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.

ILORA G. FINLAY

19 The Cathedral Green
Llandaff
Cardiff CF5 2EB

ROSEMARY BOOTH

Maryhill Health Centre
Glasgow G20 9DR

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'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?

J.F. WILMOT

16 Clarendon Street
Leamington Spa
Warwickshire CV32 5SS

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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

to be particularly foresighted to imagine the problems which the health service could face if it became unprofitable for individuals to be involved in the nursing home business.

Health authorities are faced with the problem that the provisions contained within the Registered Homes Act 1984 are inadequate for dealing with unsatisfactory homes. It is becoming increasingly difficult for health authorities to seriously suggest closing any homes, as where could 50 or so elderly patients be housed immediately if a nursing home were to close?

I would wholeheartedly concur with Humphreys and Kassab's criticism of the lack of occupational therapy, physiotherapy or any sort of rehabilitation programme in homes. Correcting this must be seen as an urgent priority for those involved in preparing local guidelines.

I would like to see more general practitioners informing local health authorities about the homes they regard as deficient and being much more closely consulted about the opening of new homes and in the monitoring procedures.

It must be clearly stated, however, the government cannot solely rely on market forces — more effective legislation is required in the area of nursing homes as a matter of urgency.

JOHN WILKINSON

District Headquarters
Cross O'Cliff Court
Bracebridge Heath
Lincoln LN4 2HL

MRCGP candidates and the elderly

Sir,

In reply to Dr Thompson's letter (November *Journal*, p.524) expressing his concern about the low proportion of patients aged over 75 years listed in the log diaries of the MRCGP candidates, and the implication that trainees have inadequate experience of health care of the elderly, might I suggest an alternative explanation for his observations — that the log diary requirements are not conducive to the selection of elderly patients.

Candidates are required to submit a diary of 50 consecutive patients seen in practice. The proportion of patients aged over 75 years in an average practice is 5.2%.[1] An audit of my own practice, conducted last February, showed that while patients aged over 75 years accounted for 4.6% of all patient registrations, they provided only 2.9% of all surgery attendances but 39% of all home visits (17% of out-of-hour visits). Overall, they formed 7.1% of all patient–doctor encounters. This approximates to the 7.4% of patients aged over 75 years included in the log diaries quoted by Dr Thompson and suggests that these diaries accurately reflect the patient numbers seen in practice but probably underestimate the time spent on their care. As the work profile per general practitioner includes 30 to 40 daily surgery consultations and two to five home visits[1] candidates will have difficulty increasing the proportion of elderly patients in their log diaries without recruiting additional patients from this age group.

If the examiners consider that health care of the elderly is accorded too low a priority in the MRCGP examination, I suggest restructuring the log diary requirements to include a higher proportion of either home visits or patients aged over 75 years. This would give candidates the opportunity to display the skills needed in providing a good standard of care for this important section of the community.

HELEN J. GRAHAM

1 Forest Hill Road
Honor Oak
London SE22 0SQ

Reference

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Role models: influence and change

Sir,

In their study on ways of influencing the behaviour of general practitioners (November *Journal*, p.517), Horder and colleagues note particular difficulties with attempts to change the behaviour of general practitioners over 40 years of age. One particular influence noted in the paper is the 'personal contact with a prestigious and committed teacher'. This is qualified by the comment that 'the learner must be convinced about the reason why change is needed'. One approach to studying this phenomenon of change in a doctor's behaviour is to consider a particular group of doctors.

Trainee general practitioners undergo degrees of change as part of the transition from being a hospital doctor to becoming a general practitioner. There are a number of strategies for bringing about change in the professional role of trainees. Change can be achieved through identifying with and modelling on a particular role model, or learning from and identifying with peers through a group. In understanding the process of change in trainee general practitioners, we are concerned with the former strategy: that is, how trainees react to their trainer's style of doctoring, whether they see him or her as a role model, either selectively or as a whole, or whether they in fact see their trainer as a negative role model, causing them to use their own resources for adopting new professional roles. Trainers too vary in their capacity to provide a role model. Undoubtedly, not only conscious but unconscious role modelling takes place in a medical practice and this involves both positive and negative characteristics of the role model. Both aspects of role models influence trainees' new professional roles as general practitioners.

Thus the process by which a new role is adopted consists of more than the exposure to new surroundings. The trainee must also gain insight into the norms of behaviour associated with that role. When trainees enter general practice one of the requirements is for them to acquire a new kind of relationship with the patients. This will usually involve a deconditioning of some attitudes and styles of doctoring acquired and internalized in hospital medicine. One sphere where trainees might be significantly influenced by their trainer's style of doctoring and where hospital medicine does not provide a satisfactory model is the handling of their patients' emotional anxieties. Furthermore, as trainees need to develop a new knowledge base, skills and attitudes relevant to their new professional roles as general practitioners, role models may be of value in influencing and bringing about this change in trainees' modes of behaviour.

RUTH SHAW

21 Hogarth Hill
London NW11

International affairs advisory group

Sir,

The College has recently set up an International Affairs Advisory Group which has the responsibility of identifying priorities for the College and advising General Purposes Committee and Council.