

vaginal swab and that the smear should be repeated in six months.

The main issue in this debate appears to be whether all patients with an inflammatory smear should have a colposcopy, as some authors have suggested.² This would be very time consuming and costly to the NHS and our results and those of Kelly and Black suggest that this would not be of much benefit at this stage, although repeating the smears of those with inflammatory changes at more frequent intervals may be more appropriate.

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Postcoital contraception

Sir,

In their article on postcoital contraception (August *Journal*, p.326) Burton and Savage conclude that emergency contraception must be better promoted if the abortion rate is to be reduced. Although this sounds logical, they do not cite the evidence by which they reached this conclusion. I wonder if this is one of those situations where the assumed logic is not in fact supported by the epidemiological evidence.

Are we being wise in pushing forward an ever greater range of contraceptive options? The range and availability of contraception has considerably increased in the last two decades. The abortion rate has also increased. Paradoxically, could it be that increasing contraceptive availability is causally linked with increased demand for induced abortion?

Surely much more research is required before reaching the conclusions which Burton and Savage have drawn.

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Terminal care at home

Sir,

Dr Herd's paper describing terminal care in West Cumbria (June *Journal*, p.248) illustrates that good terminal care may be provided at home in a semi-rural area without the support of an inpatient hospice type facility. His figure of 53% of people with cancer being able to die at home is encouraging.

A review of the literature of the last 10 years or so indicates an increase in the percentage of patients able to remain at home until their death, cared for by various types of home care team. In 1978, Doyle¹ at St Columba's Hospice in Edinburgh, found that 28% of patients receiving home care died at home. By 1980 this figure had increased to 41%. In 1979 the team from St Joseph's Hospice, London cared for 50% of their patients at home until their death.² In 1988 this figure was 61%.³ Rees⁴ from St Mary's Hospice in Birmingham found that 30% of patients receiving home care died at home in 1981 and was able to report a rise to 55% in 1986. The North London hospice home care service, without the backup of a hospice inpatient unit, reported that in 1985 they cared for 58% of their patients at home until they died.⁵ In 1989 the Tunbridge Wells hospice at home service was able to care for 71% of its patients at home until their death (unpublished results). Similar figures are also quoted in other countries. The South Auckland hospice in New Zealand cared for 59% of patients at home until death (unpublished results), and in Bologna, Italy, 60% of patients die at home.⁶

Ward⁷ points out that when a home care service operates from a hospice, fewer patients remain at home until their death than when a free-standing home care service is in operation (29% versus 65%). Similar figures are given in the American national hospice study (27% versus 62%).⁸ Although this does not apply to the hospice based services described above,^{1,4} it would seem that sometimes the readiness with which a patient is admitted may be related to the ease of access to a hospice bed. Dunphy and Amesbury³ looked at the reasons why patients receiving home care were admitted and found that most required more nursing than could be provided at home by family and professional carers. This is similar to the findings of Dr Herd.

The increase in the proportion of patients able to remain at home until their death has come about through a better understanding of the services required by patients and an increased ability of the caring teams to provide them. Co-operation between general practitioners, community nurses and hospice teams can lead to an increase in the number of patients cared for at home, while technological advancements such as the delivery of drugs by syringe driver have led to improved symptom control.

It may be that 60-70% of people able to remain at home until their deaths is the maximum that we can achieve with the resources currently available. An increase

to the 70-80% suggested by Dr Herd would be a marvellous achievement and may be aided by the use of volunteers, Marie Curie nurses and so on.

Cost comparisons between inpatient care and home care are complex because of the large numbers of different groups involved. In Australia Gray and colleagues⁹ have shown that home care with 24 hour nursing and medical cover is no more expensive than hospital care. However, it may be that it is the perceived cost of such 24 hour cover that limits the achievement of a high percentage of people dying at home.

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Surveillance of the over 75s

Sir,

I work as a busy general practitioner in a deprived area with stretched social services and nursing staff. I doubt whether my practice could find a nurse auxiliary to complete the home assessments of over 75 year old patients required by the new contract¹ as suggested by Dr Wallace in his editorial (July *Journal*, p.267).

When our practice nurse makes her yearly visit to elderly patients she ascertains what carers are available. She makes a shrewd assessment of the state of the house, she asks the patient if they have difficulty reading a newspaper and if they are a car driver asks them to read a number plate. She usually notices if the patient cannot hear her and has an auroscope to identify wax in the ear. She makes discreet enquiries into the state of the patient's bowels and bladder. Many of our elderly patients are too busy to endure a full mental assessment and a chat about

what they perceive to be their problems will reveal that many are still mentally and physically able. The whole interview takes at maximum half an hour with additional time for record keeping and referral to other agencies. A yearly review of all medication is performed by the patients' general practitioner.

Recent studies from Andover² have shown increased hospital admissions and inappropriate referrals when untrained volunteers are used to visit the elderly. My interpretation of the new contract is that intensive surveillance is not required or desired and a practical, caring and above all commonsense approach should be taken.

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Management of myocardial infarction in the community

Sir,

The paper by Liddell and colleagues concerning the management of suspected myocardial infarction in the community (*August Journal*, p.318) highlights the general lack of commitment to and poor training in cardiac life support in the UK.

The resuscitation of patients by any means should be the responsibility of all health care providers from paramedic to doctor. I have now worked in an American environment for a year and I am impressed by their determined approach to this problem and by their training methods.

All American doctors are taught advanced cardiac life support at medical school and must pass a test demonstrating their ability before they can proceed to an internship (house job). Those continuing to work in hospital or high risk primary care must retake the test every two years. However, the advanced cardiac life support course is open to all medical staff; it teaches intubation, diagnosis of arrhythmias, defibrillation and the use of drugs to a fixed protocol. All trained members are expected to use all these techniques until further trained help is available. I believe the setting up of a similar system in the UK would be of great benefit, both in general and community hospitals.

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Medical sickness certification

Sir,

Dr Murfin's editorial on medical sickness certification (*August Journal*, p.313) is very topical. I feel that this certification should not be part of general practice. It is an open secret that certificates are given virtually on demand, though officially nobody will admit it. Anyone who wants or demands a certificate can have one from an obliging general practitioner. If it is refused the patient can demand a home visit, followed by a certificate.

I feel that there should be no difference between payment of sickness benefit and unemployment benefit. Everyone in the UK needs money for food and I cannot imagine that sick people eat more than unemployed people. If medical sickness certification were abolished then people would either be sick or unemployed, and all would get the same benefit. This would save the millions of pounds which are spent processing medical certificates and would also reduce the workload at the surgery.

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Debate on euthanasia

Sir,

Dr Bliss's paper on voluntary euthanasia (*March Journal*, p.117) has, as intended, provoked lively discussion. Ethics and religion can be interpreted subjectively and each of us is free to decide on our own particular case. I have no wish to be remembered by my nearest and dearest as a demented incontinent bereft of dignity and utterly dependent on others. Hence I am in favour of the 'living will', a legal document in which people can specify how they wish to be treated if terminally ill. However, I feel that there should be a yardstick to guide the individuals making the will and those who will be involved in implementing their decision, particularly the family and the doctor. The Barthel scale¹ for assessing disability after acute stroke could form the basis of such a scale with additional parameters for factors such as cognitive function. Statement of the individual's wishes by way of a living will made well in advance is highly desirable, and the concept should be widely publicized. In the absence of a living will, however, the relatives should be allowed to express what they consider would be the wishes of the individual concerned. In the latter circumstances, close scrutiny of all aspects of the case should be made, taking into account the possibi-

ty of selfish motives on the part of the relatives, but with the main focus on the medical aspects of the case. On the other hand, families should not be allowed to veto testators' wishes if the criteria they have laid down are reasonable. It is important that the testator should be made aware that the conditions under which they state that euthanasia should be performed must be responsible ones otherwise there might be risk of contention by the family and the doctor.

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Reference

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Vocational training: the meaning of 'satisfactory completion'

Sir,

The development of vocational training has been seriously hampered by persistent doubts about the meaning of the statement of 'satisfactory completion' which trainees are asked to provide as part of the procedure of attaining Joint Committee on Postgraduate Training for General Practice certification. Some people have interpreted the term as indicating attendance at a programme of training, others as a statement reflecting a trainee's level of performance.

Recently the Joint Committee invited the Royal College of General Practitioners and the General Medical Services Committee to help end the ambiguity. The purpose of this letter is therefore to state, in straightforward terms, that the three bodies concerned with standards in general practice regard 'satisfactory completion' as indicating that, in the view of the person signing, the trainee has achieved a satisfactory level of competence in the field of medicine to which the statement relates.

Given this, it will be possible in future to assure the public that the certificates of prescribed or equivalent experience issued by the Joint Committee do indeed indicate that doctors completing vocational training for general practice in the UK have achieved a satisfactory standard of competence and performance.

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