The role of the general practitioner in helping the elderly widowed*

ANN CARTWRIGHT, B.SC, PH.D
Director, Institute for Social Studies in Medical Care, London

Introduction

FIRST of all I would like to thank you for asking me to give this annual Gale Memorial Lecture. I am grateful for the opportunity and honoured by the invitation. The list of people who have given this lecture in the past is illustrious and daunting. I feel especially honoured because I think I am the first social scientist to be included. This presents a particular challenge because, in the past, social scientists have been viewed with some suspicion and concern when they ventured into the medical field. I think these suspicions are understandable—to allow someone from another discipline to view your work and your relationship requires courage. I believe that Dr Gale as an epidemiologist would have approved of your courage. At the end of the evening I hope you will not feel you were foolhardy.

In some ways my introduction may seem a diversion from my theme, as I am going to start by saying something about antenatal care.

Recently there has been some discussion about the opportunities that pregnancy and childbirth offer for health education, preventive care and for the establishment of a good doctor-patient relationship. The theory is that if general practitioners are involved in care at this important time, doctors have a chance to influence such things as diet, smoking and drinking habits, to learn about the social conditions of the family and the woman's anxieties and concerns, and to cement or establish a relationship of trust and respect. This relationship with the family is particularly helpful while the children are small and contact is likely to be relatively frequent.

In this lecture I want to consider the view that the crisis of widowhood is another important time with great potential for furthering or creating good doctor-patient relationships. I am going to present some data which show the needs of elderly widows and widowers during the early months of their widowhood and which also indicate that the opportunities created by this crisis are great but are not always realized and acted upon.

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The study

First I want to describe a study of bereavement which a colleague and I completed recently (Bowling and Cartwright, in press). The study was carried out in eight areas, registration districts of England, chosen at random but with probability proportional to the number of deaths in the area. Our aim was to interview the widows of men aged 65 or more and the widowers of women aged 60 or over. We took as our starting point a random sample of 200 deaths registered in January 1979 in each of the study areas. Among these we identified 503 deaths of married people in the required age groups.

The bereaved

The widows and widowers were visited in their homes some four to seven months after they had been widowed. Fifteen were found to have died in the meantime. Of the others, 361, that is 74 per cent, agreed to be interviewed. A further 4 per cent were too ill or confused to be seen, but someone close to them gave us some information about their situation. Two per cent had moved, but 20 per cent were unwilling to talk to us about their experiences. So our final sample may be under-representative of people who were particularly distressed after the death of their husband or wife. For example one said, "I'm not ready to discuss anything—it's still too upsetting."

A further indication of this bias is that a higher proportion of widowers agreed to be interviewed than widows, 83 per cent compared with 70 per cent, and other studies have suggested that women find it more difficult than men to adjust to bereavement (Parkes, 1972).

The general practitioners

In addition to obtaining the views and experiences of the elderly widowed people, we were interested in the

Table 1. Some variations in the response of general practitioners with the views and experiences of the widowed.

	General practitioner completed general questionnaire	General practitioner completed questionnaire about patient*	Number of widowed (=100%)
Widow or widower and spouse had:			
Same doctor	63%	42%	262
Different doctor, same partnership	56%	47%	43
Different partnership	48%	24%	46
Widow or widower described general practitioner care of spouse as:			
"Very good"	63%	44%	211
"Fairly good"	54%	33%	79
"Not very good"	50%	30%	30
Widow or widower described general practitioner as:			
"Very sympathetic"	69%	48%	148
"Fairly sympathetic"	55%	38%	47
"Rather unsympathetic"	33%	24%	21
Widow or widower thought doctor had time to discuss things:			
Yes	64%	47%	265
No	44%	20%	66
Widow or widower consulted own doctor since widowed:			
5 or more times	74%	51%	39
1–4 times	61%	43%	192
Not at all	55%	32%	117

*These percentages relate to the proportion of widowed about whom a general practitioner completed a questionnaire (whereas the figures quoted in the text relate to the proportion of despatched questionnaires that were returned), so part of the 'failure' is due to the widowed not giving their agreement to this part of the study. But the variations in the completion rates among general practitioners in these different categories could not be explained by variations in the widow's or widower's agreement. Indeed, in relation to sympathy, it went in the opposite direction: the widowed were more likely to agree to us approaching their general practitioner for information if they regarded their general practitioner as "rather unsympathetic"—90 per cent compared with 72 per cent of those who described their doctor as "very sympathetic" or "fairly sympathetic".

attitudes and practices of their general practitioners, since they were likely to be the most frequent and accessible source of professional help. So during the interview we asked the widows and widowers for the name and address of their doctor, and 97 per cent gave us this information—all had NHS doctors. A few widows and widowers had the same doctor as others in the sample, so the 349 widowed gave us the names of 295 doctors. All these doctors were sent a postal questionnaire about their general views and experiences of caring for elderly bereaved people. After two reminders, 61 per cent of the questionnaires were completed and returned. The response rate was relatively high among members of the Royal College of General Practitioners: 76 per cent compared with 58 per cent of non-members. I should point out that all the differences to which I draw attention are statistically significant at least at the 5 per cent level.

In addition to general questions about caring for the bereaved, we wanted to obtain information from the doctors about the individual widows and widowers in our sample. So we asked the widowed if they were willing for us to ask their doctors about any help and advice the doctor had given to them and for the doctor to give us information about their health and treatment. We explained that we would not tell the doctor anything the widow or widower had said to us. Seventy per cent of the widowed agreed to this and signed a form giving their permission. Their doctors were sent a copy of this form and a questionnaire about the individual patients. Fifty-six per cent of these forms were completed. Again the response was higher for College members than others: 78 per cent against 52 per cent of non-members.

Clearly these response rates are disappointingly low and a cause of concern. It is possible to look at variations in response rates with data available from the DHSS about age, sex, qualifications and number of partners. We found no significant variations between responding and non-responding doctors in any of these basic characteristics. But those in practices with an average list size of 3,500 or more were less likely to reply to the general questionnaire: 50 per cent compared with 65 per cent.

We can also look at variations in response rates of doctors in relation to some of the experiences and views of the widowed. Table 1 shows that general prac-

titioners were more likely to respond if the widow or widower and their spouse had been registered with the same practice. Doctors were also more likely to participate if the widow or widower described the way they had looked after their spouse as "very good".

Table 1 also shows that the general practitioner more often replied to our questionnaire if the widow or widower regarded their general practitioner as very sympathetic and if they thought the doctor had time to discuss things. Responding to our questionnaire and making patients feel there is time to discuss things might be expected to go together if time was the important factor. But we also see from this Table that the more frequently the widowed person had consulted their doctor, the more likely the doctor was to participate in the study.

It would therefore seem from these data that the study has a bias towards the general practitioners whom the widows and widowers had found more caring and more sympathetic.

The carers

The final group of people included in this study were the carers or 'familiars' of the widowed. We wanted to interview these people mainly because we were concerned to find out about the problems of helping an elderly widowed person from their viewpoint. In addition, we were interested in having another perspective on the problems facing the elderly widowed. We asked the widows and widowers to identify the person who knew most about their circumstances at the time of interview: 94 per cent of the widowed people did so; rather fewer, 80 per cent, agreed to give us their full name and address so that we could approach them for an interview. The response rate of those for whom we did have this permission was 84 per cent, which means that for 59 per cent of the widows and widowed interviewed we also saw a familiar. Almost half the supporters interviewed were daughters, a quarter were sons, the rest were roughly evenly divided between other relatives and friends or neighbours. One per cent were professionals. The majority, two thirds, were women.

Results

Those too ill or confused to be interviewed

We were able to get some information about those who were too ill to be interviewed from the people who knew most about their circumstances. Only 4 per cent of our initial sample were in this group, but they are important because their needs are substantial.

Six of these 19 people were in various institutions and all but one of them were visited fairly frequently by relatives who continued to be concerned about them and who, in some instances, were still actively involved in their care.

Turning to the 13 *still* living in the community but too ill or confused to be interviewed, four lived with daughters, three with sons and six lived alone. Clearly, detailed statistical analysis is inappropriate, but the picture built up by reading through these case histories gives an indication of a submerged iceberg of need in this section of the community. There are also illustrations of the conflicts and strains involved in caring for elderly people at home. Daughters in particular start to do more and more things for their parents as they become increasingly frail, confused and eventually helpless. This is often a gradual process with no sharply defined points of decision. It can develop into an almost intolerable situation, imposing enormous psychological and physical demands.

From the viewpoint of services, I think there are three important implications. The first is that the occasion of the death of one elderly person is an opportunity to find out about the circumstances of a surviving spouse and to intervene if appropriate—it may be a chance to arrest a process of gradual deterioration. The second is that the proportion of widows or widowers who are in these sorts of fairly desperate circumstances is small and huge resources are not involved, but there are a few living in horrendous circumstances or making almost intolerable demands on their relatives. Thirdly, while relatives may be prepared to take on the care of elderly relatives in circumstances which restrict their lives, and those of their immediate families, they need support from services. Sometimes it seemed that it was not active intervention that was called for but the carers wanted general practitioners to be aware of what they were doing—partly because they wanted this appreciated, but also for back-up in emergency. I would like to illustrate some of these points by quotations from an interview with a daughter whose widowed father had come to live with her, her husband and their three children after her mother died. She described her father's health as "good" for his age (83), although he was incontinent. This was one main problem:

> "When he passes water he doesn't care where he goes. My bathroom floor and my kitchen floor are constantly flooded. He wees out on the front lawn too —everywhere. . . . It gets on the nerves of the family a lot. He does a lot of tapping with his stick which can be very annoying—I think it's boredom, he never does anything. He needs an interest. As soon as I get up in the morning I have to run around mopping up after him, and when I get home from work the first thing I do is run in and mop up after him. He wees everywhere. The other day I caught him doing a wee in one of my pint cups. It's a terrible worry. I never know what I'm going to find."

He had not been in touch with the health or social services, except to see his doctor about his blood pressure. He also suffered from a number of other physical and mental problems such as rheumatism, sleeplessness and nerves or depression. The daughter felt that the doctor should visit him regularly. Other things she thought might help were "somewhere to go during the day with people of his own age" and a

Table 2. The widows' and widowers' supporters.

Relationship	Person seen most often	Person most comfort	Person most practical help
	%	%	%
Son	15	15	19
Daughter	26	32	32
Other relative	14	17	16
Male friends	3	1	2
Female friends	22	12	11
Person from more than one category*	19	19	14
No one	1	4	6
Number of widowed (=100%)	347	339	342
Ratio female/male	2.5	2.9	2.1

*Including all the family.

downstairs lavatory. She felt that caring for her father had adversely affected her life but she seemed resigned to this and thought he would stay with them in their home for the rest of his life:

> "If I'm being honest I don't think the home is as happy. The atmosphere is different. . . . It's just something I have to put up with and there's nothing much I can say or do about it."

Views and experiences of the carers

The small proportion of elderly people who were too ill or confused to be interviewed probably presented the greatest burden to their relatives. Many of the widowed who were interviewed also had a lot of support from their families and friends. Table 2 identifies the people whom the widows and widowers said they saw most often, who had been most comfort to them and who had given them most practical help. Daughters were mentioned most often on all three criteria; female friends were next most likely to be mentioned as the person they saw most often and sons as the person giving most practical help. But even over practical help women were mentioned twice as often as men.

Supporting the elderly widowed created conflicts of responsibility for a number of the carers. For instance one daughter said:

> "It makes for problems. My husband gets angry. He says I've given far too much time to my parents. I can't get to see elderly in-laws and other friends as much as I'd like. I pay for a lot of extra things for him [widower], especially food, and I also pay for his laundry. It's aged me and taken away a lot of the joy of living."

Again it was only a minority, in this instance 14 per cent, who felt their activities were much restricted by caring for the elderly widowed, but one in five had given up or cut down on such things as visiting friends or neighbours, going out to social activities, going on holiday or entertaining people at home. More of them, nearly two fifths, expected problems in the future.

One in eight of these carers felt that either the widowed person or other friends or relatives were expecting them to do too much for the widow or widower, and a similar proportion felt the widow or widower was not getting the support they needed from their general practitioner.

So, although the majority of the familiars were quite prepared to support and help the widowed, there was a certain amount of resentment about the amount of care they were expected to give and the failure, as they saw it, of both informal networks and formal services to provide adequate support.

Contact with general practitioners immediately after the spouse's death

Turning now to the needs of widowed people in the early days of their bereavement—and the role of the general practitioner at this time—I would like first to show you when and how the general practitioners said they heard of the deaths of their elderly married patients (this analysis is confined to the couples who had the same doctor). Table 3 shows that when the person died at home the general practitioner usually knew within 24 hours; for over half he or she learned within six hours. The doctor also knew within 24 hours about almost half the deaths occurring in hospital or other institution, but for 30 per cent of these institutional deaths the doctor did not learn about the death for over three days. The way the general practitioner heard is shown in Table 4. It seems strange to me, now that nearly all general practitioners have secretaries or receptionists, that hospital staff are more likely to notify general practitioners of a patient's death by letter than by telephone. Most telephone messages reached the general practitioner within 24 hours of the death, whereas most letters arrived within a week. However, the majority of general practitioners (87 per cent) were satisfied with the way and the stage at which they heard of the death, although one doctor who said he had learnt of the death from the death column in the local paper stated that this was the usual method and wished he could have heard earlier.

When we asked the general practitioners what they thought they should do when an elderly patient (of pensionable age) was widowed, the most common view,

Table 3. How soon general practitioners heard about their patients' death.

	Home deaths	Institutional deaths	All deaths
	%	%	%
Present at death	*8*	—	*4*
Within six hours	*51*	*18*	*34*
Within 24 hours	*27*	*29*	*28*
Within three days	*7*	*23*	*15*
Within one week	*3*	*18*	*11*
Within one month	*2*	*6*	*4*
Did not know until heard from ISSMC	*2*	*6*	*4*
Number of deaths (=100%)	60	66	126

Table 4. The ways in which general practitioners heard about their patients' deaths.

	Home deaths	Institutional deaths	All deaths
	%	%	%
Present at death	*8*	—	*4*
Message from widow or widower	*24*	*16*	*20*
Message from other relative	*22*	*8*	*14*
From partners or locum	*33*	*11*	*21*
From hospital by telephone	—	*19*	*10*
From hospital by letter	—	*26*	*14*
Meeting or consultation with widowed	—	*2*	*1*
Arrived after death	*4*	*2*	*3*
Not until ISSMC wrote	*2*	*6*	*4*
Other source	*7*	*10*	*9*
Number of deaths (=100%)	55	62	117

held by 41 per cent, was that they should visit the widowed at home. Thirty-six per cent said it would depend entirely on the circumstances, and 15 per cent thought they should just respond to direct requests for help, leaving 8 per cent who felt they should contact the widowed, possibly by letter or telephone, to see if they needed help. Most doctors, three quarters, thought that if a general practitioner was to contact an elderly patient who had been widowed the doctor should do so as soon as possible or at any rate before the funeral. What happened to the widows and widowers in our sample? The majority had not seen a general practitioner after their spouse died and before the funeral; but a general practitioner had visited nearly a quarter of them in their homes. Table 5 shows that this was more likely to happen if the doctor thought general practitioners

Table 5. Relationship between the doctors' views and the experience of the widowed.

Widow or widower saw general practitioner before funeral	Doctor feels that when an elderly patient is widowed the general practitioner should:	
	Visit them at home	Depends on circumstances or other answer
	%	%
At home	*45*	*18*
At surgery or elsewhere only	*4*	*10*
Did not see general practitioner	*51*	*72*
Number of widowed (=100%)	53	79

should do this, but even in this group slightly less than half had had a visit. Does this matter?

We asked the widows and widowers who did not have any contact with their own doctor during that time whether they would have liked to have done so. Only one in eight said they would. But before we conclude that most of the elderly widowed were getting the help and support from their general practitioners at this stage of their bereavement if they wanted it, I would like to make two points. The first is that one of the limitations of these sorts of surveys is that patients are generally reluctant to express anything that might be taken as a criticism of their doctor and tend to make the best of what has happened—not to wish that things had been otherwise. So, in a study of childbearing, 91 per cent of women who had a home birth said they would prefer to have their next baby at home, while 83 per cent who had their baby in hospital would like the next birth to be in hospital too (Cartwright, 1979). Similarly in this study, 91 per cent of the widowed whose spouse had died at home said they were glad it happened there, and a similar proportion of those whose husband or wife had died in hospital said either that it would not have been possible to look after them at home or that it was better that they had been in hospital.

What I am suggesting is that the widowed were unlikely to say that they would have liked their doctor to call if the doctor had not done so. They might not even have admitted to themselves that they felt rather hurt that their general practitioner had not been to see them. The fact that only one in eight did say this should not be construed as implying that none of the others would have appreciated such a visit.

My second point is that it would in effect be a more damning criticism of general practitioner-patient relationships to believe that so many of the elderly widowed would not have been glad to see their doctor in these circumstances. When a person loses their husband or

Table 6. Contacts with general practitioner during the five to seven months after their spouse died.

	All consultations	Home visits	Consultation with own general practitioner
	%	%	%
None	24	67	34
1	25	17	24
2-4	37	13	31
5-9	9	2	7
10 or more	5	1	4
Number of widowed (=100%)	350	340	348

Table 7. Some symptoms reported by the elderly widowed.

	%
Rheumatism, or aches and pains in the joints, muscles, arms or legs	59
Sleeplessness	50
Nerves or depression	47
Forgetfulness or confusion	43
Backache	39
Breathlessness	37
Any difficulty hearing	31
Any difficulty seeing	23
Loss of appetite	17
Number of widowed (=100%)	350

Table 8. Symptoms reported by the widowed and by general practitioners.

	Reported by general practitioner as present	Proportion of which general practitioner aware*	Proportion with symptom reported by general practitioner not patient
Rheumatism, etc.	35%	45%(86)	5%
Sleeplessness	21%	34%(67)	4%
Nerves or depression	27%	38%(61)	10%
Forgetfulness or confusion	8%	10%(60)	4%
Backache	20%	29%(56)	8%
Breathlessness	16%	28%(54)	5%
Any difficulty hearing	8%	19%(42)	2%
Any difficulty seeing	6%	18%(28)	2%
Loss of appetite	8%	11%(18)	6%
Number of widowed (=100%)	133		133

*Figures in brackets are the numbers on which the percentages are based.

wife, I think they need to redefine and re-establish their relationship with people who are important to them. The relationship between general practitioners and their elderly patients often is, and possibly should be more often, important enough to be recognized and emphasized in this way at the time of bereavement. Contact at this time can also provide insight and clues into the bereaved's situation and needs.

Contact with general practitioners in the early months of widowhood

While only a minority of the widowed had any contact with a general practitioner before their spouse's funeral, by the time we saw them, some four to seven months after the death, the majority, three quarters, had had some contact with a general practitioner (Table 6).

Some indication of their health problems during this time is given in Table 7, which shows the proportion of widowed people reporting various symptoms. Loss of appetite, nerves or depression, sleeplessness and forgetfulness or confusion were the ones most frequently said to have developed since, or become worse, after their spouse's death. Doctors were rarely said to have been consulted about forgetfulness or confusion: only 15 per cent of those who reported such symptoms said they had consulted a doctor about this—but of course some of these patients may have forgotten, or been confused on this point. A third had told their doctor about their lack of appetite, half about their nerves or depression and only just over half, 55 per cent, about their hearing difficulties.

If we look at the patients for whom a general practitioner completed a questionnaire (Table 8), we see in the first column that general practitioners reported fewer symptoms than the widowed. The second column shows that general practitioners recorded 42 problems with hearing and were therefore aware of only 19 per cent of their patients' reported hearing difficulties, but they were aware of a third of the problems with sleeplessness and two fifths of the nerves and depression. Ten per cent of these widowed patients were thought by their general practitioners to be suffering from nerves or depression which the patients did not report to us. This proportion was 2 per cent for difficulty in hearing.

Table 9 shows the proportion of the widowed who reported problems with various activities. Altogether, two fifths of the widowed either could not do or had difficulty with one or more of these. This Table is again confined to those for whom the general practitioner completed a questionnaire and shows that general practitioners were most aware of patients' difficulties in going out, but relatively unaware of the problems many of them had with going up or down stairs and uncertain about difficulties over getting in or out of the bath or cutting their toe nails.

The fact that around a fifth of the widowed had

Table 9. General practitioners' awareness of problems reported by widowed.

General practitioner	Widow or widower reported problem with: Using public transport	Going out	Going up/down stairs	Getting in or out of bath	Cutting toe nails
	%	%	%	%	%
Aware of problem	*39*	*52*	*33*	*19*	*18*
Uncertain	*30*	*19*	*14*	*38*	*38*
Thought no problem with that	*31*	*29*	*53*	*43*	*44*
Number of widowed (=100%)	33	27	43	32	45

problems with going out or using public transport emphasizes the need for home visiting among this group. But I want to suggest that a need for some home visiting may not be confined to those with mobility problems. While the system of self-referral by patients seems to work reasonably well in general practice as a whole, it has been shown by Williamson and colleagues (1964) that it fails to meet the needs of many elderly patients. And when an elderly person loses their husband or wife, the feelings of helplessness and hopelessness associated with bereavement may make it difficult for them to recognize their needs in the first place, or to do anything about them if they are aware of such needs. Depression is often associated with apathy and we have just seen that nearly half the elderly widowed said they had problems with nerves or depression—and for almost three quarters of these the problem had developed since, or been accentuated by, the death of their spouse. If, in addition, they had looked to their husband or wife for advice about whether or when to consult a doctor, this spur will now be missing. In practice 16 per cent of those reporting nerves or depression had had no contact with a general practitioner since their spouse died.

But home visiting by general practitioners has declined markedly in recent years and one study found that half the general practitioners surveyed would like to see it decline even further (Cartwright and Anderson, 1981). General practitioners are therefore likely to be less aware than they were in the past of the home circumstances of their elderly widowed patients. I suggest that at the time when the elderly widowed are having to cope with living alone, with making decisions that were formerly shared or taken by the spouse who has died, and with dealing with additional and unfamiliar household tasks, a visit to the home is likely to be particularly revealing. It may also be especially rewarding. As Dr D. J. Pereira Gray, who gave this lecture in 1979, has said: "A cup of tea given to the doctor at home by a widow who wants to talk about her dead husband may be worth several counselling sessions" (Gray, 1978).

There is also some evidence that home visits may *contribute to doctors*' enjoyment of their work. In our general practitioner study we found that the proportion of adult patients reporting a home visit was 20 per cent where their doctors said they enjoyed their work either "very much" or "moderately", but only 10 per cent among patients of doctors who said they did not enjoy their work very much or not at all (Cartwright and Anderson, 1981).

Table 10. Some variations in the proportion of the widowed who were given a prescription when they were seen by a general practitioner before the funeral.

Number of home visits to spouse who died in year before death	Proportion given a prescription	Number of widowed (=*100%*)
None or 1	*77%*	22
2-9	*61%*	28
10 or more	*48%*	29
Widowed described general practitioner's care of spouse as		
Very good	*52%*	50
Fairly good / Not very good	*76%*	21

Treatment

I want now to look at the treatment the elderly widowed received from their general practitioners in the early months of their bereavement.

Three fifths of those who saw a doctor in the first few days of their bereavement—before the funeral—were given a prescription. Table 10 shows that the doctors were more likely to give a prescription at that stage if they had had relatively little contact at home with the person who died, and that the widowed who described the general practitioner's care of their spouse as "very good" were less likely to be given a prescription than those who thought it was "fairly good" or "not very good". (This Table relates only to the widows and widowers who saw a general practitioner before the funeral and to those who had the same doctor as their dead husband or wife.)

If we accept the assessment of the widowed person, it would seem that the less involved doctors are more likely to give prescriptions for bereavement. And when we come to consider the drugs taken by the widowed in

Table 11. Views on sympathy and drug taking.

Since spouse's death had taken prescribed	Found general practitioner		
	Very sympathetic	Fairly sympathetic	Rather unsympathetic
Minor tranquillizer	*39*	*43*	*62*
Any psychotropic drug	*44*	*49*	*67*
Cardiovascular or diuretic drug	*38*	*26*	*29*
Number of widowed (=100%)	148	47	21

Table 12. Proportion of all surgery consultations general practitioner estimated were for reasons they felt to be trivial, unnecessary or inappropriate.

Proportion considered trivial, unnecessary or inappropriate	%
90 per cent or more	—
75–90 per cent	*10*
50–75 per cent	*19*
25–50 per cent	*27*
10–25 per cent	*28*
Less than 10 per cent	*16*
Number of general practitioners (=100%)	177

the four to seven months after their spouse's death, we find in Table 11 that those who felt their doctor to be unsympathetic were more likely to have been prescribed psychotropic drugs—mainly minor tranquillizers. In contrast, they were less likely to be taking prescribed cardiovascular or diuretic drugs. These sorts of associations could be explained either in terms of differences between patients or between doctors.

Variations in doctors' attitudes

I would like to move on to some of the differences in attitude we found between doctors. Other studies (Cartwright, 1967; Cartwright and Anderson, 1981) have found that general practitioners vary in their estimates of the proportion of their consultations which they feel are for trivial, unnecessary or inappropriate reasons, and that their estimates relate to circumstances of their work and to their relationships with their patients. In this study, too, the variation in their estimates was considerable (Table 12).

It appeared that those who felt that a small proportion of their consultations were trivial, inappropriate or unnecessary had a wider view of their work. Table 13 shows that more of this group of general practitioners felt they should contact elderly widowed people to see if they are in need of help and that they should give elderly widowed people some supervision. Table 13 also indicates that few of those who estimated that they had a small proportion of trivial consultations thought that relatives of elderly patients commonly shirked their responsibilities; more of this group also would like to give more time to recently widowed patients and more felt it was appropriate for people to seek help from their general practitioners with problems in their family lives. In addition, they were less likely to use a deputizing service than were their colleagues who classified a higher proportion of their consultations as trivial.

I think there is probably a circular effect here. The belief that a substantial proportion of their work is trivial, inappropriate or unnecessary can undermine morale and inhibit doctors from identifying with their patients, taking pride in their work and having enthusiasm for practice. Doctors who hold or acquire this view may limit their work by using deputizing services, by not responding to requests for help with family problems and by not seeking out their elderly widowed patients to see if they need help. By restricting their work in this way they eliminate most of the emergencies and cut down on visits to the chronically sick: their inclination to perceive trivia is reinforced and perpetuated.

Reporting of medication by general practitioners and the widowed

The next data that I want to present again relate to the widows and widowers for whom we have data from the general practitioner, but for this comparison I have excluded those patients for whom the doctors did not record the number of consultations since the bereavement, as it is possible that the doctors did not consult their notes when completing these questionnaires.

Table 14 shows that 82 per cent of the widowed reported taking prescribed drugs, whereas only 63 per cent of the same widows and widowers were recorded by their general practitioners as doing so. The 3 per cent discrepancy in column 2 probably arose because some patients were not taking their drugs. The much larger discrepancy, whereby 22 per cent were taking drugs unknown to the general practitioner, is more difficult to explain, but it is of the same order as the difference reported recently by Arcand and Williamson (1981). In their evaluation of home visiting of patients by physicians in geriatric medicine they reported that 23 per cent of patients were taking drugs not mentioned by the general practitioner.

An analysis of the discrepancies revealed by our study suggests that, if the information from the widowed people themselves is accepted, the general practitioners were only aware of about half the patients who were taking minor tranquillizers. It did not seem as if these were just odd drugs that had been prescribed a long time ago and then taken at a time of crisis, since for all the drugs first prescribed two or more years ago the patient said they had 10 or more prescriptions. And the drugs

Table 13. Relationship between general practitioners' estimates of the proportion of 'trivial' consultations and their attitudes to other aspects of their work.

	Estimated proportion of 'trivial' consultations				All general practitioners
	<10%	10<25%	25<50%	50+%	
When elderly person of pensionable age is widowed feels should:	%	%	%	%	%
Visit them at home or contact to see if need doctor's help	*74*	*57*	*41*	*39*	*49*
Just respond to direct requests for help	*4*	*6*	*13*	*29*	*15*
Depends entirely on circumstances	*22*	*37*	*46*	*33*	*36*
Feels elderly bereaved patients should be given some supervision by their general practitioner for a while:	%	%	%	%	%
Generally	*59*	*40*	*38*	*31*	*39*
Rarely	—	*4*	*8*	*17*	*8*
Depends on circumstances	*41*	*56*	*54*	*52*	*53*
Think relatives of elderly people often shirk their responsibilities and leave it to services to look after old people	*19%*	*29%*	*46%*	*52%*	*38%*
Would like to give more time to recently widowed patients	*67%*	*56%*	*58%*	*43%*	*55%*
Feels it is appropriate for people to seek help from their general practitioners for problems in their family lives	*93%*	*90%*	*75%*	*63%*	*79%*
Uses deputizing service for nights or weekends:	%	%	%	%	%
Regularly	*14*	*23*	*42*	*52*	*35*
Occasionally	*18*	*15*	*19*	*17*	*17*
Never	*68*	*62*	*39*	*31*	*48*
Number of doctors (=100%)	28	48	48	52	176

for which only one prescription had been given had all been obtained since their bereavement. Neither could the discrepancy be attributed to hospital prescribing, since the two drugs first prescribed by the hospital had subsequently been repeated. Obtaining repeat drugs without seeing the doctor seemed a more plausible, if inadequate, explanation.

Table 14. Comparison of prescribed drug taking reported by widowed and by general practitioner.

General practitioner recorded widowed as	Patient reported taking prescribed drugs since death of spouse		
	Yes	No	Total
Taking prescribed drug	*60%*	*3%*	*63%*
Not taking prescribed drug	*22%*	*15%*	*37%*
Total	*82%*	*18%*	*100* (n=101)

Before the death

I would like now to go back in time and discuss some findings that relate to what happened before the death.

The general practitioner played a key role in talking to the husband or wife about their spouse's illness or death and was the professional person the widowed were most likely to have talked to at that stage. Three fifths of the widowed whose spouse had been ill for a week or more before their death said they had talked to a general practitioner about the illness and what was likely to happen. This proportion was the same whether the person had died at home or in hospital.

The widowed who had talked to a general practitioner about the possibility of death seemed to have a better relationship with their doctor (Table 15). But while general practitioners had talked to many of the future widows and widowers about their spouse's illness and death, it seemed that few had talked to the person who was dying. Only 2 per cent of the widowed thought a doctor had talked to their husband or wife about what was likely to happen.

Our data suggest that the elderly widowed appreciated their discussions with the doctor and that these created or enhanced a sympathetic and understanding relationship. Necessarily, we have no information about the feelings of the person who died, but a recent study has suggested that about half of patients with a terminal illness want to know that this is so (Jones, 1981). Our study found considerable differences of opinion be-

Table 15. Widows' and widowers' views of general practitioner and discussion about death.

	Proportion who had discussed spouse's illness and possible death with a general practitioner	Number of widowed (=100%)
Widow or widower finds general practitioner:		
Very sympathetic	68%	132
Fairly sympathetic	53%	45
Rather unsympathetic	43%	21
Widow or widower described general practitioner's care of spouse as:		
Very good	65%	197
Fairly good	58%	72
Not very good	39%	28

tween doctors about what patients should be told, but 82 per cent thought that if patients were to be told, then the general practitioner was usually the best person to do this. The others mentioned the patient's husband or wife or a vicar, priest or minister.

Conclusion

In summing up, I would like to point out that I am not seeking to medicalize bereavement. But old age is, sadly, a time of physical, and quite often mental deterioration. It tends to be a gradual process, and the increasingly frail and less mobile are likely to find it harder to struggle to the surgery and to be less willing to make demands and assert their needs. They become more dependent on a narrowing circle of relations and friends—and on their general practitioners. They need to feel there is a professional person they can turn to and rely on when they need help. Some need more than this because, for one reason or another, they are too confused, too apathetic, too depressed and inhibited to ask for help: they need someone who will seek them out. The death of a spouse is often a time of great need and stress; it is also an opportunity to promote trust and understanding, and to make contact with those in particular need.

I would like to end with two suggestions which I think might have appealed to Arthur Gale. The first might commend itself to him as an epidemiologist. As general practitioners set about the task of carrying out medical audit in their practices, I hope that they might sometimes take death as their starting point, and then look at the handling of both the terminal illness and the bereavement of the survivors.

My final suggestion might have attracted the educationalist in Arthur Gale. At all levels of education (undergraduate, postgraduate and continuing) I would like to see more emphasis on coping with dying, death and bereavement. Nowadays, rather more people die in hospitals or institutions than at home, but I am not convinced that this is a good or appropriate trend. I do know that most of the caring and nearly all the grieving takes place in the home. It is the general practitioner who should be the specialist in this somewhat neglected field. I think we should make sure he or she gets adequate training and support for this difficult and important task.

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Address for reprints

Ann Cartwright, Institute for Social Studies in Medical Care, 14 South Hill Park, London, NW3 2SB.

Words our patients use

"Gowled up"— stuck together, of the eyelids (by discharge) (South Yorkshire).

'Stooning'—throbbing (Glasgow).

'Beeling'—throbbing (Glasgow).

To be "dog rough"—to feel pretty bad (South Yorkshire).

To 'teem'—to pour, as of catarrh or discharge (East Riding).

"Getting off at Haymarket"—coitus interruptus (Edinburgh and environs). In Liverpool one hears "Getting off at Edge Hill" (the last station before the terminus).

'Host'—cough (Scotland).