Table 2. General practitioners' knowledge and use of techniques in terminal care ($n = 18$).

	No. of respondents		
	Know about and use	Do not know about	Know about but do not use
Subcutaneous diamorphine	9	–	9
Haloperidol as antiemetic	2	13	3
'Dioctyl' (Medo) to prevent intestinal obstruction	10	7	1
Prophylactic laxatives when opiate prescribed	12	6	–
Morphine for dyspnoea	10	6	2
High dose dexamethasone	7	2	9
Rectal diazepam	9	6	3
12-hourly morphine sulphate tablets Continus	18	–	–
Flowtron apparatus	2	14	2
Patient's drug chart	11	4	3

There is a place for general practitioners, especially those who are not trainers and therefore have little opportunity to teach or lecture, to be actively involved in the postgraduate education of their peer group. Course organizers and postgraduate tutors should make more use of the resource of knowledge and teaching skills among their local general practitioners; the preparation of a lecture is a challenge and becomes an education in itself for the presenter.

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References

1. Muir Gray JA. Continuing education: what techniques are effective? *Lancet* 1986; **2**: 447-448.
2. Rhodes P. Incompetence in medical practice. *Br Med J* 1986; **292**: 1293-1294.

'There's a lot of it about'

Sir,

Clinicians can understand more about their thinking processes from articles such as Dr A.S. Dixon's (October *Journal*, p.468) which reflects the extensive study of this topic in North America.

Why, indeed, do we regard the rapid problem-solving approach of family practice as 'cutting corners' compared with the exhaustive interviewing style we learned in medical school? I believe this is largely because of the sheer weight of our nineteenth-century inheritance both in theory and in method. We revere the physicians of that era, who, using living subjects, developed teaching hospitals as laboratories for the refinement of the concepts and classifications derived from morbid anatomy.[1,2] While we increasingly see the causes of ill-health as multifactorial, the belief in diseases as discrete entities dies hard. (So for instance, if we think of asthma in traditional terms as spasmodic wheezing, then this will impede effective treatment for the large number of 'atypical' cases.)

If classical clinical method arose from a taxonomy of disease increasingly ill-fitted to present problems then of course we must evolve a distinctive approach. Behavioural disciplines will be more useful than biomedical fields in refining our clinical reasoning, especially in incorporating patients' (as well as doctors') feelings, beliefs and values.[2-4]

Dr Dixon suggests several important functions for diagnostic labels. The patient may be helped to cope by giving 'a name for the illness', as Balint put it.[5] While some vagueness may be therapeutically helpful here, it has its limits. Cassell describes the deeper understanding made possible by understanding the precise meanings people attach to significant words in medical encounters.[6] Obviously phrases like 'there's a lot of it about', are unlikely to advance medical knowledge about disease, but even here ordinary language may help. After all, a generation ago doctors clarified their understanding of chronic bronchitis through a definition using everyday words.[6] Is there any important lesson here for developing more meaningful clinical research in primary care?

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References

1. Foucault M. *The birth of the clinic: an archaeology of medical perception.* London: Tavistock, 1973.
2. McWhinney IR. Patient-centred and doctor-centred models of clinical decision making. In: Sheldon MG, Brocke J, Rector A (eds). *Decision making in general practice.* Basingstoke: Macmillan, 1985.
3. Levenstein JM, McCracken EC, McWhinney IR, *et al.* The patient-centred clinical method. I. A model for the doctor – patient interaction in family medicine. *Family Practice* 1986; **3**: 24-30.
4. Pendleton D, Schofield T, Tate P, Havelock P. *The consultation: an approach to learning and teaching.* Oxford University Press, 1984.
5. Balint M. *The doctor, his patient, and the illness* (2nd edn). London: Tavistock, 1964.
6. Cassell EJ. *Talking with patients. Volume 1: The theory of doctor–patient communication. Volume 2: Clinical technique.* Cambridge Mass: MST, 1985.

Nursing homes

Sir,

As someone who is actively involved in the registration and inspection of nursing homes under the 1984 Act I was interested to read the detailed review of the situation in North Wales by Humphreys and Kassab (November *Journal*, p.500).

The mushrooming of nursing homes presents large problems for those of us who are involved in the planning and development of services for the elderly. The siting of a nursing home is based purely on the wish of an individual to develop a nursing home, subject to fulfilment of planning authority and health authority requirements. It is my experience that most nursing home owners are not altruists but in it for the money.

It is therefore a regrettable fact of life that the care of our old people is subjected to a market economy, and thus vulnerable to changes in market forces. To obtain inpatient residential care in a private institution all that is necessary is the wherewithal to pay the fee. There is no assessment of need or of the suitability of the placing. Very often the choice of home is made by a relative.

The worrying aspect of this of course is that it is conceivable that more old people than necessary are entering institutions. It is ironical that the government is pursuing a rigorous community care policy in the areas of mental illness and mental handicap and at the same time employing policies which encourage institutionalization of the elderly. Furthermore, one does not have