# 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,

were either caused by, or exacerbated by, the lack of any one of us being responsible for a given patient and the absence of any continuing personal care.

How lacking in continuity were we? At one third of our consultations we found that the patient had seen another partner at their last attendance. However, my partners were not impressed by this information. What small disadvantages there might have been were the price to be paid, they said, for the cardinal principle that the patient must continue to have a choice of doctor. They were adamant. No change was possible; intensive research into organizational and legal aspects confirmed this, and one partner couldn't look after a personal list if the others didn't. Sadly for us all, I left.

Partnerships, sensibly, do not want to take in someone in their late forties, so my future was either in an academic post or in single-handed practice. I chose the latter which is, of course, the ultimate in continuing personal care.

Only a minority in group practice are committed to real continuing personal care and there is some evidence that it is decreasing (Aylett, 1976); so that the big question remains to be answered, the question which all evangelists face, why does not *everyone* see the light? It is an emotionally sensitive subject; such changes are threatening to many of us, and I cannot be as optimistic as was the lecturer in looking to the future. In both my report on the extent of personal care in Wiltshire (Aylett, 1976) and my paper discussing the pros and cons of separate and combined lists (Aylett, 1977a), my remarks about emotional prejudice were edited out but eventually published in *Pulse* (1977b).

Dr Adrian Rogers of Exeter (who has also changed his practice to one giving more personal care) once said that he doubted if the majority of us would make changes in our working patterns unless they were to bring financial advantages. May all of us who believe in more personal care hope that he is proved wrong.

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## STUDENT INTEREST GROUPS

Sir,

The article by Drs M. R. Salkind and J. S. Norell (March *Journal*, p. 158) prompts me to write about a student group that met last year in Cambridge.

A voluntary activity during the second and third preclinical years in Cambridge is participation in an 'interest group' in social aspects of medicine. These groups are led by a behavioural scientist and a general practitioner.

A number of students who had been members of the interest groups and who were pursuing their clinical course in Cambridge decided that they would like to continue this kind of activity. They further decided that they would like to include within the group students of other disciplines related to medicine. A preliminary meeting was held and from it two groups were formed. The one of which I became a member (leader) was composed of four medical students, two physiotherapy students, one speech therapy student, a recently qualified occupational therapist, a voluntary social worker, a nurse, and myself. We met each week for nine months, with Christmas and Easter breaks. The second group met on a few occasions only.

The initial sessions were dominated by unrelenting criticism of hospital doctors, particularly consultants. In the absence of a consultant member of the group this criticism was in some ways unproductive. However, it did lead quite quickly to a group identity. We tried to base our discussion on patients that we (including myself) had encountered. The feelings of the individual members were expressed freely, and on occasion at considerable depth. The presence of other than medical students was invaluable, as they were responsible for day-to-day treatment of patients in hospital, as opposed to the medical students, who were supernumerary. I can recall for instance one of the physiotherapy students describing her feelings about treatment of a patient with severe (and fatal) lung problems. Several similar cases were discussed.

Later in the year, the group branched out into other activities, such as inviting a university counsellor (psychiatric social worker) to a meeting; on another occasion a patient with paraplegia came to talk about his problems.

We had two extra-curricula events. The group met in London for a meal and a theatre visit to the play "Whose Life is it Anyway?". We had an end-of-year punt party which ended at 02.00 hours. No-one could leave that particular meeting early without getting very wet.

The history of this multidisciplinary group has led me to believe that the earlier students of different disciplines meet to discuss their experiences the more chance there is of a lasting mutual understanding. An essential feature of this group was that it formed itself and was voluntary. How far it could become a more widespread activity is uncertain. However, it certainly seems worth further experiment.

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## COMPUTERS IN GENERAL PRACTICE

Sir,

The idea of having a patient's full records flashed on the screen at a touch of a button, with rapid reference to all the possible side-effects of the drugs taken does sound attractive, but before the information can be retrieved it must first be typed into the memory at great labour and expense. In a group practice with 20,000 patients, some of whose folders are two inches thick, the task of transferring it all into the memory of a computer defies description. Considered as a national problem its impossibility must be quite obvious. Even in hospitals the changeover to computers has often been disastrous and had to be abandoned. There are many applications for computers in medicine: they are small and they are specialized.

The comprehensive application of computers to a nationwide electronic data network in which patients case records circulate is a beautiful dream in which we have all indulged ourselves from time to time; however, when the hard facts about the difficulty and cost of making it work are considered its total impossibility becomes obvious.

Love those medical record envelopes—we've got them with us for centuries!

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## SPRING GENERAL MEETING

Sir,

The North of England Faculty and the Cumbria Sub-Faculty are extremely