

Terminal care: the role of the general practitioner hospital

A. LYON, MB

Trainee General Practitioner, Peebles

D. R. LOVE, MB, MRCP, MRCP

General Practitioner, Peebles

SUMMARY. A survey of all deaths occurring over a two-year period in a group practice population was carried out to assess the contribution of the local general practitioner hospital to terminal care overall. With the availability of the hospital, the general practitioners were able to provide a higher proportion of terminal care for their patients than in areas where general practitioners did not have access to hospital beds. This was particularly so in terminal care for patients dying of cancer.

Introduction

IN recent years the subject of terminal care, for so long a neglected field of medicine, has attracted considerable attention, both lay and medical. General practitioners can have an important role to play in the provision of terminal care, particularly when death occurs at home. It has been suggested that they are in danger of losing their expertise in providing terminal care because of the decline in the number of deaths occurring at home in recent years.¹

The authors' particular interest was the pattern of provision of terminal care in a community where general practitioners could care for the patient either at home or in a local general practitioner hospital. The community examined was that of Peebles and the surrounding rural area. The practice population surveyed was approximately 9,000, of whom 6,000 resided in the town. There was an above average percentage of patients aged over 65 years (20 per cent) and the patients were looked after by four general practitioner principals with access to a 26-bedded general practitioner hospital.

Method

All deaths occurring in the area over a two-year period (1 January 1981 to 31 December 1982) were studied. The death certificates were obtained from the Registrar and used to determine the place and cause of death.

The authors considered the possibility that patients who died outside Peebles—for instance, in an Edinburgh hospi-

tal—may have had their deaths registered elsewhere, but the Registrar assured them that this was a rare occurrence.

Deaths that might have been sudden in nature, such as from myocardial infarction or cerebrovascular accident, were identified and further information about the terminal illness was obtained from the patient's own doctor. This allowed an accurate assessment to be made of the number of sudden deaths where no terminal care was necessary.

Results

During the period of the study, 267 deaths occurred in the practice population. The death rate was 14.8 per 1,000 compared with a national average of around 12 per 1,000,² possibly a reflection of the high proportion of elderly patients in the population studied. The place of death for all cases is shown in Table 1. The long-stay units referred to were geriatric and psychogeriatric hospitals outside the practice area. The percentage of deaths occurring at home is in keeping with the national average of around 30 per cent,^{1,3} but it was felt that it would be a mistake to draw any conclusions about the provision of terminal care at home from this figure. If death was sudden, such as from cardiac arrest, terminal care was unnecessary. We found that 62 per cent of all deaths occurring at home required no terminal care and the true percentage of cases involving terminal care at home in the accepted sense was only 14 per cent. Table 2 shows the place of death of all patients who required terminal care, sudden deaths having been excluded.

The authors also looked into deaths from all forms of cancer, as these patients form a select group in which terminal care is invariably planned. The place of death for all cancer patients is shown in Table 3.

Table 1. Total deaths in Peebles district over the two-year period, classified according to place of death.

Place of death	Number	Percentage
Home	80	(30.0)
District general hospital	71	(26.6)
General practitioner hospital	70	(26.2)
Long-stay	31	(11.6)
Other hospitals	15	(5.6)
Total	267	(100)

© *Journal of the Royal College of General Practitioners*, 1984, 34, 331-333.

Table 2. Numbers of dying patients who received terminal care, classified according to place of death.

Place of death	Number	Percentage
District general hospital	71	(32.6)
General practitioner hospital	70	(32.1)
Home	31	(14.2)
Long-stay	31	(14.2)
Other hospitals	15	(6.9)
Total	218	(100)

Table 3. Deaths from neoplastic diseases, classified according to place of death.

Place of death	Number	Percentage
General practitioner hospital	26	(41.9)
District general hospital and other hospitals	20	(32.3)
Home	16	(25.8)
Long-stay	Nil	

Discussion

The importance of the general practitioner hospital in influencing the pattern of terminal care is clearly shown in this study. This facility enabled the general practitioners to look after nearly half of their patients to the end of their terminal illness.

In the particular cases of dying cancer patients, the general practitioners were able to provide terminal care for the great majority (68 per cent) of their cancer patients. Clearly, where general practitioners are able to carry out this proportion of terminal care, there is no reason, as Doyle has suggested,¹ for general practitioners to lose their expertise. The question arises: if there had been no general practitioner hospital, where would the 70 deaths that occurred there over the two-year period have taken place? The choice would have been between keeping these patients at home or admitting them to the district general hospital. In another study of terminal care in a community where no general practitioner hospital was available, only 10 per cent of terminally ill patients died at home.⁴ The figure in the present study was 14.2 per cent, suggesting that the amount of home-based terminal care was not reduced by using the general practitioner hospital. The obvious conclusion is that a large majority of the cases dealt with in the general practitioner hospital would otherwise have been admitted to the district general hospital. The availability of general practitioner beds for terminal care therefore relieves the district general hospital of not only a considerable workload but also the (often inappropriate) occupation of acute medical and surgical beds by terminally ill patients.

The relative merits of home and hospital-based terminal care have been discussed before and reservations

have been expressed about the adequacy and desirability of both.^{1,5,6} The hospices that have opened in various parts of the country have often set the highest standards in the quality of terminal care, but it is unlikely that hospices will ever be available to all terminally ill patients, particularly in the more rural areas. We agree with Kyle⁷ that the general practitioner hospital in certain areas may be the ideal setting in which to look after the terminally ill.

There was no attempt in this study to assess the quality of the terminal care. Even so, a local general practitioner hospital obviously offers many advantages: patients can still be looked after by their own general practitioner in their own community; relatives have easy and regular access, and without the additional burden of travelling to a district general hospital there is less likelihood of the loss of contact between patient and relatives that can occur in the terminal phase of an illness. Furthermore, the provision of nursing care is easier in a hospital setting than in the community and it means that the community nursing staff is relieved of a considerable workload (although, when called upon to provide domiciliary care in terminal cases, the community nursing services in the area are excellent).

Looking separately at all deaths from cancer, we noted that a smaller proportion occurred at home in this study than in another study⁵ (26 per cent compared with 40 per cent). It may be that where a choice exists between home and general practitioner hospital care, patients and their families will more readily accept admission than those in areas where the only alternative is a district general hospital. Often, it is difficult to decide when it is appropriate to discontinue terminal care at home and admit the patient to hospital. We have found it much easier to persuade overtaxed relatives to agree to the general practitioner hospital than to the more distant district general hospital. It would certainly appear from this study that, where the alternative of a general practitioner hospital exists, home-based terminal care for cancer patients is less prevalent. It may be that in other areas home-based terminal care is provided, not because it is ideal, but because there is no satisfactory alternative. The findings of Keane and colleagues⁶ tend to support this view.

The general practitioner hospital is an important and much-loved institution in many areas of the country. We have highlighted only one of the important roles it can play in the provision of medical care for a community, but one which we feel may be better provided in a general practitioner hospital than in any other setting.

References

1. Doyle D. Domiciliary terminal care. *Practitioner* 1980; **224**: 575-582.
2. Scottish Home and Health Department. *Scottish health statistics*. London: HMSO, 1981.
3. Ford GR, Pincherle G. Arrangements for terminal care in the National Health Service (especially those of cancer patients). *Health Trends* 1978; **10**: 73-76.

4. Reilly PM, Patten MP. Terminal care in the home. *J R Coll Gen Pract* 1981; 31: 531-537.
5. Parkes PM. Home or hospital? Terminal care as seen by surviving spouses. *J R Coll Gen Pract* 1978; 28: 19-30.
6. Kean WG, Gould JH, Millard PH. Death in practice. *J R Coll Gen Pract* 1983; 33: 347-351.
7. Kyle D. Terminal care. *J R Coll Gen Pract* 1971; 21: 382-386.

Acknowledgements

We thank the Registrar for the Tweeddale District, Mr Maher, for his assistance and Mrs E. N. Telfer, our practice manager, for typing the manuscript. We are also indebted to our colleagues, Drs Paton, Ramsay and McIntosh, for their cooperation in elucidating the circumstances of death in each case.

Address for correspondence

Dr D. R. Love, Hay Lodge, Health Centre, Neidpath Road, Peebles EH45 8BG.

The bronchodilator effects and pharmacokinetics of caffeine in asthma

A comparison was made of the bronchodilator effects and pharmacokinetics of orally administered caffeine (10 mg/kg body weight) and theophylline (5 mg/kg) in a double-blind, single-dose study in asthmatic patients 8-18 years of age. After 48 hours of withdrawal of all methylxanthines, 13 patients received caffeine and 10 received theophylline. Significant improvements in forced vital capacity, forced expiratory volume in one second, and forced expiratory flow rates occurred from one to six hours after administration of either caffeine or theophylline. The bronchodilator effect of caffeine did not differ significantly from that of theophylline and was maximal two hours after ingestion of each drug. Peak serum levels of caffeine (13.5 ± 2.9 mg/l) occurred at one hour, and peak levels of theophylline (8.4 ± 1.7 mg/l) at 2.2 ± 0.8 hours. The mean serum half-time for caffeine was 3.9 ± 1.4 hours and that for theophylline was 5.8 ± 1.7 hours. All patients receiving caffeine metabolized it to paraxanthine, theobromine, and theophylline. Mild, transient side effects were seen after both caffeine and theophylline. Vital signs did not change significantly after either drug. It was concluded that caffeine, a commonly available chemical, is an effective bronchodilator in young patients with asthma.

Source: Becker AB, Simons KJ, Gillespie CA, *et al.* The bronchodilator effects and pharmacokinetics of caffeine in asthma. *N Engl J Med* 1984; 310: 743-746.



COLLEGE ACCOMMODATION

Charges for college accommodation are reduced for fellows, members and associates. Members of overseas colleges are welcome when rooms are available, but pay the full rate. All charges for accommodation include a substantial breakfast and now include service and VAT.

Children aged 12 and over can be accommodated when accompanied by a parent. Accompanied children aged between six and 12 may be accommodated upon a trial basis, and arrangements can be made for young children to share a room with their parents at a reduced rate. Children over six may use the public rooms when accompanied by their parents. Younger children cannot be accommodated, and dogs are not allowed. Residents are asked to arrive before 21.00 to take up their reservations or, if possible, earlier.

The room charges per night are:

	Members	Full Rate
Single room	£16	£24
Double room	£30	£45
Penthouse (self-catering with kitchen)	£60	£90

Reception rooms are available for booking by outside organizations as well as by members. All hirings are subject to approval, and the charges include VAT and service. A surcharge may be made for weekend bookings.

	Members	Full Rate
Long room	£105	£210
John Hunt Room	£70	£140
Common room and terrace	£70	£140
Dining room	£35	£70

Enquiries should be addressed to: **The Accommodation Secretary, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU. Tel: 01-581 3232.**

Whenever possible, bookings should be made well in advance and in writing. Telephone bookings can be accepted only between 08.30 and 18.00 on Mondays to Fridays. Outside these hours, an Ansafone service is available.