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EDITORIAL OFFICE
14 Princes Gate, London SW7 1PU
(Tel: 020 7581 3232, Fax: 020 7584 6716).
E-mail: journal@rcgp.org.uk
Internet home page:
http://www.rcgp.org.uk

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January Focus

To start off the new year, we have a remarkable small cluster of papers dealing with palliative care. The history of research in this area has been marked by disappointment, with a number of studies running into problems of recruitment. Here there are three shedding some much needed light into that corner of primary care whose importance is emphasised by the editorial on page 3. If the existence of these papers is something of a surprise, the content will tend to confirm the gut feelings of many clinicians. On page 20, the study from the Netherlands identified four elements of good palliative care: availability; competence; continuity; and teamwork. As one of the participating doctors said: 'For me, good terminal care is … good clinical care.' The study on page 6 looks specifically at the need for good palliative care out-of-hours, and the dilemmas that patients and their carers have to deal with when availability and continuity can be elusive. The editorial underlines the importance of good care out-of-hours: failures can reduce the likelihood of patients dying at home. The practical business of good symptom control is under the microscope on page 27. When assessment of symptoms by patients and professionals was compared, there was more agreement for physical symptoms than mental ones, where the professionals rated the severity higher than the patients did. On a related theme, the debate over euthanasia has recently been reopened. At present it doesn't look very likely that the law in the UK will be changed, but the study on page 14 from Belgium (where it is already legal) illustrates the care that has to be taken over end-of-life decisions, and the sort of process that we should have to implement if it ever became legal here.

Ilora Finlay's editorial also raises another vital question. In a throwaway comment, she mentions rationing decisions. Rationing in the UK has become the elephant in the room, present but never discussed. The government never mentions it, while some commentators in the main opposition party bring it up to imply that it is a fault unique to the NHS. Those of us who have studied health care in other countries know that rationing exists in the medical systems of all western countries, and we long for the subject to be discussed openly and rationally. Anyone who doubts the universality of rationing need only turn to page 60, where the plight of poor Americans is graphically described — rationing by charging. Robust rationing decisions will require equally robust information on the economic merits of conflicting options, and the misuse of such data (in this instance to support the arguments for complementary medicine) is discussed on page 64. In the characteristic way they have of borrowing from other disciplines, medical researchers are beginning to use the technique of discrete choice experiments, mimicking the decisions we all have to make in real life, weighing up the costs and benefits of different options. The theory of the technique is discussed in the editorial on page 4, and an example, trying to assess which aspects of consultations are valued most by patients, is on page 35. The authors report that shared decision making rates lower than modern conventional wisdom would suggest, so we may have to think again about it, at least for a while.

The spirit of the festive season has infected the letters column this month (remember that the Focus column is written early each month, and this one belongs to the anticipation of early December rather than the gloom of early January). One letter from a prescription clerk, is a paean to her employer — perhaps a plea for a Christmas bonus? — and one is a rare, and wholly unsolicited, outburst of praise for the *BJGP*. Readers may think this is an unwarranted exhibition of self congratulation. Since any letter criticising the journal is almost guaranteed publication, we feel that the odd bit of flattery might be permitted.

David Jewell
Editor