in 1991–92. Similarly, Jones *et al* showed that only 25% of 332 children admitted to hospital with asthma over a 12-month period had been nebulized with a beta-agonist before admission.[17] As spacer devices have also been shown to be much less expensive, is this then the death knell of the nebulizer?

On the evidence we have there is little to show that nebulizers are any better than spacer devices. Nebulizers are more cumbersome and certainly more costly but their use is still advocated in acute asthma in children, in the elderly, and in patients with COPD. This is largely on the grounds that spacer devices present patients with practical difficulties in their use. If these difficulties are the only perceived barriers in the spacer versus nebulizer debate, then there is a need to develop and evaluate different delivery systems that can effectively deliver inhaled medication in a way that is acceptable to both patients and doctors. If this can be achieved then it is possible that, at least in asthma care, we are likely to see the redundancy of the nebulizer.

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Caring for others: consider the emotional issues

THE past 30 years in general practice have seen remarkable changes in the diagnostic and management capabilities of general practitioners, many of them due to the rapid technical and scientific developments that have taken place. This has led to changes in the content of their work and their ability to take on functions that were formerly the prerogative of hospital practitioners. Patients' expectations have been fuelled by the high profile given to medical items in the media, by the *Patient's charter*, and by relatively easy access to information sources such as self-help groups and the Internet.

General practice 'training' can no longer be seen as a completed episode in the life of a registrar, but more as part of a continuum that takes place alongside the evolution of general practice and changes in the community throughout one's whole career. Continuing professional development is a priority for all doctors. One of the main aims of the registrar year should be to develop the skills and responsibilities necessary to identify the registrars' own needs and to deal with their personal as well as their professional development throughout their working life. While, up to now, much attention has been focused on hard science, evidence-based medicine, protocols, and assessment procedures, little attention appears to be devoted to the emotional support and development of the doctors themselves.

Assessment has been aimed primarily at outcome in areas that can be easily measured and is not effective at identifying how secure the doctor feels when dealing with difficult emotional issues in patients, or how prepared the doctor is to enquire into areas that are socially taboo. Education is giving way to learning by rote, protocol, and evidence-based medicine. Little time is set aside during the training year for contemplation, philosophy, ethics, and the development of personal values.

Thirty years ago, terminal care was perceived as a failure of a system focused on diagnosis and cure. In a hospital-setting, the terminally-ill patients were relegated to a side ward, out of the limelight, while the efforts of the team were directed to more hopeful or rewarding cases. The medical support was often inadequate and frequently restricted to large doses of opiates and anti-emetics. There was little knowledge available about the basis or mechanisms that produced the symptoms in terminal illness, or the specific effects of drugs in dealing with them. The few doctors who provided patient-sensitive terminal care did so often without professional recognition and in relative isolation. The concepts and methods they developed were generally not taught in medical school.

It took the insight and evangelistic zeal of doctors like Dame Cicily Saunders and Derek Doyle, and the emergence of the Hospice movement (beginning with the establishment of St Christopher's Hospice in 1967), to awaken us to the possibilities of a more constructive and humanitarian approach. Today, terminal care has lost its negative connotations and has become a recognized discipline. It has acquired an aura of optimism, hope, and fulfilment for both patients and doctors.

In an original paper also published in this issue, 450 general practitioner principals report on their training in palliative care.[1] Their answers reflect some of the changes in terminal care that have taken place over the past 20 years or so, and uncover current needs that are still not being addressed. It reports that, while much of the management of the terminally ill takes place

in hospital, the majority of training is provided in primary care. In hospital, we are told, terminal care is often delegated to poorly-trained junior staff and has had no firm place in the undergraduate curriculum. The paper does, however, report a trend showing an improvement in more recent years.

Stress is near the top of the general practice agenda in the medical press, yet we are still reluctant to address our own anxieties and vulnerability. We ignore the signs of emotional overload in ourselves and have no effective support service. Dealing and communicating well with the dying is stressful; to do this well requires an element of emotional healthiness in one's self. The article reports on the stress that hospital junior doctors experience. All general practitioners will recognize the symptoms of unsupported stress in themselves and may be aware of the coping mechanisms they have developed in response. For harassed doctors, denial and avoidance are attractive options. Professional counsellors have built support mechanisms into the way they work.[2,3] They use other experienced counsellors as supervisors to help them share the stress and improve their skills. General practitioners should seek a similar support system to break their isolation and to enable them to deal more effectively with distressing emotional issues without the danger of 'burn out'. Support systems are not a cheap option. Additional funding would be needed for any appropriate supervisory system. It could be tied in with postgraduate educational activities, educational needs assessments, the use of mentors, and the development of personal educational portfolios.

General practice is currently at the centre of change in the National Health Service.[4] The work of hospitals is devolving increasingly into the community: when they are ill and dying, people feel happiest within their homes and with their families.[5] General practitioners must develop the skills and strengths to deal with this inevitable trend. We need the skills in management to help us attract the resources to primary care,[7] and the skills in delegation to organize the care in our communities. Work must be planned in a proactive rather than a reactive way. We must enable change to work for us, so that practice becomes more effective and more professionally fulfilling. The lessons we have learnt over the years from palliative care have been an important catalyst for change in general practice, and have given it a more patient-centred focus.

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