EDITORIALS

Terminal care in general practice

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Working Group on Terminal Care (1980)

ONLY a few years ago, the care of the dying patient was classed as a silent, neglected part of medicine. Now, although the era of taboo is over, the needs of the dying and the support of the family are problems with which we still have to come to terms. Their special relevance to the general practitioner is emphasized by two quotations from the Working Group Report summarized in this issue (p. 466):

> "When it is successful, care provided in the familiar surroundings of home, under the supervision of the patient's general practitioner and with the support of the primary health care nursing team, can undoubtedly produce the very best of terminal care."
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> "Unfortunately some general practitioners are not fully aware of what can be achieved in domiciliary care, and it seems likely that the most distress, as well as the least, occurs at home."

That the very best and the very worst of dying occur at home need not surprise us too much, for these extremes are part of the home pattern for many things, from cooking to having a baby: but it does lead us to ask what factors are involved which make dying at home 'good'.

They are, in fact, likely to be a subtle blending of many things, rather than the sum of them. People need the solace of well loved objects as undemanding and unchanging as the view from the window, or the spaniel or the cat. We need relatives we love and who love us and who, within their limitations, are competent and confident and are unfailingly always there. We need warmth, food prepared the way we like it, and the stimulus of friends and neighbours who drop in to see us. They are infected by our own placid adjustment and so are not embarrassed into irritation or forlorn lies. They help us to take it a day at a time, with none of the tortures of unreasonable hope or pain. Our other symptoms also are well controlled and however frail we may become, we are involved in our own care whilst the familiar doctor and nurse cherish us and receive our trust.

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These considerable attainments probably accompany the modern death-bed more rarely than half a century ago, and this leads us to question the characteristics of the 'bad' home death.

If we are old and infirm and staying with one of our children, we may have, instead of a safe familiarity, all the tiny humiliations of the lodger. If our relatives are harrassed and inexperienced, we can be infected by panic or guilt, so we need sedatives, and become either confused or difficult or drowsy, prematurely bedfast, constipated and incontinent. The nurse is called in late, a capable stranger in a hurry, who is linked to her patient only by his physical needs. The doctor also appears distant, trained neither to hold our hand nor to linger at the bedside, but to evade our half-hearted probing.

The precious days are empty and lonely save for our problems—fear and weakness, nausea, and uncontrolled pain. Drugs change, accumulate, have a common ineffectiveness. We smell, make noises, frighten the grandchildren, arouse the resentment of the daughter-in-law. It is at this stage that we may be pushed off to the acute hospital ward, that restless and unwilling mortuary for those not yet quite gone. We are, in E. M. Forster's phrase, "unprepossessing and unprepossessed".

Some of this may be an unalterable part of the human predicament, but how can doctors achieve more for such patients?

There needs to be a controlled emotional involvement with both patient and family. They must be able to rely on the medical voice and presence when they need it. The patient must gently be given the information he seeks and this will alter slowly as the illness runs its course.

Doctors must know their drugs better than some do now, and be less frightened of the high opiate doses or the new long-acting morphine preparations when these are indicated. They must carry the family with them, transforming for the patient the suffering into a sleep and a forgetting and thereby diminishing the relatives' grief, so that it does not haunt them or threaten the end of normal living.

There is, in fact, nothing very special about the terminal care usually needed by patients. If hospital or nurse are to be involved they should not be approached so inexcusably late as to cause unnecessary distress, and most patients need from their doctor only basic skills, attention to detail, and commitment. If all they get is a

deputizing service, negligible guidance, poor support, and inadequate symptom control, the family will never quite forget nor quite forgive. And why should they?

The Working Group Report summarizes current national policy and seems to favour the further evaluation of support teams in hospital and community. It discourages the costly building of special units save when these are linked with the social deprivation of big cities or a major teaching role. Many hospices have been founded because of the glaring deficiencies of our health care system, and largely because of their pioneer work we are seeing important changes for the better. Matthews today (p. 472) describes some of the problems involved in setting up such units.

As general practitioners we must be grateful for these achievements, and respect and support these centres of excellence. We must be wary, however, that the care of the dying does not gain the eccentric status of a specialty. It is part of general practice and we can and must be worthy of it.

Chair of General Practice at Zagreb

NOWADAYS we do not comment every time a new Chair of General Practice is established in a foreign country. Zagreb has a special claim, because of the debt which British practitioners owe to the work of Professor Vuletić in influencing some of our own patterns for vocational training, and because there have been many personal contacts between British doctors and doctors in Zagreb and Croatia. Professor Jaksić, the present Head of the Andrija Stampar Public Health School, is a familiar face and valued friend in several centres in the United Kingdom.

The first Chair of General Practice was established at Zagreb on 28 March 1980. The Royal College of General Practitioners was represented at the ceremony by the President, Dr J. P. Horder. Dr Grahovać, a practitioner in Zagreb, becomes the first Professor. Three appointments, in fact, contribute to the 'Chair', which in Yugoslavia implies not so much a Professorship as a Professorial Department. Dr A. Budak and Dr M. Sućur were also appointed as Senior Staff members.

The new Department will have an inner ring of six general practitioner teachers and an outer ring of about 60. Since it is the first and only Chair in Croatia (population 4·4 million), it accepts indirect responsibility for the whole of the country, covering basic (undergraduate), specific (vocational), and continuing training. Training does, however, already take place at three other centres.

Despite Professor Vuletić's work, which began in a practical form 20 years ago, opposition to the establishment of a Professorship has been more persistent than in the United Kingdom.

Although student career choice for this branch is rising, it does so at a level considerably lower than in the United Kingdom and in the past the ratio of specialists to general practitioners has been much higher. Specialists earn more than general practitioners. However, the middle tier of community paediatricians and gynaecologists, to whom there has hitherto been direct access, is being eliminated over the next five years, in favour of primary care by family doctors.

The now well known three-year course of specific training for general practice ends with an examination. This includes a clinical component held in the practice premises of examiners. This is something we have not yet achieved. An exchange of examiners is being organized this year between Zagreb and the Royal College of General Practitioners.

Hypertension in primary care

IT seems from the Framingham data (Kannel et al., *1975) that the rule of halves still prevails: half the severe hypertensives are unknown, half of those known are not treated, and half of those treated are not controlled. Why is this happening?*

Tudor Hart (1980)

These and other issues were discussed at a symposium on hypertension in primary care held in Reykjavik, Iceland, in April 1978, and today we publish a report of this symposium as *Occasional Paper 12*. This wide-ranging symposium not only considers the evidence about hypertension itself, but looks at blood pressure as part of a coronary risk profile. For instance, Stone, Director of the Leigh Research Unit of the Royal College of General Practitioners, emphasizes that