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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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).