LOOKING FORWARD

General practitioners and terminal care—the future

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In 1982, about 130,000 people died of cancer in England and Wales;[1] of these, about 59 per cent died in hospital, 33 per cent at home and 7 per cent in hospices.[2,3] General practitioners were involved with a great number of these since many are admitted to hospital only in the last few days of their lives.

THE hospice movement, despite its rapid expansion in the last 20 years, is still thinly spread. By December 1980, it provided (in England, Scotland and Wales) 1,297 inpatient beds (of which only 298 were within the NHS), 32 home care teams and eight hospital support teams.[1] The immense contribution of the hospice movement cannot be over-emphasized, especially in education and research, and as a catalyst for thought and discussion; but it could not pretend to attempt to provide a service for the whole community.

One is left wondering at the future of the present hospice units within the NHS, let alone the growth of new specialized services, in the current economic climate. It would need a massive expansion of the service to provide the quantity of care needed.

Care within general practice

The logical area for expansion must be within the primary care team, based on the general practitioner. He is ideally placed to provide the care needed. It is hardly necessary to reiterate the advantages of the general practitioner over other agencies in terms of his knowledge of the patient, family inter-relationships and the economic and social circumstances and his ability to provide continuity of care; an aspect of immense importance for these patients and their families.

The provision of home care services is considerably cheaper per patient than the costs of inpatient care.[4] On social grounds there are significant advantages for the patient to remain in his own home if possible.

If a significant expansion is to occur in the field of terminal care, it must be through greater involvement of the general practitioner in the community, in the hospital and in the hospice. Future effort and finance should be directed towards building up good terminal care *within* general practice and not as a separate service. Let us look at two areas for expansion:

Education

Sadly, Lamerton has recently and understandably criticized general practitioners for not attending lectures and meetings about the subject.[5] 'The plain fact is that large numbers of doctors . . . do not light up at the idea of palliative care'. We must continue to chip away at the apathy that often is exhibited and the depression that at times may threaten to overwhelm us.

Lectures in a limited number of specialized centres will not have a significant impact, except on the converted. The local hospital in each area provides a more effective centre, but better still, the educator could go out into general practitioners' surgeries and use their own patients and experience as a basis for teaching.

A far better response will be achieved if the teaching is based at a local and personal level, and on individual patients and their difficulties. The person with a specialist interest could take on the role of catalyst, be he hospice or hospital-based, or a local general practitioner. He could then take the subject out to the general practitioner.

Vocational training schemes must be prime targets, since terminal care is a common topic for many day-release study groups. An ideal opportunity would be created if schemes could include a three or six month option in terminal care including inpatient, outpatient and home care.

Involvement of the general practitioner

As far as possible the general practitioner should care for his patient during this period. If a specialist service is involved in home care, the general practitioner should be left to arrange the management, with advice and support from that service, rather than have the patient taken off his hands.

When the patient is in hospital, the general practitioner should be more involved in decision-making. He may be the most suitable person to take decisions concerning what the patient should be told, whether he should go home and what services he needs. I would like to see the general practitioner invited to the interview when the diagnosis and prognosis are discussed with the patient and his relatives, thus avoiding a source of confusion later on. Dare I suggest that he might be better at conducting that interview than many hospital staff?

Obviously, not all general practitioners have the knowledge and ability to look after their dying patients as well as they might wish. On the other hand, the hospice based service is thinly spread throughout the country. Could a local general practitioner acquire a special interest in the subject and act as an adviser for his local colleagues?

The hospice network is invaluable and must retain its present position in health care. It will always have a dual function of providing care for patients who cannot be cared for in other ways, and of educating and stimulating. However, the future must lie in the expansion of community services, centred on the general practitioner, if we are to hope to achieve the stated aim of the National Terminal Care Working Group—'Our objective now should be to ensure that every dying patient has access to professional staff who can provide the appropriate care.'[3]

References

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