Health and the home

THERE is one fact about general practice which is generally accepted to be true: that both the number and proportion of consultations taking place in patients' homes is falling and falling fast. Extrapolations from present figures suggest that home visiting in the UK could be virtually abolished within ten years.

Looked at in its historical perspective this trend is recent, certainly throughout the first 60 years of this century home visiting formed a substantial part of the work of general practice and Eimerl and Pearson in 1966 reported that it took between 40 and 60 per cent of the general practitioner's time. Thus the swing away from home visits has taken place only within the last decade.

This trend is examined in this issue.

In the James Mackenzie lecture (p. 6) Gray analyses the significance of the home using perspectives from the behavioural sciences and concludes that there is still a place for selected home visits in general practice.

Parkes, in a disturbing survey of the care of patients dying at home compared with hospital (p. 19), found that the control of pain as seen by surviving spouses was much better in hospital than at home.

Leach and White (p. 32), in a recent survey of drugs in the home, found, as others found before them, substantial numbers of prescribed medicines, most of which had been prescribed by general practitioners.

Mackessack-Leitch (p. 38) draws attention to domestic accidents, a topic which has been curiously overlooked in general practice. Surprisingly, it is the responsibility of the Department of Consumer Protection rather than the Department of Health, and large-scale surveys are now under way.

Metcalfe (p. 46), in a preliminary report of the opinions of practitioners attending an annual meeting of the College, shows that practitioners do recognize substantial numbers of family and social problems in their patients' consultations and that the majority of these arise from the home and the relationships there.

The future of home visiting in the UK is hard to see. Majority opinion suggests that its use is limited, the time it takes is unjustified, and that any attempt to reconsider its place would be "putting the clock back". Nevertheless, general practice today has to put every aspect of its work under the microscope and to balance carefully the pros and cons of each. Whatever the significance of the home in relation to health, it is surely worth much more study than it is at present being given in general practice.

Dying at home

THE urge to remain in one's lair during moments of crisis is innate and perhaps this is why so many patients ardently wish to die at home. It may also be that they are too weak to endure easily the noise, the handling by unknown nurses, the unpredictable quality of care, the indifferent food, and above all the lack of privacy associated with hospitals. It is uncommon for patients themselves to seek admission to hospital in their last illness in order to protect their families, although nearly one fifth of cancer patients who die at home are cared for by relatives over 70 years of age.

Yet because houses are smaller, part-time jobs commoner, families more dispersed, and death a feared stranger, our custom now is to take more and more of our patients each year into hospital to die. Of those who die in hospital over half will have spent most of their last month on earth at home (Ward, 1974).

If the patient, the family, the general practitioner, and the nurse are all keen to see a terminal illness through at home rather than among strangers, then the team have to work hard and well together for weeks at a time. Such a burden, when it is sustained with mutual understanding and respect, may well prove of inestimable benefit, not only for the patient but also in the management of the family's grief even before they are bereaved.

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The commonest criticism of home management—and it is made again forcefully in this issue by Dr Murray Parkes—is the poor quality of pain control. Half the patients with cancer who die at home will have little pain and only 15 per cent will have bad pain for about six weeks (Wilkes, 1965); yet the memory of this may colour the relatives' attitude for the rest of their lives.

The general practitioner is so often accused of prescribing excessively and indiscriminately. It makes a change, but not an agreeable one, to hear again and again that poor analgesia in the terminally ill is neither inevitable nor justifiable but is due to the timid handling of analgesic drugs. This, of course, is a problem not restricted to general practice. In home and in hospital, excessive reliance may be placed on aggressively marketed synthetic drugs when cheaper and more effective opiate mixtures such as the *National Formulary* elixirs are used too little and too late.

The dosage and frequency of dosage will vary perhaps rather more than some textbooks lead one to expect. The escalating needs of patients who have become addicts is a rare myth. A constant dose of heroin or morphine with stable patients who are in pain can remain effective over many months and can often be taken by mouth to the end.

It is right that we have been trained to be so cautious in our use of the opiates. Patients with asthma or cirrhosis can be killed and lavish prescribing would help the pusher and the junkie. It is, however, time to remind ourselves that the opiates remain by far the most effective drug for relieving pain in terminal illness and that the detailed and efficient care of the dying lies at the heart of modern medicine just as it did centuries ago.

References

Ward, A. M. W. (1974). *Social Science and Medicine,* **8,** 413-420.
Wilkes, E. (1965). *Lancet,* **i,** 799.

A system of training for general practice

MORE is being expected of general-practitioner trainers than ever before. The Joint Committee on Postgraduate Training for General Practice (1976) recommended that before approval as a trainer all applicants should have completed a recognized general-practitioner trainers' course, and several regional committees have since endorsed this view. With the new NHS Act now law and compulsory training required for all future principals from 1981, there is a growing need for good trainers' courses. Development has been rapid and they are now appearing all over the country.

In the short history of educational development in general practice it is natural that there should be a great many experiments, and a variety of choice for trainees is healthy. However, most courses are concentrating on introducing would-be trainers to the principles of educational theory: some are organized jointly with educationalists; on others educational experts are regularly invited to contribute; and, in some, general practitioners themselves try to demonstrate the ideas in practice.

The introduction of a systematic approach to educational theory is logical, but it can create difficulties. General practitioners who have not grown up with these new ideas often find it difficult to adapt to a new framework of thinking and those who are in their fifties and sixties find it particularly hard to absorb and then use such new ideas. Nevertheless, despite the difficulties encountered in the early days of many trainers' courses, a certain exhilaration and a corresponding rise in morale and enthusiasm is often observed by the end.

Whatever the problems there is clearly a need, for both trainers and indeed trainees, for a document outlining the main principles of educational science in relation to general practice. The problem with educational theory, like many of the other new behavioural sciences, is that it is often accused by those outside of being laden with jargon—although it hardly behoves a profession which insists on calling a wart a 'verucca' and bleeding 'haemorrhage' to complain about jargon! Jargon should, of course, be kept to a minimum, since the fewer the strange terms that are used, the more quickly understanding usually comes.

A System of Training for General Practice has been written by D. J. Pereira Gray from the Department of General Practice at the Postgraduate Medical Institute of the University of Exeter. This is the only university department of general practice in the British Isles outside an undergraduate medical school and it has concentrated particularly on vocational and post-graduate training in general practice. This booklet, the fourth in the *Occasional Paper* series, outlines the philosophy and principles of the Department and includes many of the ideas developed on the Nuffield Course of the College interwoven with practical experience of vocational training in Devon.

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