suggest that education in many aspects of terminal care is at present inadequate and that doctors are dissatisfied with their skills. This conclusion supports the findings of Parkes (1978), who reported poorly controlled pain in nearly 30 per cent of patients dying at home and in 20 per cent dying in hospital. Levy and Sclare (1976), Soukop and Calman (1977), Carne (1979) and Doyle (1980) have demonstrated that good terminal care can, and often should, be provided at home, where 90 per cent of patients spend most of their last year; yet only 55 per cent of the general practitioners in our survey had received training in symptom control, 50 per cent in bereavement counselling and only 19 per cent had had clinical instruction. It is sometimes said that skills such as communication and counselling cannot be taught, but there is good evidence to disprove this (Maguire *et al.*, 1980) and recent proof that good communication helps the dying patient.

A Central Health Services Council working group on terminal care (Wilkes, 1980) has recommended that "a terminal care component should be included in the medical training of students" and that "medical students would, like nurses, benefit from instruction in counselling techniques"; it also proposed that "all general practitioners and community nurses should have an opportunity to attend a course on terminal care". Looking at the need for specialists in terminal care the working group went on:

> "This problem [the lack of postgraduate training in this field] should be considered very seriously by the Joint Committee on Higher Medical Training and the relevant advisory committees on specialist training. Those bodies responsible for radiotherapy, general medicine, anaesthetics, geriatrics and general practice should consider whether trainees in their specialties might usefully undertake a six-month option in terminal care."

Our survey shows the preponderance of didactic over clinical instruction and the educational benefits of hospice-based training. Attachment to a hospice for any length of time was thought by half of the respondents to be impracticable, but ways must be found of providing appropriate experience in the care of the dying for medical students and qualified doctors which does not intrude into the privacy and dignity of patients. Teaching methods need to be examined and the benefits of one-to-one and small group learning should be explored.

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## Words our patients use

'Peely wally'—not looking well (Greenock).

'He really gets his hair off'—A baby having a tantrum (Shropshire).

'Cranky'—an irritable person (County Cork).

'Niggly'—petty (County Cork).

'Jag'—injection (Scotland).

'Glut'—phlegm or mucus (Scotland).

'To play steam with someone'—to get angry with them (South Yorkshire).

'To be bad with the bile'—to feel sick (South Yorkshire).

'Wingey'—not very ill, slightly fretful and feverish (as of a child) (North-east England).

'Hangy'—worse (North-east England).

'Crook'—ill (Australia and New Zealand).

'Crazy as a chook'—agitated (New Zealand).

## Patients with psychosocial problems

A study has tested the hypothesis that family practice patients with intrapersonal psychosocial problems are likely to be identified as having more health problems in general than patients not afflicted in this way. Thirty-one per cent of all patients in the study practice were defined as having intrapersonal problems (on the criteria given), and 94 were randomly selected for study. Study group patients were found to have a significantly greater number of family problems, hospital admissions, major surgical procedures, number of visits to the practice, gastrointestinal disorders and illness due to inflammatory causes than normal controls. They also had more psychiatric care, more attention from allied health professionals and more frequent psychotropic drugs.


Source: Brennan, M. & Noce, A. (1981). A study of patients with psychosocial problems in a family practice. *Journal of Family Practice,* **13,** 837-843.