abroad (MASTA) with the object of establishing a national network of British Airways travel clinics. Each clinic is able to offer a full range of advice. There is also a retail service for medical accessories for the travellers. The clinics are directly linked by computer to the London School of Hygiene and Tropical Medicine and up to the minute information is therefore available concerning vaccinations and health information in all parts of the world.

Patients may obtain the address and telephone number of the nearest clinic by ringing 01-831 5333. Telephone advice is not available and patients should make an appointment at their nearest clinic.

CAMERON LOCKIE

Green Lane, Alveston
Stratford upon Avon CV37 7QD

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Palliative care: home or hospice?

Sir,
In her editorial (January *Journal,* p.2) Finlay looked at the emergence of palliative medicine as a specialty and how best the profession should prepare doctors entering the field. She placed the emphasis on experience in general practice, where the hospice is seen to provide 'a bridge between community and hospital'. I would like to comment not on the training, but on the general issues concerning the evolution of a specialty which should enable multidisciplinary care in the community to be led by the doctor who is in an ideal situation to do so — the general practitioner.

For too long death has been 'medicalized', doctors having taken over what was the job of clergymen in Victorian times, thus largely protecting the public from death. When caring for the dying we can become engrossed in the science of symptom control, neglecting the other essential factors necessary for good care, particularly communication. Failure here reveals our inadequacy in the face of death and without an open and honest approach the patient is sent away from home where he may prefer to be if he knew what was wrong and what prognosis he had. Unnecessary hospital admissions, which drain hospital beds, could be avoided with benefit to the patients and to their quality of life. It is the general practitioner who usually knows the patient and his family best and therefore is likely to have the best rapport with them. He should use this to his advantage, reversing the trend for death to be hidden in hospitals, and helping death to be once again a 'family affair'.

General practitioners should not be perturbed by the evolution of this new specialty, but stimulated to fulfil their role as family doctors from birth to death, allowing their patients to die peacefully and with dignity, without hospice care unless it is required.

The aim of developing palliative care then should be not so much to encourage an increase in the number of hospices, as to promote a specialty enabling community care by the general practitioner at home. The essence of the problem is not so much the need for a specialist with a place where he can care for the dying but coordination of a multidisciplinary team[2] with the general practitioner as leader.

It is important that the new specialty aims to improve general practitioner care for dying patients at home through research and education, thus attempting to avoid care in an institution. This does not mean that there needs to be evidence of certified experience for general practitioners in the field or the gaining of yet another diploma; but recognition that, as Pugsley describes,[3] there are many who can advise the general practitioner in this role, but none who can perform the task better or with a greater insight into the patient and his family.

The hospice movement is of course essential and to be highly commended. Its main role should be advisory, for education and research and to help in the management of difficult cases.

RODGER C. CHARLTON

Criffel
Dalbury Lees
Derbyshire DE6 5BE

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GPs should not counsel long-term

Sir,
As a general practitioner who is also a trained counsellor, I was most interested by Rowland and colleagues' discussion paper (March *Journal,* p.118).

I have recently been reviewing my work as a general practitioner in the context of the doctor–patient relationship and the client–counsellor relationship and have concluded that it is both difficult and inappropriate for a general practitioner to have a long-term counselling relationship with a patient. Seeing someone for more than one or two counselling sessions outside normal surgery hours fundamentally alters the doctor–patient relationship and it may not be possible for the patient to allow the general practitioner counsellor to continue in the general practitioner role. This conclusion is supported by Kelleher[1] who feels that the general practitioner counsellor may overstep the boundaries of the doctor–patient relationship and confuse the patient.

My answer to the question 'Can general practitioners counsel?' is in two parts. First, counselling skills are an essential tool in the repertoire of all general practitioners for routine work and for short term counselling interventions. These skills need to be taught to doctors at all levels in their training, particularly in the light of the suggestion that 'prescribing anxiolytic drugs (is) no more effective than brief counselling by the general practitioner in treating new episodes of minor affective disorder'.[2] Secondly, longer term counselling is best undertaken with clear personal boundaries in a confidential and anonymous relationship by a 'secure frame'[1] counsellor who lives away from the locality, is not involved in a long term (often literally a lifetime) relationship with the client and who does not allow the counselling process to be compromised by any other relationship.

S.H. COCKSEDGE

The Health Centre
Chapel-en-le-Frith
Derbyshire SK12 6LT

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Importance of legible prescriptions

Sir,
The serious consequences of negligently writing medical prescriptions have been re-emphasized by the court of appeal in the recent case of Prendergast versus Sam and Dee Limited and others. Dr Stuart Miller had written a prescription for Mr