30 years of age; in a non-hierarchical structure general practitioners have few career goals to strive for. Partnerships, like all groups, may have a natural lifespan. Practice vacancies should not be the preserve of the newly qualified vocational trainee nor should the experienced general practitioner applying for a practice vacancy be viewed with suspicion as such an exchange may invigorate the doctor and the old and new partnership.

It has to be admitted that we do not know the extent of the problem of burn out: it may be just American hype. Still there are many similarities between the burnt out and the bad doctor and the figures for alcohol problems in general practitioners are not receding. It would be sad if we ignored burn out; it is an aspect of bad doctoring that can be prevented or arrested in its earlier stages and understood in its later stages.

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Useful address: National Counselling and Welfare Service for Sick Doctors, 3rd Floor, 7 Marylebone Road, London NW1 5HH. Telephone 01-580-3160.

The dying child at home

In recent years there has been increasing interest in the care of the incurably ill and dying child. A children's hospice, Helen House, has operated in Oxford for four years[1] and another near Leeds, to be known as Martin House, will open during 1987. Recently national meetings to discuss the provision of terminal care for children have been sponsored by the King's Fund Centre[2] and by Help the Hospices. Children's hospices have also been discussed in the correspondence columns of *The Times*.[3] As might be expected there is complete agreement that whenever possible the dying child should be cared for in his own home. When this is not possible the child could be cared for in the paediatric ward of his local district general hospital. Children's hospices can help to meet the extreme needs of a few families but in the UK no more than two or three such establishments can be justified.

Much of the work on home care of dying children has been carried out in the USA[4,5] but there have also been contributions from the UK.[6] General practice has played little or no part in the current debate on children's hospices or in contributing to the published work. Perhaps this is not surprising as few general practitioners have responsibility for more than one or two terminally ill children in their entire careers. On the other hand all family doctors spend a large part of their time dealing with children and some time dealing with the terminal care of adults at home. In all practices children die every year from accidents and in the perinatal period. These areas of work provide experience which family doctors should draw on when required to assist families caring for their dying child at home.

Adequate nursing support and a concerned and committed doctor are invaluable to a family managing the illness of their child at home. Indeed, in the absence of one of these factors it is unlikely that they will be able to cope at home whatever other resources are available to them. Although many general practitioners are willing to provide this support, our experience at Helen House suggests that others are either unable or unwilling to help in this way. Some families have lost trust in their doctor and feel unable to approach him, while others have been denied help.

Martinson and Enos[7] have identified six conditions which must be met before successful terminal care at home is possible:

- Cure-oriented treatment has been discontinued and the emphasis is on care and adding quality to life.
- The child wants to be at home.
- The parents desire to have the child at home.
- The parents, other children in the family, and/or significant others recognize their own ability to care for the ill child.
- A nurse is available and willing to be on call 24 hours a day for professional consultation and support.
- The physician agrees with the plan and is willing to be on call as a consultant to the nurse and to the family.

The general practitioner may be involved in deciding if terminal care at home is possible. His contribution will be especially important if he has remained involved with the child's care from the time of diagnosis. A child's attendance at a regional or national centre for specialized treatment does not reduce the importance of the family doctor and should not be used as an excuse for lack of involvement. In all cases the provision of nursing and medical cover in the home will depend greatly on the attitude of the doctor and the primary health care team. This care demands a commitment which cannot be limited by rotas but equally must be shared so that no single person — parent, nurse or doctor — feels isolated.[8] The control of pain and other symptoms in the dying child is less well documented than for adults but practical advice is available.[8-10]

In some health districts nursing cover can present problems. In the best circumstances a community nurse with paediatric training will work closely with the general practitioner and the health visitor. Macmillan nurses trained in the terminal care of adults can often make a valuable contribution. In less fortunate health districts community nurses with paediatric training may not be available. This is a disadvantage but is not insuperable as what is required is basic nursing care and love.

Much of the interest in quality assurance in general practice has concentrated on the provision of the major services which form the backbone of general practice. If we are to give due weight to quality then this word must also be applied to infrequent episodes such as terminal care in childhood. The families of dying children do not ask for specialist expertise but for help with the control of symptoms and the mobilization of community services. Above all they ask to be listened to and acknowledged as the experts in the care of their own child. This is work which primary care teams could be undertaking more often than seems to be the case at present.

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