

# BRITISH MEDICAL JOURNAL

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SATURDAY 12 MAY 1984

## LEADING ARTICLES

|  |                |      |
|--|----------------|------|
| Nocturnal asthma: mechanisms and treatment       | PETER J BARNES | 1397 |
| General practitioner hospitals: coming or going? | CHARLES D SHAW | 1399 |
| Neuroleptic malignant syndrome                   | E SZABADI      | 1399 |

## CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

|  |   |      |
|--|---|------|
| Abdominal adipose tissue distribution, obesity, and risk of cardiovascular disease and death: 13 year follow up of participants in the study of men born in 1913 | B LARSSON, K SVÄRDSUDD, L WELIN, L WILHELMSEN, P BJÖRNTORP, G TIBBLIN                           | 1401 |
| Relative contribution of humoral and metastatic factors to the pathogenesis of hypercalcaemia in malignancy  | S H RALSTON, I FOGELMAN, M D GARDINER, I T BOYLE  | 1405 |
| How well can we predict coronary heart disease? Findings in the United Kingdom Heart Disease Prevention Project  | R F HELLER, S CHINN, H D TUNSTALL PEDOE, G ROSE   | 1409 |
| Analysis and management of renal failure in fourth MRC myelomatosis trial  | MRC WORKING PARTY ON LEUKAEMIA IN ADULTS  | 1411 |
| Therapeutic venous infarction of an aldosterone producing adenoma (Conn's tumour)  | CHRISTOPHER J MATHIAS, W STANLEY PEART, DANIEL B CARRON, ANNE P HEMINGWAY, DAVID J ALLISON      | 1416 |
| Cyclosporin A nephrotoxicity related to changes in haemoglobin concentration   | SIMON ROBSON, JAMES NEUBERGER, GRAEME ALEXANDER, ROGER WILLIAMS                                 | 1417 |
| Respiratory symptoms related to work in a factory manufacturing cimetidine tablets   | I I COUTTS, S LOZEWICZ, M B DALLY, A J NEWMAN-TAYLOR, P SHERWOOD BURGE, A C FLIND, D J H ROGERS | 1418 |
| Screening for steatorrhoea with an oxalate loading test  | D S RAMPTON, A D McCULLOUGH, JOLANTA S SABBAT, J R SALISBURY, F V FLYNN, M SARNER               | 1419 |
| Testicular carcinoma in situ in children with the androgen insensitivity (testicular feminisation) syndrome  | JØRN MÜLLER, NIELS E SKAKKEBAEK   | 1419 |
| Research in General Practice: Finding funds  | JOHN HOWIE  | 1421 |
| Organising a Practice: Making an appointment system work   | D N H GREIG   | 1423 |
| Mental illness in inner London   | CONRAD M HARRIS   | 1425 |
| Child consultation patterns in general practice comparing "high" and "low" consulting families   | PETER D CAMPION, JENNET GABRIEL   | 1426 |

## MEDICAL PRACTICE

|  |  |      |
|--|--|------|
| Planned and unplanned deliveries at home: implications of a changing ratio               | J F MURPHY, MARJORIE DAUNCEY, O P GRAY, I CHALMERS       | 1429 |
| Major disaster planning  | ANTHONY R BLISS  | 1433 |
| Appropriate Technology: Appropriate technology for diagnostic imaging in small hospitals | P E S PALMER   | 1435 |
| Hospital Topics: Contribution of isolated general practitioner maternity units           | A J M CAVENAGH, K M PHILLIPS, B SHERIDAN, E M J WILLIAMS | 1438 |
| ABC of Asthma: Clinical course   | JOHN REES  | 1441 |
| Clinical Algorithms: Memory loss   | ROBERT A WOOD  | 1443 |
| Any Questions?   |  | 1444 |
| Materia Non Medica—Contribution from JIM THORNTON  |  | 1445 |
| Medicine and Books   |  | 1448 |
| Personal View  | TED LANKESTER  | 1452 |

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|                                 |      |
|---------------------------------|------|
| CORRESPONDENCE—List of Contents | 1453 |
|---------------------------------|------|

|          |      |
|----------|------|
| OBITUARY | 1464 |
|----------|------|

## NEWS AND NOTES

|                  |                        |
|------------------|------------------------|
| Views            | 1461                   |
| Medical News     | 1462                   |
| BMA Notices      | 1462                   |
| One Man's Burden | MICHAEL O'DONNELL 1463 |

|  |                        |
|--|------------------------|
| SUPPLEMENT   | PROCUREMENT SECTION    |
|  | CURRENT SERIAL RECORDS |
| The Week   | 1466                   |
| FPCs; professional conduct; and pay  | WILLIAM RUSSELL 1467   |
| From the council: Frustration over NHS resources                                     | 1468                   |
| Quality assessment in health   | R J MAXWELL 1470       |
| BMA annual general meeting   | 1472                   |
| CCHMS chairman reminds consultants on rules for treating private patients in the NHS | 1472                   |

## CORRESPONDENCE

|   |   |   |
|---|---|---|
| <b>Hospices</b><br>D C Hogg, MRCP; M P Cole, MD; G D Kearsley, MD; H Taylor, MA; G Thorpe, FRCP; K C Calman, FRSE.....                  | <b>Self help in venereology</b><br>D Murray, MRCP.....  | <b>Postmarketing surveillance of adverse drug reactions</b><br>W M Castle, MD, and J A Lewis, FIS....   |
| <b>Obstruction of the urinary tract: a role for surgical intervention in utero?</b><br>I R McFadyen, FRCOG.....                         | <b>Patient information booklets</b><br>Rachel J Inglis, MA.....   | <b>Development of pituitary adenoma in women with hyperprolactinaemia</b><br>J P Sheehan, MRCP, and D A Sisam, DO;<br>A E Pontiroli, MD, and L Falsetti, MD.... |
| <b>Maternal plasma volume and disorders of pregnancy</b><br>R C Goodlin, MD.....  | <b>Medicine in the Third World</b><br>C S Barclay, MB.....  | <b>Hepatitis B and dialysis</b><br>L R Solomon, MRCP.....   |
| <b>Treatment of end stage renal disease</b><br>J B Eastwood, FRCP, and others.....  | <b>What carbohydrate foods should diabetics eat?</b><br>D L J Freed, MD.....  | <b>Staining of the bath by dithranol</b><br>A P Warin, FRCP, and others.....  |
| <b>Acute stridor in a preschool child</b><br>J L Emery, MD, and Elizabeth M Taylor, MB; A D Milner, FRCP; M Hardingham, FRCS.....       | <b>Drug induced Parkinson's disease</b><br>J Williamson, FRCPED.....  | <b>The GMC should be more concerned with the postgraduate rather than the primary qualifications of overseas doctors</b><br>J A Strong, CBE.....                |
| <b>Idiopathic ulceration of the small bowel</b><br>J F L Shaw, FRCS, and E McDermott, FRCS; M J Glynn, MRCP, and R A Parkins, FRCP..... | <b>Fractures and hypercalciuria: two markers of severe dependence in alcoholics</b><br>S De Marchi, MD, and others..... | <b>More doctors, less pay</b><br>R Hopkins, FDSRCS.....   |
| <b>Sexually transmitted diseases in pregnancy</b><br>A M Bell, MB, and others.....  | <b>Haemoperfusion in acute intermittent porphyria</b><br>V Kordač, MD, and others.....                                  | <b>How large is the problem of medical negligence?</b><br>A Simanowitz, DIPLAW.....   |
|   | <b>Risks of radioiodine treatment of thyrotoxicosis</b><br>K E Halnan, FRCP.....  |   |

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*Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.*

## Hospices

SIR,—As a general practitioner for the past nine years I was amazed that general practitioners and general practice were not mentioned in Dr Tony Smith's leading article on hospices (21 April, p 1178). I have looked after many dying patients at home. I always give them my home telephone number, and I consider the art and care needed in looking after the dying as central to my job as a general practitioner. I find this a most rewarding part of my work.

I have watched with alarm the rapid growth of hospices and am baffled by whose patients are going into them to die. They are not mine, and I question the need for hospices. I consider the care of the dying to be very much the duty of the general practitioner.

For patients living alone it would be advantageous to have somewhere where the patient could be admitted, but he should still be under the care of the general practitioner.

The passing years have seen the erosion of the clinical compass of most of general practice. Is the care of the dying also now to pass out of the hands of general practitioners? That an article such as Dr Smith's could have been published without mentioning general practitioners is an indication of how serious this problem is from the point of view of good, conscientious general practitioners.

D C HOGG

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SIR,—I read with misgiving Dr Tony Smith's leading article on hospices. I agree that there

has not been a policy in most regions for establishing hospices and that therefore there is not uniform support for them from the NHS. But I would want to point out that the "well intentioned amateurs" to whom he refers established hospices in response to an obvious need that the NHS was not meeting. The public has enthusiastically endorsed this work with both money and voluntary work. Dr Smith suggests that this era may have to give way to "hard headed professionalism." I wonder why he thinks this preferable when the professionals did not start the hospices.

Part of the strength of hospices has been their informality and their caring for the individual patient and his family, which may be lost sight of by professionals.

M P COLE

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SIR,—More consistent NHS help is urgently needed for some of the 40 independent hospices. Dr Tony Smith does not emphasise the importance of the growing number of hospital support or pain control teams. There are at present three of these attached to hospices, eight with home care teams, and five others. Nor does he emphasise the urgency of having a senior doctor, oncologist, or anaesthetist specialising in pain control or a general physician who is responsible for advice on terminal care.

Especially in these days of limited NHS funds everything must be done to encourage voluntary input into terminal care, but every-

one must recognise that coordination and advice (but not dictation) from a central body is urgently needed.

There is a need for regions to review their terminal care facilities and for districts to report to them on this element in their operational plans. Likewise, there is a need for more instruction of the medical profession, both undergraduate and postgraduate, in the recent developments in terminal care.

G D KEARSLEY

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SIR,—Dr Tony Smith poses the question whether care of the dying should be part of the NHS or shared with the private sector. Surely there has never been any doubt that most dying persons have and will continue to be cared for by the NHS. The issue which the hospice movement raises is the quality of that care. The criticism of conventional hospital practice is that in concentrating on the physical symptoms it often ignores the human dimension. Although compassionate and dedicated care is rendered to the physical needs of the dying, there is less time for personalised attention and psychological support that maybe required.

Hospice care in contrast seeks not only good symptom control but also attempts to create an environment in which the emotional and social needs of patients and their families are met. The care of the dying is managed with greater dignity and sensitivity. This highly personalised approach is not a distinct