has taken refuge for so long?

We could begin by accepting three propositions:

a) The inevitability of death for all. This being so, the quality of days lived is very much more important than their quantity.

b) The desirability of death for the dying.

c) The preferability of meeting death voluntarily rather than being forced to die *faute de mieux.*

The acceptance of (a) would clear the air of subterfuge in the sick room. We should be able to talk of dying as we talk of taking a holiday. In this respect our society is less fortunate than those in the past, when death was an almost daily occurrence. We have made death so rare that many delude themselves that it need never be considered at all.

With regard to (b) we should respect the wishes of those who want a 'quick exit' once the event is only a matter of time. Legislation for voluntary dying (not suicide) is overdue. Society is so pro-vitalist today that freedom to live is guaranteed but not the freedom to die. The result is a great deal of avoidable misery both for the patient and the relatives.

Doctors should be in the forefront of those who are seeking a new approach to dying. This new approach is already being forced on us by burgeoning world population and diminishing resources. Mere postponement of dying had some validity when religious belief sustained the idea of death-bed repentance. With the general absence of belief an intelligent person should be allowed openly to welcome death without any imputation of depression or connotation of suicide. Society has generally accepted contraception and legal abortion in the limitation of unborn life. The acceptance of voluntary dying is merely the corollary of the same argument at the other end of life. What an immense cloud would be lifted from man's horizon if the idea

were seriously to gain ground in the next 20 years!

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DEEP VEIN THROMBOSIS AFTER AIR TRAVEL

Sir,
I was interested in the letter in the January *Journal* (p. 57) from Drs Dove, Capra, and Mitchell-Heggs. I have knowledge of only two cases of deep vein thrombosis after air travel and this stretches over a period of some 23 years.

The first case was a 44-year-old captain who sustained a deep femoral vein thrombosis after sitting in a very badly designed pilot's seat for six hours. Luckily he was treated in hospital and did not develop a pulmonary embolism.

The second case was a 75-year-old lady who travelled from London to Johannesburg without leaving her seat for the entire 16 hours of the journey. She went on to have a small pulmonary embolism but fortunately survived.

We are conscious of the risk of deep vein thrombosis in airline passengers, particularly when they sit for extremely long periods without moving, and in fact cabin crew are trained to encourage people not to sit for long periods. Passenger seat design over the years has, however, improved enormously and many of the bad features in the older type of seat have now been removed.

I think that airline passengers, particularly the elderly, should be advised to take every opportunity of walking around the airport buildings at refuelling stops and stretching their legs from time to time on the aircraft during flight. The large wide-bodied jet encourages movement of this kind and cabin crews are instructed not to prevent passengers from moving about except, of course, in conditions of turbulence.

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Sir,
Dr Dove and his colleagues (January *Journal,* p. 57) ask for cases of deep vein thrombosis seen after prolonged travel. I remember as a house physician admitting an elderly man who developed a deep vein thrombosis, without embolism, a few days after sitting in the passenger seat of a motor car driven from Cornwall to Ipswich. The journey was made in early autumn and lasted about 12 hours. The consultant physician (Dr J. W. Paulley) felt that it was likely that immobility was the cause of the thrombosis.

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GROWTH CHARTS

Sir,
Many general practitioners, especially those who have worked in child welfare clinics and hospital paediatric departments, will be familiar with the growth and development records (percentile charts) prepared by Tanner and Whitehouse, and printed in a set of six (two sexes, three age groups) by Printwell Press. These excellent charts measuring 11 × 8 inches are, however, of an unwieldy size for use with the FP 5/6 record envelopes, which I envisage will be with us for many years yet. I understand the Birmingham Research Unit of the College produces a preschool record card which is indeed comprehensive, but applicable to that age group only, and the percentile chart displayed is for weight alone.

I have discussed with Printwell Press the feasibility of their producing their growth and development charts on unfolded card of suitably reduced size with height on the obverse, and weight on the reverse, dispensing with the material on the front and back pages of the larger card. May I, through the good offices of the *Journal,* conduct some market research and enquire as to whether there might be any demand for such cards? (Surely the general-practitioner paediatrician proposed in the Court Report will find a use for these.) Perhaps any fellow members who feel sufficiently enthusiastic about the matter will write to me direct.

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Reference

Court Committee (1976). *Report on the Child Health Services.* London: HMSO.

RECORDS FOR HOUSEBOUND PATIENTS

Sir,
I am looking for ideas in respect of the medical records of housebound patients and I am wondering if any of your readers can help.

I want to be able to leave the A4 record at the home of a patient so that my partners, assistant, or nursing staff can see what has been going on and make entries in the notes.

The problem is, of course, that it will often be inappropriate for the notes to be read by the patient or a relative. I therefore want to find a suitable container that is cheap, durable, capable of holding an A4 folder up to one inch (2·5 cm) in thickness, and having a locking device which would enable it to be opened by selected staff.

I feel that, in order to be a practical proposition, this container needs to cost less than £1. The specification is probably therefore impossible but I would be grateful for any ideas.

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HOW MANY PATIENTS?

Sir,
Reading the first editorial in the January *Journal* (p. 3) in juxtaposition with John Fry's Mackenzie lecture (p. 9), one could perhaps be forgiven for suspecting that the College supports increasing list sizes.

No real attempt has been made to explain the low and reducing workloads quoted. These figures are contrary to the experience of many others who have increasing workloads of seven items per patient year and more.

A great deal depends on patients' expectations, and therefore upon the attitude of both doctor and patient. If John Fry's 15 per cent incidence of emotional states were in reality 45 per cent, then his workload would automatically be increased by 30 per cent. More important, the doctor deserves the patients he gets. Recognition of emotional states attracts emotional patients. It is possible, therefore, that low workloads will get lighter and high workloads heavier.

The argument is, in fact, about the role of the general practitioner. If the often quoted 'pastoral' responsibility is taken in conjunction with the undoubted intention of the DHSS to reduce hospital inpatient care, then an average list size well below 2,000 is required.

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