LETTERS TO THE EDITOR

THE DIABETIC, THE HOSPITAL AND PRIMARY CARE

Sir,

As a general practitioner who has had personal experience of running a diabetic clinic in general practice for the past eight years, I read the article by Professor Wilkes and Ms Lawton (April *Journal,* p. 199) with considerable interest.

I regret that the authors make no reference to the role of the health visitor in educating the patient about the continued management of his diabetes. By virtue of her unique functions and training she is able to visit the diabetic at home to instruct him and his partner in all aspects of his management, including diet and personal care.

In addition to visiting the patient in his home, in my practice the health visitor is responsible for arranging for patients' attendance at the practice diabetic clinic which she also attends and helps to run. She is also well placed to follow up defaulters and act as a link between the hospital clinic and the practice.

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HOME CONFINEMENT

Sir,

I am reluctant to be drawn into a correspondence on home confinement, as I am no longer involved in intrapartum care. However, Dr M. J. V. Bull (April *Journal,* p.208) describes me as a protagonist of domiciliary obstetrics but I feel this overemphasizes the view I held in 1976, and I believe my present opinion is more clearly in accord with his own.

The debate and arguments aroused by the editorial in the *British Medical Journal,* (1976), have moved on a good deal, but essentially what I was saying in 1976 was that my own experience of domiciliary obstetrics between 1960 and 1966 seemed to indicate that the home *could be* a comparatively safe place for confinement. This judgement was based on a review, which produced favourable perinatal mortality figures for home confinement, but recognized that primigravidas were unsuitable for home delivery (Hudson, 1968). Interestingly, the overall perinatal mortality figures I quoted then compare favourably with those produced at Oxford. The overall figure was 8.9 per 1,000 live births and still births, though half of those were accounted for by congenital malformation incompatible with life. Dr Bull's own figures at Oxford produce an overall perinatal mortality over the 10-year period of 12.2/1,000 births. However, comparisons may be rendered valueless without a complete analysis of age, multiparity, and social grouping.

It now seems to me that we must accept at present that it would be difficult, if not impossible, to return to any significant degree of home confinement. Several factors point to this conclusion. There are probably very few general practitioners wishing to return to the anxieties and difficulties of home obstetrics. Moreover, it seems unlikely that the district midwifery services are capable of the expansion that would be necessary, and the majority of consultant obstetricians are opposed to domiciliary confinement.

In retrospect, I am sure that the debate regarding the place to be born can be seen to have been productive and important. It focused attention on the good things about general practice based obstetrics, and pointed the way to how hospital could be made more like home.

Undoubtedly, units such as those at Oxford and here at Basingstoke, where consultants and general practitioner obstetricians work together within the same physical environment, provide an ideal setting for modern obstetric practice.

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TERMINAL CARE AT HOME

Sir,

Dr A. Hillyard asks if it is common to refuse adequate analgesia among patients dying at home (April *Journal,* p.242). I have worked for over a year with the Macmillan Home Care Service based at St Joseph's Hospice, Hackney, and found this was rarely a problem.

People commonly expect to take pain-killers only when pain is present. So it is of great importance to explain to the patient with continuous pain why a dose of medicine is needed before pain returns and thus before he or she thinks it necessary.

The patient can be told that 'saving up' the medicine for really severe pain will have the reverse of the expected effect—and that his body will not 'get used' to the opiates to a significant extent.

We are the guests of patients and their families in the home. The hospital patient is in our territory and therefore under greater pressure to conform to our expectations. He will usually readily accept all prescribed treatments.

In the end it is the patient who matters. Our duty is to offer all appropriate care and to leave the final decisions to him, if that's the way he wants it.

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PERSONAL CARE

Sir,

How exciting to read Dr Pereira Gray's lecture, "The Key to Personal Care" (November *Journal,* p. 666). How stimulating to see the letters relating the views and experiences of those with a similar concern for this aspect of care. How satisfying for me personally to see at last such general recognition of a subject so important to me over the past six years.

In the early 1970s, it became increasingly clear to me that the way we worked in our group practice was unsatisfactory. We were four keen and caring partners who got on well and who worked together with little friction considering our differences in age, background, and approach. But the more I looked at the way we worked and the service we gave, the clearer it became that many of the problems experienced by the patients, by ourselves, and by the others with whom we worked,