

Homoeopaths have been reported as being against orthodox immunization<sup>1</sup> and advocating homoeopathic immunization<sup>2</sup> for which no evidence of effectiveness exists.<sup>3</sup> As yet there has been no attempt in the United Kingdom to monitor homoeopaths' attitudes in this respect. The above findings imply that there may be a problem.

The British homoeopathic doctors' organization (the Faculty of Homoeopathy) has distanced itself from the polemic of other homoeopaths against orthodox immunization, and editorials in the *British Homoeopathic Journal* call the abandonment of mass immunization 'criminally irresponsible'<sup>3</sup> and 'most unfortunate, in that it will be seen by most people as irresponsible and poorly based'.<sup>4</sup> Homoeopathic remedies may be safe, but do all homoeopaths merit this attribute?

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## Cancer patients' place of death

Sir,

I was interested to read the study by Seamark and colleagues (*July Journal*, p.359) examining general practitioners' and hospital doctors' views of the appropriate place of death for cancer patients. It raised many important issues that surround the management of patients with terminal cancer. Unfortunately, it failed to address the complexity of palliative care that can necessitate cancer deaths occurring in particular locations.

The appropriate place of death remains the subjective decision of the patient, possibly in light of medical advice and social circumstances. It is never an objective decision to be made by medical staff. Therefore this study of doctors' opinions has doubtful significance. The method

used in the study also has to be questioned. In asking doctors to self-appraise retrospectively their patient management, especially with regard to such an emotive issue, the study is open to marked bias, be it covert or overt. Such reporting is not sufficiently objective to lend itself to the statistical analysis used in the paper.

The studies quoted by Seamark and colleagues, showing that more than three quarters of cancer patients expressing a preference wished to die at home or in a hospice<sup>1,2</sup> and that over half die in hospital,<sup>3</sup> could mislead as they confer too simplistic a view. A more recent prospective study of the preferred place of death of cancer patients referred to home care shows that as patients deteriorate in their final months, many change their minds and no longer want to die at home (from around 75% of patients to about 50% in the last week before death).<sup>4</sup> This shows that there may not even be a perceived problem of inappropriately placed cancer deaths, as only a small percentage of cancer patients did not die in the preferred location they expressed in their last week.

Equally the hospital admission of patients who subsequently die away from home, even though appearing to be against their expressed wishes, should not necessarily be seen as inappropriate. This decision would have had to be made without the firm knowledge that death would be the outcome and has to reflect many changing factors, with each patient's individual needs having to be assessed at that particular time. For example: the patient's wish for continuing treatment or investigation despite his or her poor condition; the need to obtain satisfactory symptom relief via interventional methods, such as tapping ascites; the lack or inability of social support to cope at home; the lack of community care resources to manage patients at home; insufficient domiciliary palliative medicine input; limited availability of beds at hospices or community hospitals; and the need to exclude or treat possible reversible pathology.

Even in the hospice setting, predicting death can prove surprisingly difficult and therefore such predictions should not be expected of doctors to ensure an appropriate place of death for their patients. Similarly, once a patient has been admitted to hospital for appropriate reasons, it may not be appropriate to pursue discharge home or transfer to a hospice, even though death may have become imminent, again for the reasons given above, or perhaps if the patient has become too ill to move. Fortunately, hospital-based palliative care services are now rapidly expanding to provide excellent symptom control, with certain additional practical benefits

that hospitals can offer (the flexibility of a large number of beds; access to other specialist opinions and diagnostic services; 24-hour nursing and medical cover by staff to whom the patient may already be known; appropriate medical notes on site; and it may be nearer for visitors than hospice facilities).

Palliative medicine is patient centred and, as such, conforms poorly to generalizations. It is essential to remember that patients, their diseases and their circumstances are different and patients are entitled to individual attention. There is no fixed ideal or an appropriate place of death for any cancer patient; rather the aim should be a holistic approach considering all the patient factors at any given time, including whether death may be imminent, in order to take the appropriate action.

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Sir,

Dr Gannon's letter raises points regarding our research paper (*July Journal*, p.359) that require a response. It may well be that doctors' opinions on the appropriate place of death of their cancer patients can never be objective, but the reality is that doctors have an important influence on the final place of death of their patients. Our paper analysing the place of death of cancer patients whose general practitioners had access to community hospital beds showed that fewer patients died at home or in a district general hospital compared with patients whose general practitioners did not have access to community hospital beds.<sup>1</sup>

It is generally acknowledged that obtaining cancer patients' views on their care is a difficult task and that their expressed preferences may change with time. However, there is evidence that proxy opinions carry some credence and that the view of the medical carer, rather than that

of the relatives, may correlate with the patient's views more closely.<sup>2</sup> It would seem reasonable in a retrospective study, such as the study we undertook, to ask the opinion of those clinicians intimately involved in the final stages of their patients' care. Indeed the study reported in the July *Journal* found that in settings outside the specialist services unit the place of death was viewed as appropriate in over 90% of cases and even in the specialist services unit up to eight in 10 terminally ill cancer patients were thought to have died in an appropriate place.

A holistic approach to death and dying is indeed desirable but such an approach requires a degree of choice. At the time of the study there was no specialist palliative care support or nearby hospice facility for the inpatients of the specialist services unit. The clinicians strongly indicated that their management of terminally ill patients would have been altered had there been a nearby city-based hospice. This has since been shown to be the case with the opening of the Exeter and district hospice in 1992 on the same campus as the specialist services unit. Over the past two years there has been a decrease in specialist services unit cancer deaths for patients whose general practitioners do not have community hospital access, with the new hospice accounting for the difference observed (unpublished data). We would maintain that for a substantial group of terminally ill cancer patients, death in settings other than a busy acute specialist unit is more appropriate.

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## Videotaped consultations

Sir,  
In their letter (August *Journal*, p.443) Bain and MacKay raise two issues about

videorecording consultations: informed consent and the effect of videorecording on patients who give consent.

We, along with the General Medical Council, believe that patients are entitled to take part in research or in the assessment of doctors if they have given appropriate informed consent. In our research using videotaped consultations in the summative assessment of registrars (trainees), we endeavoured to avoid coercion of patients by using the guidelines produced by the GMC.<sup>1</sup> Before these guidelines were introduced, a consent form was used that had been approved by the Joint Committee on Postgraduate Training for General Practice.

Bain and MacKay's apparent view that patients are not capable of making decisions and have to be protected from themselves is somewhat patronizing. Bain and MacKay cite Servant and Matheson in support of their arguments.<sup>2</sup> In this study patients were not invited to take part in videorecording but were invited to put themselves forward if they would like to be videorecorded. Therefore the response rate of 10% relates to those patients who took the trouble to present themselves as volunteers. The proportion of patients who did not care one way or the other (in our view the majority) are included in the 90% claimed to reject the use of videotaped consultations. To suggest that this study produced a consent rate of 10% is not true; no-one can consent to something unless they have been asked. These points were all made in subsequent correspondence published in the *Journal*.<sup>3-6</sup>

Bain and MacKay quote Herzmark approvingly.<sup>7</sup> We agree entirely with Herzmark that more patients will refuse consent if given plenty of opportunity and accept that this opportunity should be given. However, we think it a pity that Bain and MacKay have selectively quoted Herzmark. May we redress the balance by quoting the following from the same paper: 'no overall effect of filming was discovered when patients rated their stress after the consultation, rapport with the doctor or other aspects of the consultation'.<sup>7</sup>

Bain and MacKay cite a study in which they asked patients to speculate on how they thought they might feel if asked to be videotaped.<sup>8</sup> While speculation may be interesting, speculation is what it remains. This work was carried out in four practices, one of which had a view on the use of videorecording in training at variance with the Joint Committee on Postgraduate Training for General Practice and all training regions in the United Kingdom. Bain and MacKay's study avoided giving the patients any explanation as to why video-

recording was being contemplated. They state that this was to avoid bias, but in fact asking people to agree to something without giving them an explanation produces bias.

We have recently published a paper in which we measured the effect of videotaping on patient satisfaction with consultations.<sup>9</sup> It was demonstrated that patient satisfaction was not affected by the presence of the videocamera. If patients had felt uncomfortable or coerced their satisfaction with the consultation would have been diminished.

Throughout the development of summative assessment we have tried to act in the best interests of patients and registrars. The purpose of summative assessment is to protect patients from doctors who are not yet competent. Our work will always place patients foremost in our considerations.

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Sir,  
Bain and MacKay (letter, August *Journal*, p.443) suggest that Southgate's<sup>1</sup> guidelines for videorecording general practice consultations may provide patients with