with the routine work of general practice along with tutorials and wide reading will suffice, they are inevitably pressurized by membership courses, books and pamphlets (published to help pass the examination), plus the general air of concern among their fellow trainees.

It has taken some years to get vocational training generally recognized and the Joint Committee on Postgraduate Training for General Practice (JCPTGP) has laid down rules which in this region are applied fairly firmly. A trainee is not allowed to do less than one year in a training practice before becoming a principal, yet the pressure to study for and pass the examination tends to erode the last two or three months of the trainee year.

We appreciate the need for a certificate of satisfactory completion of vocational training which hopefully implies the attainment of a minimum standard, but would suggest that the College examination should not be taken until a minimum of six months to one year as a principal in general practice has been completed.

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Trainer/trainee workload

Sir,

As a trainer participating in their study, I was most interested to read the paper by N. Caine and colleagues (September *Journal,* pp. 419-422). It should be pointed out however, that most of the data were obtained in 1979 and this may affect the validity of the conclusions drawn.

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Part III — home, hotel or hospital?

Sir,

Having provided medical care for the majority of the residents of our local part III 'home' in Corsham, Wiltshire for 10 years, I have now carried out a survey of the physical, mental and social state of those living there at the beginning of this year. Fifty-three residents were assessed with an age range of 66 to 99 years. The average age of those entering the home is now 86 years.

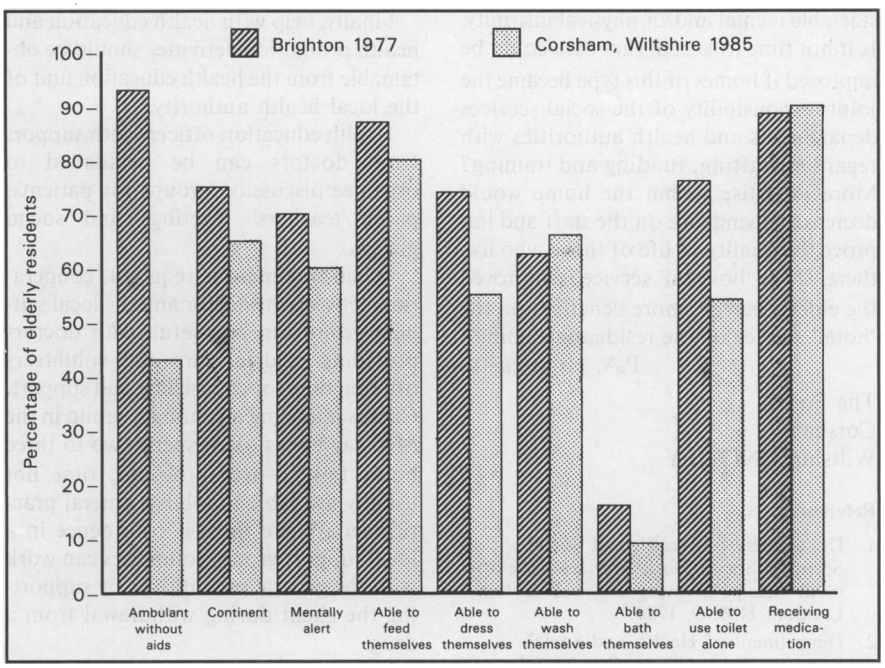

Figure 1. *The degree of dependence of elderly people in residential care (n = 53 for Corsham, Wiltshire).*

Forty-five different medical conditions were identified. The 10 most common were: arthritis (19), cardiac failure (12), senile confusion (11), defective vision (9), defective hearing (6), schizophrenia (5), depression (5), iron deficiency anaemia (5), hypertension (4) and vitamin B12 deficiency (4). In spite of a policy of regular review to reduce medication, 136 different oral drugs were being administered by the staff. The degree of dependence on the staff is shown in Figure 1 and the results of a similar survey carried out in Brighton in 1977 are also shown for comparison.[1]

Sixteen residents were mildly confused, 10 moderately so and five severely. This was a subjective assessment with no formal testing. The lack of both psychogeriatric beds and social services homes locally for the elderly mentally infirm means that our home must provide what help it can. It is no wonder that clear-headed residents find it distressing to live with those whose habits range from the mildly bizarre to the frankly disgusting.

The staff of part III homes are not required to have any health care training and few have had any formal training for the work. The work would not be undertaken by anyone who did not have a genuine caring attitude towards the elderly. However, the natural thing is for the staff to carry out tasks for partially disabled people rather than to encourage them to make the most of their residual faculties. When time is short and there are many tasks to be done, maximal help is the only answer in the short term, however counterproductive this may be in the long term.

With regard to transfer to hospital, our aim has been to apply the same criteria that would be used for a patient remaining at home if there was considerable family support. This includes terminal care if the last illness is not too prolonged. The Department of Health and Social Security guidelines for residential homes for the elderly[2] makes a distinction between professional health care and that which might be provided by a competent caring relative. If the former is required the health authority should provide it. If the latter is required, it is the responsibility of the social services department. But where is the dividing line? We know that unqualified people can learn complex skills — for example, the relative who gives home renal dialysis. The caring relative has to cope with only one patient suffering from a few conditions and taking a few drugs. The untrained staff at this home are expected to deal with over 50 residents with 45 different medical conditions and taking 136 different drugs. In addition they are expected to divide their time between the physical, mental and social needs of all in their care. Does this not suggest a need for professional expertise among the staff members rather than expecting them to call when necessary on the already overstretched domiciliary health care professionals?

As greater effort is made to keep the increasing elderly population in their homes, who are to be the part III home residents? It will be only those with con-

siderable mental and/or physical infirmity. Is it not time to accept that care could be improved if homes of this type became the joint responsibility of the social services departments and health authorities with regard to staffing, funding and training? More expertise within the home would decrease dependence on the staff and improve the quality of life of those who live there. If the 'hospital' service is improved the elderly can get more benefit from the 'hotel' service of the residential 'home'.

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The prevention of drug misuse

Sir,

Publicity about combatting the problem of drug misuse often implies that considerable resources are necessary. While this may be true for difficult cases, much can be done by general practitioners using few resources for those misusers wanting help.

First, there is the prevention of access to drugs and prescription record systems could alert general practitioners to the misuse of medicines. Several of the 92 clients attending a voluntary drug counselling and support service in the Medway towns area of Kent raided parents' and relatives' medicine chests for anxiolytic, antidepressant and analgesic drugs. One client bought 100 dipipanone tablets monthly from a patient who had had them prescribed for chronic pain.

Secondly, there is the provision of information about drug use. The display of the telephone number of a drug advice and support group and copies of the current Department of Health and Social Security publications — *Drug misuse, a basic briefing, What every parent should know about drugs, What parents can do about drugs,* and *What to do about glue sniffing* — left in the waiting room can provide help for patients too embarrassed or cautious to ask for help and advice outright.

Finally, help with health education and health promotion activities should be obtainable from the health education unit of the local health authority.

Health education officers with support from doctors can be persuaded to organize discussion groups for patients, parent/teachers' meetings and social groups.

When treatment is required, cooperation between the doctor and the local self-help group can be useful, with doctors providing medical care and volunteers offering time for counselling and support. Clients attending a voluntary group in the Medway towns often spend two to three hours talking over problems, time not usually available to a busy general practitioner. Where there is confidence in a local support group, volunteers can work with the general practitioner by supporting the client during withdrawal from a drug.

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An unusual presentation of childhood asthma

Sir,

Two prospective studies found the prevalence of itching associated with asthma attacks to be 41% and 70%, respectively.[1,2] The site of itching was usually constant in each patient, affecting the anterior part of the neck or upper back in most patients.

Case report. A.S. (date of birth: 20 June 1972) first consulted his doctor at the age of one year with respiratory symptoms. He consulted during the following nine years, on 14 further occasions, with a history of cough. Thirteen prescriptions were given at these 15 consultations: six were for antibiotics, four for antitussives and three for bronchodilators. At the age of 10 years and 10 months he presented complaining of 'tingling' in his back.

My patient has written a letter describing his symptoms:

> 'When I get a tingly back I sometimes become out of breath very quickly. When I get one I don't let anyone touch it or I don't sit against anything (like the back of a chair). As soon as I do get one I ask my mum to give me a 5 ml dose of Bricanyl syrup [Astra], which stops the tingly feeling and out of breathness. It feels like putting your hand against a television screen and getting all of the static off it. The tingly feeling only affects my back. The Bricanyl syrup takes one hour to work on my back.'

When he presented with the 'tingly back' he had rhonchi on auscultation, he demonstrated dermographism and his peak expiratory flow rate was 270 l min^{-1}. On direct questioning he admitted to exercise intolerance. A full blood count showed eosinophilia (12%) and a chest X-ray was normal. He was treated with sodium cromoglycate and terbutaline and two months later was able to exercise without getting breathless. His peak expiratory flow rate had increased to 340 l min^{-1} (25% increase), confirming the diagnosis of bronchial asthma.

Comment. Symptoms of asthma which are not typical can lead to a delay in diagnosis,[3] as demonstrated by this patient. The recognition of prodromal itching as a clinical sign in asthmatics may lead to an earlier diagnosis. It is unclear whether my patient's symptom was indeed relieved by terbutaline sulphate as he describes, or whether the itching resolves spontaneously — the reported duration of the symptom is from a momentary episode to 30 minutes or more.[1,2] The pathogenesis of this symptom remains unclear but its recognition has obvious implications for earlier diagnosis and treatment of asthma attacks.

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2. Orr AW. Prodromal itching in asthma. *J R Coll Gen Pract* 1979; **29:** 287-288.
3. Marks BE, Hillier VF. General practitioners' views on asthma in childhood. *Br Med J* 1983; **287:** 949-951.

Corrigendum

Spiritual healing in general practice

Dr G.W. Taylor, The Surgery, 53 Circuit Lane, Reading RG3 3AN, is a member of the Joint Working Party of the College and the Church's Council for Health and Healing. In his letter in the September *Journal* it was not made clear that he would like to have information from doctors who attend doctor/clergy *groups* or who have a member of the clergy or a spiritual counsellor attached to the practice.