Hon. Nicholas Edwards, MP, has announced the appointment of Mr David Jones as Chairman of the Welsh Board for Nursing, Midwifery and Health Visiting which was established on 15 September 1980.

Mr David Jones is currently Area Nursing Officer with Gwynedd Health Authority, and was previously Divisional Nursing Officer and Principal Nursing Officer (Education) at Gwynedd.

CORRECTION

In the October issue of the *Journal* in the article "The epidemiology of prescribing in an urban general practice" by J. C. Murdoch, the legend to Figure 1 should have read "Age and sex distribution *in the practice* as at December 1977", and the blue and yellow bars in Figure 5b and c should each have been one shade only. These errors are greatly regretted.

LETTERS TO THE EDITOR

SPECIALIZATION WITHIN GENERAL PRACTICE

Sir,

I have followed this correspondence with much interest, being one of those who has long been convinced that specialization within general practice is beneficial to patients and doctors and that it can also help in all our endeavours to raise the standards of general practice.

This conviction gave rise in 1973 to the establishment of this Department as an extra-mural department within an NHS group practice, whose principal concern was to study the aetiology, natural history, and treatment of common respiratory diseases.

Like Dr W. J. Bassett (August *Journal,* p. 500) I would plead for the abolition of the term 'specialoid', which has no exact meaning and carries the connotation of would-be or failed specialist. Although this Department's commitment to research and teaching clearly demands specialist knowledge, its whole *raison d'être* is that it operates in the context of general practice. Therefore, our interests and our self-image are those of general practitioners and not specialists. Every member of the Department is also a principal of the practice.

In arguing so clearly the case for specialization within general practice, Dr R. J. Gallow (August *Journal,* p. 501) has drawn attention to one of the most difficult problems we have encountered, namely the necessity for retaining authenticity as general practitioners. Trying to keep up to date with specialist knowledge, while fulfilling research and teaching commitments, is obviously liable to conflict with the day-to-day work of the practice. This is largely a problem of logistics, and our Department is fortunate in receiving financial assistance from the DHSS to enable the practice to care for a smaller than average number of patients without loss of income.

Similarly, there can be a conflict of loyalties between one's general and specialist interests, which is soluble only if every doctor and member of staff feels an equal loyalty to the Department and the practice. Furthermore, a general practitioner with specialist interests may become less adept in providing care over the whole range of conditions for which patients consult him.

Legal and financial problems have also arisen and their solution is the more difficult because of the differences between the structure of a partnership whose principals enjoy equality and that of a Department whose members differ in academic standing and research experience. This is soluble only with goodwill and enthusiasm.

If one accepts that there is a need for other units, such as ours, in general practice, which might examine emotional illness (particularly that associated with modern lifestyles), depression, disorders of old age or common viral infections, the questions arise how, when, and where the requisite specialist knowledge is to be acquired. So far there has been no scheme in which such training could be obtained within the context of general practice. To my knowledge, every general practitioner who has carried out research has developed his interest and expertise after entering general practice.

Part-time appointments in hospitals are essential for general practitioners wishing to maintain a specialist interest. They help to keep one's academic knowledge up to date and provide an opportunity for discussion with a variety of experts in related fields.

However, part-time appointments do not reduce the need for training programmes for those who wish to develop academic interests in general practice before they become principals. Such a training programme would reduce the long and painful process of having to teach oneself after one has entered practice.

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Director, Department of Clinical Epidemiology in General Practice (Cardiothoracic Institute)
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Sir,

The debate between 'pure' generalists and those who practise with a degree of special interest has been taken a stage further by Dr W. J. Bassett and Dr R. J. Gallow (August *Journal,* p. 500).

There is something to be said on each side, but surely the crucial test is not the depth of special interest but whether it allows the general practitioner to remain responsive to the wide range of problems brought by his patients. As Dr Gallow suggests, the pursuit of a special interest should entail an obligation to feed back into general practice the results of such studies. It may be appropriate to recall the literature arising over the years from those who have attended Balint seminars.[1-8]

Dr Howard Bacal's survey of group attenders, for example, implies that the skills needed to elicit a history of angina (not always straightforward) have much in common with the skills needed to elicit the emotional and personal factors related to the angina, which may be vital in management. Specialized training in this field may therefore enhance the whole work of a general practitioner.

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TERMINAL CARE

Sir,

The articles on terminal care in the August issue of the *Journal* (p. 466 and p. 472) deserve to be studied carefully. They highlight some issues that, following the renaissance of general practice and the establishment of a specialty of primary care, many thought were solved. We refer to the whole question of the still increasing degree of specialization in medicine; of the current trend for some hospital specialties to extend their activities outside the hospital; of specialization, or the development of special interests, within primary care; and of the effect of these factors upon the quality of patient care.

The report of the Working Group on Terminal Care is a very comprehensive document. It elegantly summarizes the benefits and dangers of care provided in various situations, and also the need for the education of all the staff involved in terminal care. The report, however, starts from a basis of where people die now (59 per cent in hospital and 30 per cent at home), and seems to assume that such a state of affairs will, or should, continue. But the report also states: "When it is successful, care provided in the familiar surroundings of the home, under supervision of the patient's general practitioner and with the support of the primary health care nursing team, can undoubtedly produce the very best terminal care." We suggest that an important omission from the report is the potential contribution of the community hospital. We five, who have access to community hospital beds, find that terminal care can become the complete responsibility of the primary care team for most patients, except those needing prolonged hospital care, such as psychogeriatric patients. We are in a position to admit the patient, to support their families, and to obtain additional treatment and advice from various specialties, thus co-ordinating care in its primary setting.

For some years students from the Welsh National School of Medicine have been going to the Barry Community Hospital and have been able to see how terminal care can be managed in this situation by the primary care team.

We are consequently concerned at the tenor of the second article in the *Journal,* "Setting up terminal care units". We feel that it would be retrogressive to step up the development of hospices. It would be preferable to train and educate existing general practitioners in the use of general practitioner beds for the care of the terminally ill, and to spend limited resources on the development of new community hospitals.

We recognize the very valuable function that the hospices and terminal care units have served, and may continue to do as centres of education and research, but we do not believe that terminal care could become a specialty without detriment to the overall national quality of care.

We suggest that, within each group practice, one doctor should maintain a special interest in terminal care and should ensure that his partners are kept up to date. We also believe that the College, through its vocational training and continuing education activities, has a major role to play in preventing the emergence of yet another specialty for which there should be no need.

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Sir,

As a general practitioner working in a continuing care unit I read with interest your editorial and the two articles on terminal care in general practice in the August issue (pp. 450, 466, and 472). I felt it might be appropriate to inform your readers of the formation of the Scottish Association of Care and Support Units in February 1979, which at present comprises five functioning units with one, Strathcarron Hospice, in an advanced stage of planning. The functions of the Association are as follows:

1. To promote the interchange of clinical and nursing experience in the management of progressive disease.

2. To look at ancillary services associated with the overall care of patients including social work, pastoral services, psychiatric services, diversional therapy, physiotherapy, and transport services.

3. To discuss matters of general organization for the day-to-day running of the units in the proposed federation.

4. To promote the extension of the services provided into the community.

5. To consider suggestions for the coordination and development of continuing care without prejudice to the autonomy and philosophy of individual centres.

To these ends we have already had two clinical meetings, the first at Aberdeen and the second at Dundee, and we are planning to have two such meetings each year. If anyone interested in this subject would like more information, especially if he or she is involved in the setting up of such a unit or a home care service, we should be very pleased to help.

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COMPUTERS IN GENERAL PRACTICE

Sir,

A patient who experiences sudden chest pain ideally requires an immediate electrocardiogram. Many general practitioners cannot do this as they do not possess an electrocardiograph, feel diffident about interpreting the recordings, or find the heavy and cumbersome machine difficult to take to the patient's home and set up in a bedroom where there is sometimes a good deal of electrical interference.

An alternative to this would be a self-interpreting electrocardiograph. Computerized interpretation of electrocardiograms has been with us for many years and is averred by some to be better than the human.

The expensive part of an electrocardiograph is the chart pen recorder, the part that draws the trace on the paper. If this could be eliminated it would be possible to make the instru-