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MEDICAL PRACTICE

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CORRESPONDENCE

We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

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.

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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.

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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 everyone 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