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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-

ment small and cheap—the size of the Wellcome Diary and costing about £50. Calculators such as the Sharp EL5100 have an alphanumeric display and probably sufficient memory and calculating power to perform electrocardiogram interpretation and to display the diagnosis. Additional plug-in modules might provide updated advice on treatment and a bubble memory could hold the basic signal which would be recorded on to paper by a conventional electrocardiograph machine on return to the surgery.

Although the demise of paper records in general practice seems certain, pie in the sky claims for computers fail to appreciate the size of the onerous task of transferring existing paper records into the memory of a computer. The use of a dedicated computer, in this case dedicated to the electrocardiograph signal, does appear to be a more attractive proposition, particularly in view of the large proportion of general practice which is taken up by cardiovascular diseases.

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MEDICAL RECORDS

Sir,

The article by Dr Roger Gadsby, "Recording information about immunizations" (July *Journal,* p. 410), is very important indeed. A few months ago I had a detailed questionnaire to complete about a patient who is being considered for compensation for brain damage due to immunization. It was a tedious job going through 15 years of case notes and illegible writing. There was just a mention of DPT, but no batch number or name of manufacturer.

Dr Gadsby is right to draw attention to the important point of 'over-immunization'. This can be avoided by proper recording of all immunization procedures.

FP7A and 8A seem to me to be out of date as smallpox is no longer being used. The spaces for DPT and other immunizations are so small that it is difficult to enter the batch number and manufacturer's name. The format needs to be reviewed, and there should be a space for comments, e.g. under pertussis one could write 'parents declined', or 'contraindications'.

Different manufacturers have different identification details: some say lot number, some say batch number, some say both, and it is difficult to know which one to record for future identification (perhaps in 15 to 20 years' time).

FP7A and 8A should be available as normal stationery supplies, so that details can be entered every time an immunization is done. On no account should the details be entered on continuous cards or anywhere else, as sometimes happens when notes are not available for children who are not registered or when waiting for records to come from the family practitioner committee. In Stoke-on-Trent, computer print-outs are sent with dates of immunization. I think the date should be entered on FP7A and 8A rather than the print-outs be filed, which makes notes bulky, but I do not see the batch number or manufacturer's name on these cards.

It is wishful thinking to suppose that patients would keep their own immunization record cards like passports or other valuable documents, but if they did, then the familiar jabs of tetanus at accident departments would not be so common.

Lastly, I agree with Dr Gadsby that no matter how much may be said about the shortcomings of the present record envelopes, at present they are still the proper place to keep patients' immunization details.

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Sir,

The editorial in the July issue of the *Journal* (p. 386) rightly emphasized the urgent need to reform medical records in British general practice. However, this and the following editorial on computers in primary care regrettably may well have encouraged delay in the improvement of medical records by failing to make the vital distinction between small dedicated computer systems designed for specific tasks and larger computers which attempt to store all information and replace the A4 folder. We must heed experts like Mr Brennig James, Lecturer in Electronics, London University, whose letter to the Editor (July *Journal,* p. 441) so clearly states the impracticability of large scale total computer data storage. I will give odds of 10 to one that less than five per cent of practitioners will be able to abandon paper records within the next 15 years.

I should be very interested to hear from anyone prepared to take me up on this offer. Otherwise I feel experts should concentrate on promoting the best available record system which, as all who have tried the system would agree, is an A4 folder system rather like that so ably described by Drs Marsh and Thornham (1980).

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Reference

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THE JOURNAL

Sir,

In joining correspondence on the *Journal* may I add how great was my anticipation and pleasure in reading former issues of the College *Journals.*

After joining the College in 1959 I visited the original premises off Sloane Square and requested, and received, every back number of the *Journal.* These *Journals* to me often read like a novel, the articles being tales of discovery from general practice. Many of them, though, were more notable for their ideas and inspiration than for their substance. The current *Journal* contributions are certainly more disciplined and do contribute to the substance of general practice but the cost, I suspect, is that far more of a current issue remains undigested or, dare I suggest it, unread. Indeed, the practice manager no longer reads the *Journal.* Perhaps some auditing of readers would not be out of place?

In spite of the "editorial headache in keeping the balance", suggested by Dr J. S. Norell (September *Journal,* p. 567), contributions might be shared between those who write scientific, disciplined, and statistical material and those of us who, while not lacking in ideas, often lack the know-how and discipline to translate such ideas into substance.

Sir, whilst all roads lead to Rome, some travellers may prefer alternative routes.

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Sir,

As a recent candidate for the MRCGP examination, I had cause to read through recent copies of the *Journal* with some care. I underlined in the list of contents on the front page those contributions I thought of immediate and practical interest as an examinee, and which were relevant to my work in general practice over the last seven years. In one third of the copies of the *Journal* I found nothing I considered worth underlining.