Letters to the Editor

PALLIATIVE CARE IN THE COMMUNITY

Sir, I read Dr Donald's article (*Proceedings* 1995; **25:** 550–7) with concern as it reiterates a growing feeling that care for the dying is being transferred from the general practitioner (GP) to the specialist.[1] The impetus for this trend is emphasis on the science of symptom control in palliative care. Consequently, GPs are no longer perceived as sufficiently experienced to undertake competently care which they have always done, and yet continue to do so as an integral part of their role. Unfortunately, the care of the dying is increasingly within institutions, and specialists in palliative care are at risk of becoming symptomatologists with worrying implications for the future.

Most patients wish to die at home and not in an institution.[2] Yet in the UK in 1981 about 59 per cent of cancer patients died in hospital and only 33 per cent at home.[3] Patient's choice of place of death has now deteriorated slightly[2] and in 1990 only 26 per cent of deaths of patients with cancer occurred in the home.[4] Thus death continues to be institutionalised. Despite the growth of the hospice movement, death is hidden away from society, and so inevitably remains a taboo subject for many. For these reasons it is important that dying should be integrated within the community, with the death being in patients' own homes when appropriate.

To facilitate this general practitioners and other members of the primary health care team are in an ideal position to manage the co-ordinated care of terminally ill patients in their own homes. Furthermore, many have already developed and been entrusted with a long relationship with the patient. As there may be exceptions to this, it would seem more effective if appropriate referral for specialist advice when symptoms are not being controlled or the carers are not coping, was further explored.

To ensure that future GPs remain skilled in this area it is important to equip undergraduates with the necessary skills. However, as an undergraduate teacher for many years, I was disturbed when I asked medical students what they would do after they had broken the bad news to a patient that he or she had cancer. Invariably the reply suggested that they would refer to the palliative medicine team.

The competence of GPs in palliative care is discussed by Donald who gives the findings of the GP Palliative Care Facilitator Project 1992–1994. Only 9 per cent of GPs rated themselves as 'good' in managing terminally ill patients. I suspect that GPs are a very modest group of physicians and perform better than they perceive or that they assume that it is a natural part of their practice.

In an unpublished survey conducted in 1992 in the UK and New Zealand, I asked both GPs and consultants (CONS) to provide their perceived ratings (from 0 to 5) of ability and confidence when breaking bad news (BBN), counselling a dying patient (COUNS) and providing pain control (PAIN) to a terminal cancer patient. The table shows that, they rate themselves as quite proficient in palliative care. The mean ratings are higher than might have been expected from the GP Palliative Care Facilitator Project 1992–1994.

Evidently then, there is a role for both generalists and specialists within palliative care and they should work together, aware of each others' skills, and emphasising the long held vision, '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.[5]

TABLE

Perceived personal ratings of GPs and consultants in providing palliative care.

	Sample size	*Response rate (%)*	*BBN*	*COUNS*	*PAIN*
GPs (UK)	16	64	3·56	3·31	3·81
GPs (NZ)	33	66	3·82	3·33	3·81
Cons (UK)	27	36·5	3·26	2·63	3·19
Cons (NZ)	29	22·8	4·07	3·34	3·83

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TOWARDS VICTORY IN EUROPE: THE BATTLE FOR WALCHEREN

Sir, The account by John Forfar (*Proceedings* 1995; **25:** 451–75, 623–38) of the involvement of 47 RM Commando in the D-day landings and the Battle for Walcheren vividly records the vital contribution of the Medical Section to all Commando operations. Where the fighting men went, so did the Medical Section. A wounded man could be certain that he would be treated and evacuated wherever he was—a great boost to Commando morale. Few doctors in the Armed Forces had to meet the physical demands or face the constant danger accepted by the Commando Medical Officer. Front line involvement was common, but I doubt if many doctors, or in fact any, crossed to the German lines—as did Captain Forfar—to advise on the treatment of a wounded German soldier. These articles appearing 50 years after World War II are a fitting reminder to the older generation and a possible revelation to the younger, of the contribution of some of their colleagues.

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THE SUPER SPECIALIST

Sir, I have carried out autopsies in Australasia, the Middle East and the United Kingdom, both in teaching and provincial hospitals. It is with certainty I have come to the conclusion that patients admitted to specialised wards and not suffering from the particular condition in which expertise is offered, are at risk to their lives. For this reason I believe that a doctor who shall be called a Super Generalist is needed. His medical education must be profound with experience of many branches of medicine. He shall be housed with great dignity in the centre of the hospital. There he shall peruse the literature in quiet contemplation for two hours every day. When he goes out of his office he shall carry a golden stick as an emblem of authority and shall be preceded by a clerk. He shall enter all wards, examine any records and during these diagnostic excursions shall rescue patients who are in the wrong environment. He shall be paid twice as much as the consultant.

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College Notices

Deaths of Fellows

GORDON DIGGLE

Dr G. Diggle died on 20 December 1995. He was born on 16 December 1913 and graduated MB ChB (Hons) at Edinburgh University in 1936. Specialising in psychiatry he took the DPM at the University of London in 1939, and the Membership of this College the same year. He was appointed Medical Superintendent at the Mid-Wales Mental Hospital at Talgarth, Wales in 1949 and was a consultant psychiatrist to the Welsh Hospital Board in 1963 until his retirement in 1974. He was elected to the Fellowship in 1972.

KAHAN CHAND KANDHARI

Dr K. C. Kandhari died on 28 July 1995 aged 85 years. He graduated MBBS in Lahore in 1934. After serving with the Army Medical Corps during World War II, he took the DTM at Calcutta University in 1947. He took the Membership of this College in 1951. Specialising in dermatology he was instrumental in this becoming a separate specialty in India. He was Emeritus Professor of Dermatology at the All India Institute of Medical Sciences in New Delhi for 25 years following his appointment in 1970. He was elected to the Fellowship in 1963.

PHILIPPUS JOHANNES KLOPPERS

Dr P. J. Kloppers died on 22 October 1995. He was born on 26 May 1917. He graduated MB BCh (Hons) at the University of Witwatersrand in 1939 and gained his MD there in 1944. Elected as a Fellow of the American College of Chest Physicians in 1946 he became a Member of this College in 1965. He was President of the Association of Physicians of South Africa from 1967–68. He was Professor of Medicine at the University of Pretoria and Head of the Department of Medicine at the H. F. Verwoerd Hospital. He was elected a Fellow in 1970.

DAVID MICHAEL MITCHELL

Dr D. M. Mitchell died on 1 April 1995. He graduated MB BCh in 1933 and gained an MD at the University of Dublin in 1939. Specialising in dermatology he became a consultant physician at the Adelaide Hospital in Dublin. He contributed to the literature and was a member of several professional organisations. He was a former President of the Royal Academy of Medicine of Ireland and former Treasurer of the Royal College of Physicians of Ireland. He was elected to the Fellowship in 1977.

MICHAEL JAMES RAYMOND

Dr M. J. Raymond died on 7 September 1995. Born on 22 March 1922 he qualified at University College Hospital in 1946. After working with the victims in Belsen he decided to specialise in psychiatry and took the DPM in 1953. He gained the Membership of this College in 1956 and was appointed a consultant psychiatrist at Netherne Hospital in 1958. He became a Fellow of the Royal College of Psychiatrists in 1973 and was elected a Fellow of this College in 1982.