

in some cases a lot of persuasion was necessary to get the patient to agree to follow-up and treatment.'

Diabetes is a lifelong illness with a significant morbidity and mortality. Most patients will have preconceived ideas about such a diagnosis, and to lay the responsibility of screening for this on them by means of a postal test is an unjustified abrogation of responsibility.

As in any screening, be it cervical smears, blood pressure, or mammography, most patients' expectation is that the test will be normal. Unlike those symptomatic patients who attend our surgeries, they have not considered the possibility of some pathology being found. If then, the patient gets a positive home dipstick result, are they not likely to be upset, fearful, and anxious? While it is easy to say that these fears are unfounded or allayed by offering a contact number, perhaps those patients who were reluctant to cooperate in this study were struggling with their new found 'pathology'.

Although the authors have outlined a cheap screening method, I am not satisfied that the pitfalls and potential harm justify the saving, nor indeed is it clear to me that, although the majority of patients found it acceptable (i.e. those reassured by a negative test), this applied to those for whom the result was positive.

There is no substitute for a face-to-face discussion on the implications and significance of a test (however simple to perform) that could have such profound and lifelong consequences.

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Death and the general practitioner

Sir,

I note the comments made by Jeremy Brown in the International digest section (June *Journal*)¹ about the expectations of the family practitioner by relatives of deceased patients.²

I recently had the good fortune to visit the department that produced this paper, which is a residency programme in central Ohio run by an experienced group of family practitioners. The authors were principally residents at the department and the

director of the Department of Family Practice. Jeremy Brown makes some pertinent comments about the differences between American and British general practice on this particular issue.

While I was present at the residency programme, we discussed the role of the GP dealing with death and the dying patient and home visits. All of the American family physicians I spoke to were astonished that British GPs tend to visit the bereaved relative as a routine courtesy. This was only one of a number of variations between the way we practice in the UK and the way our colleagues practise in the USA.

I would agree that the questions in the paper were devised by the authors and reflected their expectations; the results, pleasingly for the authors, confirmed these expectations. Looking at any one area of US family practice and comparing with British general practice, the gulf is massive; this paper is only one of many that highlight the differences in clinical behaviour, attitudes, and relationship with the patients. This came as a great surprise to me and emphasized the unique doctor-patient relationships that exist in the UK.

I would disagree somewhat with Jeremy Brown's assumption that all American doctors are extraordinarily reluctant to visit patients' homes, although I did note the increasing pressure to visit only with the approval of the HMO (Health Maintenance Organization), which is the Insurance Company that approves the need for a visit in the first place.

I suspect there are a great many things that can be learned from the experiences of doctors visiting America and vice versa that would enhance the quality and content of general practice, but it is particularly exciting to be given the opportunity to see this at first hand and be able to comment on these issues.

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Sir,

There has been a recent flurry of literature that appears to convey a message that the primary health care team is no longer perceived as being sufficiently competent to

undertake the care of the dying.^{1,2,3} This message was first delivered in this context in 1984 by Smith, then deputy editor of the *British Medical Journal*, when he stated that 'the era of well-intentioned amateurism is to be succeeded by hard-headed professionalism.'⁴

An extended role for specialist palliative care has been proposed again this year,¹ and it certainly has its place. However, no mention is made of the role already undertaken by the primary health care team and the extent to which palliative care is successfully implemented with cancer patients in the community. Furthermore, an increased need for specialist palliative care of non-cancer patients has also been postulated.¹ This is despite that fact that a large number of patients with non-cancer diagnoses are already given palliative care within the community by doctors with whom they have built therapeutic relationships over many years.

Is there evidence of a deficiency in the quality of care currently received in the community by both cancer and non-cancer patients that would warrant specialist referral? This needs to be verified before such proposals concerning the transfer of care are made, which may lead to a potential disintegration of the continuity of care provided by the primary health care team and its highly personalized approach in favour of the specialist.

Care of the dying is central to the work of the primary health care team. There is a role for the specialist, but it is the primary care generalist or 'gatekeeper' who should decide when this is appropriate. Furthermore, dying is a natural process, and the involvement of a specialist, who may be viewed as a symptomatologist, has the potential to further medicalize the situation.⁵

It is just over a decade since a palliative care specialist poignantly reiterated in this journal the role of the generalist in this important facet of primary care when he stated, 'Perhaps we should remind ourselves that it is better to help a colleague with a difficult case than to tell him he is wrong and that he should make way for the expert.'⁶

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