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.

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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.

Occasional Paper 4 should not be taken to represent

the policy of the College. It is clearly an individual and, at times, personal account of one way of training for general practice. Some of the suggestions, such as those stressing the importance of three-year programmes and trainee participation in small-group work, are controversial. Nevertheless, for the 1,500 trainers now appointed its appearance meets a growing need and it is recommended to trainers and trainees not only as a simple introduction to the educational theory of vocational training, but as a useful discussion document for trainers' courses or workshops.

A System of Training for General Practice is available now from the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU, price £2·75, including postage.

References

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The natural history of recurrent herpes simplex labialis

We performed a daily examination of 80 patients with recurrent herpes simplex labialis to define the course of the disease and to identify quantitative and objective measurements for use in monitoring the efficacy of antiviral chemotherapy. Pain, lesion size, mean virus titres from lesion swabs (10^5 plaque-forming units), and frequency of virus-positive lesions (89 per cent) were maximal during the first 24 hours and decreased thereafter. Lesion punch-biopsy virus titres increased from a mean of $< 10^1$ plaque-forming units in the prodromal and erythema stages to a mean of $10^{4 \cdot 7}$ in the vesicle stage. Measurements potentially useful in monitoring antiviral efficacy include: time to loss of crust, time to complete healing, intensity and duration of lesion pain, area defined by lesion virus titre and duration of lesion virus excretion, and maximum lesion virus titre after the first visit. Early application of topical antiviral therapy should be able theoretically to alter the course of this disease.

Reference

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