

References

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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 co-ordination 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-